# Standard Operating Procedure

# Caseload Team Midwifery Practice

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**Key Amendments**

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| January 2021 | Document updated and approved at maternity Governance | Maternity Governance |

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| 1.0 | Feb 2019 | Caitlin Wilson: Consultant Midwife<br>Louise Turbutt: Matron for Community Midwifery | Commence Teams |
| 1.1 | 01/11/19 | Caitlin Wilson, Consultant Midwife | Change to escalation and sickness cover |
| 2.0 | 1st Nov/20 | Caitlin Wilson, Consultant Midwife | |

## 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 continuity of carer team in the community and all maternity staff working at WAHT.

## Definitions

| Term | Definition |
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| MCoC | Midwifery Continuity of Carer |
| 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.

- Continuity Team Leader: The team is expected to self-manage day to day workload, off duty, study leave and annual leave and caseload allocations. The team leader is shared with other teams and has the oversight of overall operations of continuity of carer teams. The team leader will support the team with sickness, absences, annual appraisals, equipment maintenance and ordering, stock, estates issues. The team leader is also expected to review monthly hours worked ensuring that any time that is owed or owing is highlighted and a plan is in place to support the team.

- 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.

**Staffing**

Teams will consist of 4-8 midwives (approximately 6.2WTE) in order to operate successfully. Each Team will have an identified team leader (Band 7) who will be operational support to the teams (equipment, PRDs, sickness monitoring, estates issues, staffing issues and hours monitoring monthly and at 17 week intervals as per AfC).

Continuity of Carer team members will maintain close working relationships with the obstetric team (and named consultant for the team), the safeguarding team, midwifery management team and Lead for Continuity of Carer.

The team will hold weekly meetings to ensure that referrals and managed and allocated appropriately and actioned in a timely way, co-ordinate activities, encourage reflection and learning and to ensure quick resolution to any issues

Regular engagement and sessions with PMA and team coaching is expected to support the teams.

**Sickness**

Any sickness needs to be reported in line with the Trust Sickness and Absence Policy (insert link here)

Where sickness is short term (ie less than 2 weeks), the team will work together to cover outstanding availability for labour care (on calls) where possible. Long term sickness (more than 2 weeks) the team will not be expected to cover the ongoing workload. Team leaders are responsible for supporting the team in reallocation of work and inform Matron for Community Midwifery and Continuity of Carer and Matron for Intrapartum Services and Consultant Midwife.

**Annual Leave, Study Leave, Rosters and Requests**

Midwives are expected to work in a flexible way, balancing their hours over a 4 week roster period. Team members are required to keep a log of hours worked. These are to be submitted on weekly basis for e-roster input. Each team will have an allocated e-roster data entry administrator.

Each team is to have only midwife off on annual leave at one time, where possible. The team are to work together to ensure that leave is effectively planned across the year.

Each member of the team is responsible for ensuring that have and take their protected days off each week. The team will work together to ensure that overnight on calls are not allocated before a day off or the last working day before commencing annual leave.

Study leave to be negotiated with Team Leader (such as Masters Degree, NLS and NIPE or conference attendance). The allocation of caseload is to reflect the allocated study leave. Where possible, course attendance should be booked well in advance to allow for caseload planning and allocation.

Rosters should be planned as far in advance as practical for the team and available for the team to view a minimum of 12 weeks in advance (Trust Policy link here). The team leaders are responsible for ensuring that this occurs.

**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.

**Availability/On Calls**

At full establishment the team are expected to provide 24/7 on call availability for women in their designated continuity of carer team. Each team may vary how they prefer to organise the on call responsibilities but midwives can expect to be on call 2-4 times a week recognising that this may vary across the monthly roster.

Each team member will have an allocated work mobile phone. This will be diverted to on call colleagues when off duty, on protected time off or annual leave. Text messaging will have an automatic reply set when off duty, on protected days off or annual leave.

Teams are expected to manage, plan and priortise the delivery of service to women booked under their care.

Teams are not expected to be part of the routine escalation policy (insert escalation policy link here). Exceptions may apply and this decision will be made by the Director of Midwifery.

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.

**Referrals**

Generic 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.

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

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 as well as complexity and parity.

**Availability for Out of Hours Labour Care/Emergency Care**

Day time

When scheduled to be available, 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.

Night:

The on call midwife will take all calls for the team; The on call will be responsible for home assessments, triage calls and attend a woman in labour.

The team is responsible for diverting their phones to the on call midwife.

## The Continuity Journey

### Team Principles

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) midwife to ensure there is a designated midwife overseeing care in the absence of the named midwife.

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 and meet with midwife sessions on a monthly basis. This can be virtual via Microsoft Teams (no confidential information to be shared on these platforms).

When fully staffed (6.2 WTE), the continuity of carer midwifery team will provide 24/7 care coverage for women on the caseload model. Team is to work together to ensure 24/7 coverage of workload and determine how out of hours care labour care is covered (ie overnight)

Where women have complex social needs the overall caseload booking for the month need to be reduced to reflect the workload. Examples where caseload can be reduced by 1 would be: homelessness, interpreter required, substance misuse what is role of the specialist midwife in these cases

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, Consultant Midwife and Matron for Community Midwifery and Continuity of Carer.

Any notes with personal identification of women will be securely stored at all times as per Trust Policy (link here)

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

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 MCoC 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. Overnight availability for students is to be flexible with consideration to the students' own availability and ability.

**Antenatal Care**

Women who are eligible for allocation to a continuity of carer team, should be booked as soon as possible following referral. 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.

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/co-ordination of the care pathway. Contact details of the named midwife and the rest of the team should be given to the woman at the time of booking.

Continuity midwives should follow WAHT guidance for antenatal care including the schedule of visits.

Referrals for midwifery continuity of carer may come via the Consultant Midwife in the Consultant Midwife clinic, if these women are deemed to benefit significantly from continuity of carer (ie previous traumatic birth). This will be discussed with the designated team on a case by case basis.

Women attending triage for assessment who require transfer to the intrapartum area, the designated continuity team midwife (if not the named midwife) should endeavour to attend as soon as possible. The midwife in triage or labour ward (if transferred immediately) will provide care to the woman until the continuity of carer midwife attends. Where women have attended triage or DAU and returned home, the continuity midwife will follow up with the triage/DAU team regarding the outcome of admission and any ongoing plan.

Where women are admitted to the antenatal ward during pregnancy, the continuity of carer midwife/or team will aim to review the woman once a day, and continue to co-ordinate care

with the core staff in the maternity unit. Routine care is expected to take place between 9-5 pm daily.

If a woman requires and induction of labour (IOL) the continuity of carer midwife/or team will commence the IOL process, where possible, following WAHT guidance for IOL. This will take place during 9-5 and the continuity midwife if not expected to attend for IOL commencement if there is a delay to the process due to beds etc. The continuity midwife is not required to stay with the woman in the absence of uterine activity/other needs requiring 1:1 care. The MCoC midwife will commence care once the woman is requiring labour care or 1:1 care and is being transferred to labour ward.

**Care in Labour**

Women in all continuity of carer teams should be counselled about choice of birth place and birth preferences in line with current guidelines. Woman can be referred to the Consultant Midwife where birth choices would indicate birth on the obstetric unit. Collaboration with the MDT and the woman is required to ensure that the safest plan of care is in place support the choice and preference of the woman.

Midwives will be expected to follow WAHT guidelines for Intrapartum Care

Elective caesearean sections should be attended by the named midwife where possible and continued until the woman is stable

Women should be made aware of signs of labour and encouraged to contact their named midwife directly. Women need to be informed that if their named midwife is not available/off duty they will be able to speak with another member of the team through the phone divert system.

Women requiring assessment for rupture of membrane or labour, the continuity midwife on duty will arrange to meet the woman at her home or hospital, arranging to continue care as required. This assessment is expected to take place within 60 minutes of advising the woman that an assessment is recommended.

Women who are deemed low risk at the onset of labour may be offered a home assessment by the midwife on duty. Women can be offered the choice to remain at home for the birth of her baby following a complete assessment for suitability and discussion with the team, the woman and any birthing partners.

Where women choose to birth at home, the attending midwife on duty is responsible for ensuring that all appropriate equipment and supplies are available at the woman's house and that a second midwife can attend following homebirth guideline.

Where a woman requires 1:1 intrapartum care, the on call midwife will provide this for no more than 12 hours continuously or sooner if they feel unsafe to continue. Handover to the team should be arranged if the woman requires ongoing labour care. If there are no team members to take over due to sickness/sleeping/multiple labourers at one time, then the woman's care will need to be handed over to the unit staff, with an aim that the continuity team will resume care as soon as possible and safe to do so.

Where a continuity midwife is on the unit caring for a woman in labour, it is the responsibility of the Band 7 co-ordinator to ensure that meal breaks are provided.

All documentation and transfer of the woman to the postnatal ward should be completed by the continuity midwife attending. Once transferred to the postnatal ward, care will be handed over to the core midwifery staff on the ward.

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.

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.

**Postnatal**

Postnatal care should follow the WAHT postnatal care guideline

Women and babies on the continuity 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