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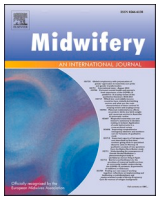

Sustaining continuity of carer in practice: a service evaluation of a local maternity system in Northwest England

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ABSTRACT

Where midwifery is integrated fully into health systems, evidence demonstrates that relational, midwifery-led continuity of carer (MCoC) improves biopsychosocial outcomes for birthing women, people and babies. MCoC is where one or a small team of midwives are the lead carer throughout the childbearing continuum regardless of place of birth, pre-existing or emerging risk factors; working with multidisciplinary professionals if required. In England, wide-scale system changes and implementation were underway to scale up MCoC. However, this was halted due to multiple complexities following the pandemic and ongoing staffing issues. Our mixed method study carried out in 2021 was an external research evaluation across a region of four NHS sites who were at different stages of MCoC implementation. Here we report qualitative insights capturing the successes and challenges in four different contexts to help guide the reintroduction of MCoC services. Recruitment was conducted via stakeholder events and social media; included 123 survey participants (68 providing qualitative data) and 28 interview participants. Thematic analysis was carried out with a global thematic network approach to interpret the data. One global theme of 'Making it Work: Sustaining MCoC' was developed comprising of four organising themes - 'making a difference', 'making a start', 'making it count', and 'making it fit'. Collectively, these findings highlight what works well for staff, families, and the service, alongside MCoC challenges and how to overcome them. These findings offer practical insights to support successful implementation - 'making it work: future transformations' – critical to the ongoing sustainability of a service wide transformation.

Introduction

The World Health Organization (WHO) (WHO 2024) recommends transitioning to midwifery models of care as a cost-effective, lifesaving strategy to improve the wellbeing of mothers, families and their babies. These models include midwifery-led continuity of carer (MCoC) - whereby one or a small of team midwives care for birthing women and people throughout the childbearing continuum, liaising with the wider multidisciplinary team if/when required (WHO 2024). Such models have strong evidence demonstrating improved maternal-neonatal biopsychosocial outcomes in comparison to usual models of care (Sandall et al., 2016; Sandall et al., 2016). Qualitative findings demonstrate that midwives and women value the cultivation of meaningful relationships across an extended period of time that is underpinned by 'getting to know' each other, and personalised care (Dharni et al., 2021; McInnes et al., 2020; Pace et al., 2020). As a complex intervention the mechanism of effect that underpins MCoC is not entirely clear (WHO 2024). However, relational care is theorised as a key mechanism of improved outcomes; women benefit from having an advocate, someone to navigate complex care and receiving care/support for decision-making by a known professional (Sandall et al., 2016). Moreover, the WHO acknowledge that the recommendation for MCoC is context specific – it requires well-functioning midwifery programmes and integrated midwifery care for successful implementation and sustainability purposes (WHO 2024).

In England, the conclusion of the 2016 maternity review *'Better Births'* was that the maternity services should be safe and personal (NHS England 2016). McoC was recommended as one of the main proposed changes in policy and has been at the heart of the National Maternity Transformation agenda (NHS England 2016; NHS England 2017; Sandall, 2018). McoC encompasses the philosophy and commitment of *Better Births* to provide personalised, relational, and safe care, but

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requires system-wide change of maternity services (Sandall, 2018). Rather than staffing the 'building', staffing resources need to be reallocated away from hospital settings (but with some core staff required for a safe service) into small teams of midwives working in the community. Essential to the success of the model is for midwives to be enabled to have control over their working patterns/diaries, cultivate relationships with women, and supportive teams to maintain the crucial work-life balance (Sandall, 2018). While the NHS Long Term plan offered policy direction with explicit directives for maternity units throughout England to increase and fully implement their McoC establishment by 2022 (NHS England 2017), challenges during and since the pandemic halted wide-scale implementation (Sandall, 2018; McCourt et al., 2023; NHS Digital 2022; Royal College of Midwives 2022) e.g., in 2022, the Ockenden Review was published, a national inquiry into a failing maternity service, recommended pausing MCoC until safe staffing could be ensured across England. While some MCoC services remain, the national strategy has been paused.

In this context, in 2020, we were commissioned to carry out a regional evaluation of the implementation of MCoC across the maternity services within North-West-Local Maternity and Neonatal System (NW-LMNS) in England. This region included four maternity organisations (covering an urban and rural wide geographical area) which had set up a range of MCoC teams, who were at different stages of implementation. At the time, there were reports of local challenges and barriers to the implementation and successful sustainability of MCoC teams. Therefore, we sought to evaluate the service; - exploring the facilitators and barriers from a range of stakeholders across the service, the perspectives of those within and outside of MCoC teams, to explore which models of MCoC worked/did not work and why, the percentage of women on the MCoC pathway and their outcomes. However, there were many data limitations (e.g., the organisational data systems were not designed to capture the quantitative insights) which meant the full evaluation was incomplete. However, we successfully conducted a mixed-methods survey and carried out qualitative interviews across the NW-LMNS capturing important insights to guide future organisational readiness for when MCoC is resumed. The purpose of this paper is to report on the qualitative findings from those who were working in the various MCoC teams from across the region to provide local insights to the facilitators and barriers, the benefits and challenges of implementing such a national strategy within complex maternity systems.

Methodology

Research design

A mixed-methods service evaluation design was used and this paper reports on the qualitative findings related to those working within MCoC teams to share insights of their experiences of early adoption, implementation, the 'everyday' working of MCoC teams and in some cases sustained MCoC.

Setting and context

The NW-LMNS consists of four NHS maternity services with geographical variations which are highlighted in Table 1. The study commenced Nov 2020 and finished April 2021, notably during a time of great uncertainty regarding the COVID-19 pandemic with differing degrees of impact across these four services. Regarding MCoC implementation or sustaining the services, initially all services continued with progressing their plans which has been captured in this study. Whilst an extreme and unusual context for the study, we still managed to capture important insights specifically regarding MCoC implementation and sustainability which has longer-term applicability outside of the pandemic.

Recruitment and participants

Recruitment was carried out via our stakeholder and professional networks within the North-West-Local Maternity and Neonatal System (NW-LMNS) and social media platforms. Purposeful and snowballing techniques were used, however, given the timing during the peak of the pandemic, there were challenges to recruiting service users. For the

Table 1
Site contextual information.

Site	Births p/ year	Maternity service structure	Number of MCoC teams	MCoC team models	Sustainability
1	~4600	1 obstetric unit 1 adjoining birth centre 1 freestanding birth centre Homebirth service	4	A city-based geographical team. A homebirth team. A diabetic specialist team. A birth centre attached geographical team.	Services sustained during and beyond COVID-19 with adaptation to caseloads, intrapartum cover and individual continuity.
2	~6000	1 obstetric unit 1 adjoining birth centre 2 freestanding birth centres Homebirth service	2 established 2 in early stages (teams confirmed and prep to launch underway)	A geographical team. A diabetic specialist team. (Further two – geographical in planning during the study)	All teams disbanded following COVID-19, removal of national compliance monitoring in response to national safe staffing guidance. One geographical team reformed in late 2024 based on Core20Plus5 enhanced continuity priorities to address inequities in outcomes and experiences for vulnerable, marginalised and minoritised childbearing women, people and families.
3	~3000 awaiting info	2 obstetric units 1 freestanding birth centre Homebirth service	1	Geographical team (disbanded during the study)	No recovery following COVID-19, removal of national compliance monitoring in response to national safe staffing guidance.
4	3000	1 obstetric unit 1 adjoining birth centre Homebirth service	0	In the process of setting up their first MCoC team during the study.	No progress following COVID-19, removal of national compliance monitoring in response to national safe staffing guidance.

NB:.
Geographical teams: 8–10 midwives with caseload ratios 1:32–42 based on the NHS England's Better Births Continuity of Carer model.
Diabetic teams: 8–10 midwives with caseload ratios 1:42–62 approx. based on team continuity.
1 homebirth team: 8–10 midwives with caseload ratios 1:36–42 based on caseloading models.

overall study, eligible participants were maternity professionals, students and service users from all four sites whether they had or had not experienced MCoC. For the purposes of this paper, we have only included the participants who had experience of working within a MCoC team or received care by such a team.

Consent and data collection

Two forms of data collection were carried out: a mixed method survey and interviews.

Survey

The online, confidential, and anonymous survey was created via Qualtrics to explore staff perspectives, experiences, and insights into MCoC. This was open to all staff whether they were working in MCoC teams or not, captured demographic and professional information where consent questions were built into the first part of the survey (see Supplementary File 1).

Interviews with maternity staff and service user(s)

During the recruitment phase, potential participants who made contact with the team were sent a Participant Information Sheet and consent form and for those wishing to participant, semi-structured interviews were undertaken to explore participants understanding, involvement and experiences of MCoC. Demographic information was collected. Interviews were carried out by AB and CF recorded on Microsoft Teams, uploaded to the University secure network before being deleted from the Teams space. Service-user participants were offered a £20 voucher to thank them for their participation.

Data analysis

Interviews were transcribed by an external company, reviewed, checked and anonymised by AB and CF. All qualitative data (interviews and open text responses) were analysed using Stirling's (Attride-Stirling, 2001) thematic network analysis method. This involved identifying codes and descriptive themes (basic themes) and then re-categorising the themes into more abstract principles (organising themes). Thereafter, organising themes were drawn together to encapsulate key metaphors as global themes, using a web-like map to present the salient relationships between these groupings (Attride-Stirling, 2001). Ongoing discussions within the research term enabled reflexivity throughout analysis.

Ethics

Ethics approval was received by the Health ethics sub-committee at the lead author's university (project no: HEALTH 0128) and governance approval was granted by the three NHS Research & Development departments.

Reflexivity

The four authors are from a midwifery ($n = 2$), health science ($n = 1$) and psychology ($n = 1$) background: all are mothers and three have a background in perinatal research. The midwifery staff led on the interviews, with insights shared with the other team members on an ongoing basis to prevent against potential biases influencing what was captured. All the team members believed in the importance of continuity of care for women and families, and that appropriate infrastructure, leadership and resources was essential for a safe and equitable service.

Results

From across the dataset, we have included the qualitative views of 18/26 survey participants and interview data from 26 midwives (all working within a MCoC team), one stakeholder (involved in the implementation of MCoC) and one service user (who had received care from a MCoC). Across the sites, we interviewed 10 midwives from Site 1; 9 midwives from Site 2 and 7 midwives from Site 3 (see Table 2 for demographic information for these participants). As there was only one service user and one stakeholder recruited, their demographic data is not presented to ensure anonymity.

Making it work: sustaining MCoC

Here we present the global thematic network 'Making it Work: Sustaining MCoC' (Fig. 1) which illustrates how local services are supporting and sustaining MCoC across the system. The global theme is underpinned by four organising themes 'making a difference' 'making a start: preparing for MCoC', 'making it count: everyday continuity' and 'making it fit: overcoming hurdles' to describe the essence of supporting and sustaining MCoC. We present each of the four organising themes in turn before drawing together the key recommendations in the discussion 'Making it Work: future transformations'.

Making a difference: meaningful midwifery

This organising theme describes how MCoC was seen as 'making a difference' for staff and service-users alike; both through reciprocal care benefits and professional development opportunities. From the qualitative interview data, many participants working in McOC teams felt the model offered '*a positive change for everybody*' and '*a whole different way of working*' [SITE_ 1_Staff 09], thus a radically different way of working. Participants were enthusiastic about the mutual benefits of continuity including providing better care for women through more time for each appointment believed to help facilitate better and trusting relationships with women. Being available to offer advice or reassurance in a timely manner within such an established, trusting relationship was considered to improve outcomes for participants and women, including those with more complex needs.

> *'I am more 'with woman' now than I have ever been in my career. I know my women; I know when something is not quite right and know their needs and wishes. I thought I had that on community, but I actually didn't. Now I know how case-loading facilitates time to care for women.*' [SITE 1_MCOC_Survey]

Such enthusiasm was expressed by some MCoC midwives as offering

Table 2
Midwife demographics.

Ethnicity		Year's qualified	
White British/Scottish/Irish	24	0–2	2
British Asian	1	2–5	4
Pakistani	1	5–10	6
		>10	14
Band		**Prior experience of MCOC**	
Band 5	1	Yes	13
Band 6	13	No	12
Band 7 or 8	10	Unknown	1
Band 6/7 shared position	2		
		Time in current MCOC post	
Position		0–2 years	15
MCoC midwife	15	2–5 years	3
Manager/leadership position supporting MCoC	8	5+ years	1
Joint role (leadership practice)	2	Unknown	5
Hospital	1	N/a	2

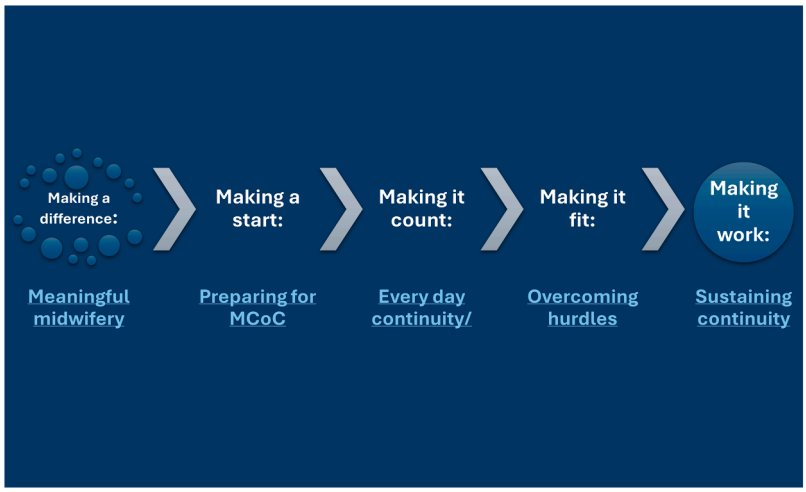

Fig. 1. Global Theme: 'Making it Work: Sustaining MCoC'.

them a meaningful sense of purpose, a *'dream job and the sort of midwifery that made me want to be a midwife'* [SITE3_STAFF_03] and where there were pressures within their role, this positive sense of purpose helped mitigate this in practice, *'outweighing the challenges'* [SITE1_Staff 07]. For most staff, the relationships and connections they forged with women and families in their care generated the most meaningful midwifery moments. Building a relationship through *'familiarity and service'* enabled midwives to offer more holistic needs-led support.

Additionally, midwife participants shared how MCoC offered important learning and development opportunities where these midwives valued the opportunity to work in diverse areas across the entire midwifery scope of practice. This approach enhanced their professional accountability, maintained and developed their midwifery skills particularly in midwifery-led birthplace settings. Furthermore, the independent working encouraged taking greater responsibility for their own knowledge, skills and problem solving further elevating their confidence and competence:

> *'I think the learning is amazing, because you have to learn because you're on your own and you've got to find the answer, so you, you do, you find the answers. So it's made, made me more confident and more independent and being able to just do, do things myself and figure it out, rather than being in, on a ward where you just ask somebody'* [SITE1_Staff 07]

Such individual responsibility for women and families' care, needs and outcomes also came with challenges particularly during the transition to MCoC models where initial feelings of overwhelm due to the *'relentless'* nature of the model were reported. However, most participants discussed how this was part of the learning cycle and transition to MCoC working:

> *'I think after a while you get used to it and you get used to being able to go, no I've finished now, and that's the end of it. But at first it is quite difficult to get yourself used to that, because these women are constantly on your mind'*. [SITE 1 Staff 07]

Making a start: preparing for MCoC

This organising theme captures participants' perspectives on 'making a start: preparing for MCoC' that outlines the early preparation to commence the MCoC transformation; a time of uncertainty and a lack of clarity of just how to set up the teams. For example, some midwives interviewed shared during the early planning stages there was a lack of national direction with little guidance of *how* to initiate implementation or what it would look like in reality. As such, prior to setting up the first teams, extensive preparation was undertaken by some of the midwifery leaders. This preparation varied across the sites. At SITE 1 this was shared across senior leadership and the MCoC lead, at SITE 2 and SITE 3 this was primarily led by the continuity of carer leaders (Band 7). Regardless of approach, all leaders interviewed, reported that early preparation took time, with some describing the initial landscape as '*cloudy*' and '*a struggle to start to look for one team'* [SITE2_STAFF_01]. This led to sites taking tentative, step-by-step approaches:

> *'lots of meetings, head scratching, how might this look? What might this look like? What are the different models?'* [SITE1_STAFF_ 01].

Choosing which MCoC model/s to implement was based on experience and sharing knowledge from other maternity services. Care was taken to think about skill mix and experience level of potential MCoC midwives with considerations to the potential implications of working patterns and/or part time working. Therefore, there was a lot of trial and error, over the first phases of implementation and this transitional time was valued for *'finding their feet, figuring out what to do'* [SITE 2_STAFF_02]. This included taking bold action to '*completely unravel'* [SITE1_ Staff_ 02] an early complex care MCoC model that was unsustainable and did not meet *Better Births* recommendations:

> *'As it stands at the moment, it's not a continuity model, it is hybrid set of midwives who are working in exactly the same way that they always have, there's no clear… there's no clear vision for how that's going to become continuity from the women's point of view.'* [SITE3_ STAFF_ 04]

In addition to choosing the type of MCoC team, care was taken to consider the training needs of the incoming MCoC midwives; some had previous experience of working this way and others did not. Participants yet to start in their team identified they would need '*support from fellow midwives who are out there'* [SITE 2_STAFF_07] and that each team member would have different skillsets, *'with strengths and weaknesses'*, that could be used in a collaborative way for shared support. Additionally, ensuring staff had access to clinical supervision was considered important and put into place to facilitate the new ways of working. Some of the more experienced midwives were mindful of those less experienced and took team managerial tasks as a supportive measure:

> *'As a more experienced midwife, I sort of feel a bit more responsible for making sure that the team is run well because they're dealing with enough and they don't want to be worrying about the off-duty or the holidays or the things that we're sort of taking ownership of.'* [SITE2_ STAFF_03]

In some instances, the challenges were transitional as midwives adapted the model and way of working. For example, getting used to night on-calls or getting called out frequently in a short space of time and the subsequent tiredness were difficult. However, the midwives reported

either getting used to it or accepting the ebb and flow *'usually balances out'* [SITE1_MCOC_Survey] and one participant acknowledged that improvements to the running of the team *'couldn't happen until you have actually worked in the model'* [SITE 1_MCOC_Survey]. Other early issues raised related to system challenges such as IT systems and the booking system (women's initial appointment into the service). At SITE 1, the lack of end-to-end IT system was a key challenge when identifying the 'correct' women to start receiving MCoC based on initial predetermined eligibility criteria. This meant midwives had the time-consuming task of physically attending various clinics to manually '*sift through folders to find women of the relevant gestation for the team, for when it commenced of the appropriate postcodes etc.'* [SITE 2_STAFF_01]. Additionally, each site had to manually create a new data management system with the expectation that continuity midwives would input data for each care episode for reporting and evaluation purposes. All these challenges were described as excessively time consuming and problematic. At the time of the interviews, a new end-to-end system was being implemented across the LMNS which should overcome the IT issues and challenges.

Furthermore, engaging with all maternity staff across the service was viewed as essential and instrumental to driving the changes. Initial and ongoing engagement events were viewed as vital to the system-wide change so they could '*spread the news and experiences of our good work …'* [SITE 1_MCOC_Survey], and to overcome preconceptions or challenges from the wider maternity teams. Such engagement events had reported success. For example, one participant [SITE 2_STAFF_07] was inspired to join a team where videos and insights about MCoC were shared.

Making it count: everyday continuity

This organising theme captures the participant views, perspectives and experiences of 'everyday continuity' and how staff make their work count for women, people and families alongside their colleagues, the wider service and their own personal lives. For example, ensuring care was covered for the essential visits was important to the midwives and involved a lot of consideration due to the unpredictability of on-calls and uncertainty of staff availability on any one day. However, *'being in charge of your own workload, with flexibility'* [SITE 2_STAFF_06] was a mitigating factor of this potential stressor. Individual autonomy within an autonomous team was viewed as essential to making the day-to-day work. However, if self-management was not enabled it had a negative impact. For example, one midwife reported she was '*misled into the idea of managing own workload*' creating tensions and barriers to success.

Different models were in place in relation to on-calls and working patterns. The rostered model was valued by some, as having set shifts gave a structure to their diary to allow for antenatal/postnatal care planning and the on-calls were only once or twice a week. However, the rostered model made it more challenging for midwives to cover intrapartum care, due to the on-call rota system, where the midwife on call usually covered care for the whole teams' caseload:

> 'I've been at the birth of about five or six of my ladies. I think my colleague [X] was about ten months in before she was at the birth of any of her ladies, so… I've been quite lucky really, I've managed to be at quite a few. Antenatally and postnatally… pretty much a hundred percent of antenatal care is covered' [SITE 1 STAFF 07]

Many of the participants shared how they felt MCoC encouraged a commitment to caring '*that you fully give yourself a hundred percent all of the time'* [SITE1_Staff_09]. Finding the work meaningful enabled the midwives to enjoy busier moments, even when they worked overtime, and feeling overworked was often mitigated by caring for the women in their own caseload but pressures increased when *'responsible for everybody else's women as well'* [SITE1_Staff_09]. Further pressures, related to a lack of understanding from the wider team and services to what constituted the continuity midwives' role and saying no was challenging:

> *'It's easier just to say, okay yeah I'll do it, rather than say, actually no, it's not my job to triage somebody with a reduced foetal movement, that's, you know, that's what day assessment is for.'* [SITE 3_STAFF_04]

However, this approach to care provision – offering meaningful midwifery care was instrumental to making the everyday MCoC teams' work. This extra support and care were also believed to be recognised by service-users who valued midwives 'going above and beyond' for them. Midwife participants shared that those women with previous experience of other models of care, '*are so grateful for it [MCoC] and feel it's a really good model and they're quite privileged' to be experiencing it'* [SITE1_Staff_09]. However, this midwife also reported how women and families could be left disappointed to have '*been promised this continuity of carer and then their midwife leaves or becomes sick and the promise and expectation is took away'*. Thus, offering a caution when considering the sustainability of MCoC services. Conversely, the local stakeholder participant shared overwhelmingly positive feedback from local families within MCoC models of care, fostering a positive reinforcement that the MCoC is valued:

> *'I very rarely hear anything negative about continuity of carer at all from anybody, and that comes from those that are delivering that service as well.'* [Stakeholder_01]

Making it fit: overcoming hurdles

This organising theme explores the system and service-level challenges and hurdles experienced by the participants and how they worked to overcome them, where possible. Systemic pressures were experienced differently across the sites due to the varying service contexts, structures and associated demands and while there were significant pandemic pressures, here, we focus on contemporary issues relevant to the post-pandemic era.

Beyond the initial challenges highlighted earlier, the participants described other issues as the MCoC bedded into the service. Concerns were raised regarding a lack of management support and understanding for MCoC working patterns and hours where the expectation was MCoC midwives had their workload protected, but they were frequently called into the unit to make up staffing numbers at the expense of their caseload. This was a key source of tension, stress and overwork, compounded by a lack of understanding from the wider teams of their working patterns and commitments:

> *'So things are going unnoticed, when we are working over our hours, nobody is pulling us up and saying, are you okay, do you need support. There's pressure from, pressure from outside of the team, it's like those midwives or staff that don't understand how we work expect more of us than what we perhaps should be doing.'* [SITE 3_STAFF_04]

Furthermore, resistance and scepticism from the wider team members not in MCoC models oscillated throughout. Some participants reported myths and misinformation spread across the midwifery workforce leading to negative attitudes, fears and resistance. This negativity seemed to be contagious and led to the MCoC leads feeling drained. Some staff interviewed reflected that negativity is usual when introducing change and captured the relief that MCoC works:

> *'There will always be a conflict… I'm just glad that it works because now we've got six Continuity teams.'* [SITE 1 STAFF 05]

Another everyday pressure related to challenges with on-calls where one participant observed that in the team continuity model they are *'on call for a lot more women'* [SITE 2_STAFF_04] because they are on-call not just for their caseload but the whole team. Some highlighted difficulties sleeping when on-call, but also recognition that over time this would get easier. Covering on-calls was difficult as only one person is on-call each night. If the midwife was called out earlier in the night, and then returned home to bed, the rest of the night was not covered. This was

raised as a particular issue for the weekend roster as '*the service won't pay for two on-calls at the same time*' [SITE 2_STAFF_03]. Pay for on-calls was also raised as problematic whereby the payment structure was reported to be at the mid-point of a band, unfairly disadvantaging those at the top of their band. Additionally, an issue of *'owing hours'* [SITE 2_STAFF_06] was raised; where a midwife is called out at night and cannot work the next day shift, they are down on their contracted hours.

Within this context, the participants shared insights of how to overcome these core challenges - through effective system, service, team and personal leadership to strengthen MCoC. It was important, to some midwives, to feel strong visionary leadership from their maternity unit leaders. Participants also shared how essential practical and pastoral leadership and management support was, both from a senior level within the service but also from the MCoC and team leaders. These included activities such as ensuring training, building confidence and clinical restorative supervision. Moreover, nurturing collaboration through regular, ongoing communication that was open and honest was viewed central to progressing implementation and to meet the needs of the team. Conversely, for others, lack of senior direction and leadership created barriers to effective implementation, leaving MCoC and team leaders feeling powerless to enable necessary change:

> *'There's no support there from managers, there's no vision or, there's no culture that is pushing forward for this meaningful change. It feels very much like they're trying to tick the box in terms of numbers, but it's not in the spirit of continuity…'* [SITE2_STAFF_04]

In terms of everyday challenges within the teams some related to different styles of working, which required ongoing adjustment and communication to address to foster the close-knit relationships between team members that were seen as vital to effective working. It was also important that the autonomous and flexible nature of MCoC was supported and protected. This was valued for service-users so the midwives were enabled to offer genuinely flexible appointments that suited their needs, and a flexible model created a better work/life balance for family-friendly working for the midwives. However, it was also considered important to have some clear structures and boundaries with work patterns to help avoid burnout. Being able to '*switch off*' was important self-care. It also included being protected from staffing the unit and being called excessively to cover work unrelated to their caseload. When these components were protected and facilitated, the MCoC midwives' skillsets grew. This protected autonomy improved midwives' leadership, accountability and independence, resulting in self-managed teams:

> *'Yes, so I'd say the biggest difference is that the [MCoC] team [now] do not require as much hand holding and like to be independent and take responsibility.'* [SITE3_STAFF_03]

Discussion

In this paper we have reported on the qualitative findings of an evaluation of MCoC implementation in different context settings from the perspectives of those working within MCoC teams. Four organising themes have been presented informing a global theme*: Making it Work: sustaining continuity*' highlighting the complexities and challenges of implementing MCoC and ways to strengthen and sustain it in practice. Our findings reflect and add to a recent national rapid evaluation of MCoC rollout consisting of 60 survey responses, 16 interviews and three case studies in different NHS maternity sites (McCourt et al., 2023). The national review found similar facilitators and barriers particularly at the organisational and system level e.g., leadership, facilitating buy in, resourcing effective planning, preparation and implementation etc. (McCourt et al., 2023). However, our study captured granular insights primarily from the midwives' perspective related to their lived experiences of the early adoption, implementation and in some cases sustained MCoC – highlighting their motivations, needs and experiences adding to the body of evidence for a future recommencement of MCoC.

Any health system-level change, such as MCoC requires a multi-faceted and context-sensitive approach to ensuring optimal implementation (Braithwaite, 2018). Sandall (2018) outlines the desirable features of successful implementation of McoC as:

> *'…effective planning, project management, communication, collaboration, and teamwork; having useful tools in place, with a clear implementation strategy, staff and organisational ownership, and effective change leaders / champions; ensuring that the proposed implementation meets the identified need and is consistent with the organisation and stakeholders' aims; building in monitoring, evaluation and feedback, with incentives, flexibility, and autonomy for those working in the model'* (. p.7)

Here we expand these recommendations to offer four transformation features for how maternity services, midwives and those leading MCoC can successfully implement McoC working.

Preparation, support and resourcing

Appropriate resourcing

Ensuring sufficient resourcing is highlighted as essential for the success of MCoC (McCourt et al., 2023) from appropriate staffing levels, payment uplifts, equipment and reporting technology. Robust IT systems are also essential for monitoring purposes, and to assess the extent to which 'continuity' is a reality for women.

Pastoral support

As highlighted across the findings, it was important for staff to have access to appropriate, meaningful, and timely preparation and support. More experienced midwives were mindful of less experienced midwives across the teams and reported care and consideration for the workload by taking on team managerial tasks to provide ongoing support. Maternity staff in general are experiencing high levels of burnout and exhaustion, like other health staff, and so consideration for staff well-being is needed prior to and during system-wide transformation (House of Commons Health and Social Care Committee 2021; Hunter et al., 2019). Restorative supervision, through local Professional Midwifery Advocates, could be a way towards offering this, providing individuals with an opportunity for debriefing, empathic support and follow-up with more specialist support as needed.

Training and skills development

Transition training and upskilling was also considered crucial to ensure confidence building and quality care delivery. Maternity training and development is a priority to enhance safety and deliver personalised care to all people using maternity services (Health Education England 2019). Recent reports addressing safety concerns across maternity have called for a strengthening of midwifery training and it is important that maternity workforce training needs are considered to support MCoC transformation (Ockenden report 2020). The need for effective preparation, support and resourcing offered was closely linked to effective leadership and management both within and around the MCoC teams.

Engagement and collaboration

Effective leadership and management

In this study, a lack of senior direction and leadership created barriers to effective implementation, leaving MCoC and team leaders feeling powerless to enable change. Participants shared how strong leadership and management was essential to sustaining MCoC in practice, both from a senior level within the Service but also from the MCoC and team leaders. Compassionate and inclusive leadership has been shown to offer important approaches to transforming cultures and practice across nursing and midwifery (King's Fund 2020). Midwives interviewed also highlighted the need for effective personal leadership and management skills to ensure individual caseloads and workload

were managed effectively.

Ongoing communication

Regular, open and consistent communication was important for transformational change. This was required at a system through to a team and individual level. Effective communication is known to support service change and improve health outcomes, across maternity care (King's Fund 2012). For MCoC to be sustained ongoing communication is needed across all community, service, staff areas to ensure optimal engagement and implementation.

Building team relationships

Collaborative leadership and close-knit relationships between team members were seen as vital to good communication and effective working. This is in line with effective teamworking ethos whereby positive leadership, communication and shared decision-making are essential (King's Fund 2012; Crowther et al., 2016). Developing and strengthening maternity teamwork within and beyond the MCoC teams was important for sustainability.

Flexibility and adaptability

Work-life balance

Participants shared how important it was for MCoC midwives, leaders and the maternity service to have flexibility and adaptability to meet service-user needs and achieve a positive work/life balance. For some, this flexibility was essential and supported family-friendly working (Zolkefli et al., 2020). Moreover, the drive to build relationships with women and people in their care resulted in a desire to adapt their lives to the needs of their caseload. This reciprocity is known to improve the sustainability of midwifery continuity (McAra-Couper et al., 2014; Crowther et al., 2016). However, it was also considered important to have some clear structures and boundaries with work patterns to help avoid burnout.

Autonomy and protection

MCoC seemed to enable midwives to work autonomously, having the freedom to direct their own working lives and patterns, as individuals and as MCoC teams. Midwifery autonomy is known to sustain the midwifery profession and enable optimal work life and practice (McCourt et al., 2023; Zolkefli et al., 2020; Crowther et al., 2016). For sustainability of MCoC (Zolkefli et al., 2020), it is essential that this autonomy is protected (McCourt et al., 2023). Protected autonomy can improve midwifery leadership, accountability and independence, resulting in self-managed teams (King's Fund 2020). Crucially, MCoC teams must be protected from ever-expanding caseloads and should be aligned with the Better Births (NHS England 2017) recommendations of 36 per year (27 women at any one time). Moreover, they must be protected from 'covering the unit' and escalation procedures when there is short staffing (McCourt et al., 2023). It was also important for midwifery leaders to have autonomy to develop services and manage change with the freedom and independence (Adcock et al., 2022).

Strengths and limitations

A key strength of this work relates to capturing insights from different maternity sites in one region in England, with varied McoC practices and experiences, at different stages of implementation. Given that the region covers both urban and rural England with various levels of deprivation/affluence, with many of the urban areas identified as very low-income areas (Office for National Statistics, 2021), these findings are transferable to other similar contexts. By combining qualitative insights from a large number of survey respondents and 26 in-depth interviews, this represents a reasonably large data set for a qualitative project. Overall, the findings are transferable to similar contexts where maternity care is publicly funded, and midwives are embedded within the maternity system. However, as with all studies there are limitations. First, we centred the findings from staff involved in McoC teams so to capture insights into their everyday working. However, they were most likely particularly motivated towards working in MCoC models thus, conveying particular perspectives. We did mitigate against this in our wider study where we captured qualitative insights from non-MCoC staff which can be found in Supplementary File 2. Second, we were unsuccessful in recruiting more service users for the study, likely due to the time of recruitment, which was carried out during another COVID-19 lockdown. Service user perspectives about the local implementation would have provided valuable insights to help the services shape their local MCoC service. Therefore, it is vital that future studies should include service users from the locality for a more extensive evaluation. Additionally, a future evaluation would include direct comparisons between sites accounting for different MCoC models, workforce and working patterns.

Conclusion

The four transformational features have outlined key recommendations for wider policy and practice based on the perceptions, views and experiences of those midwives and leaders included as part of the evaluation. They capture the impact of MCoC on their working lives from the meaning it offers to the challenges posed and ways to overcome them. Crucially, the success of MCoC is contingent on the wider system and maternity team's knowledge, understanding and buy in of the service; where this has been cultivated, MCoC teams were successful and sustainable. With the current rollout paused in England, these findings can provide key insights to improved implementation processes and procedures in the future.

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CRediT authorship contribution statement

Anna Byrom: Writing – original draft, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Gill Thomson:** Writing – review & editing, Supervision, Project administration, Methodology, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Naseerah Akooji:** Methodology, Formal analysis, Data curation. **Claire Feeley:** Writing – review & editing, Project administration, Methodology, Formal analysis, Data curation.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.midw.2025.104603.

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