Enhanced Midwifery Team Service Evaluation Report
March 2013
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1. Executive Summary*

1.1 Introduction
The Enhanced Midwifery Team (EMT) is a team of six experienced midwives that provide vulnerable women in Liverpool with needs based individualised care packages.

The service is offered to women with significant mental health problems; alcohol or substance misuse, social services involvement or learning disabilities. Women get 1:1 care at home during the antenatal period and up to 6 weeks postnatally.

The Objectives of the Enhanced Midwifery team are to provide their caseload with:

- Easy to access Midwifery care
- Individualised care tailored to their needs
- A named midwife providing 1 to 1 care in their own home

In order to:

- Increase early access to antenatal care
- Improve public health outcomes (breastfeeding, smoking cessation, reduce obesity)
- Reduce harm to ‘at risk’ mothers and babies

1.2 The Evaluation Approach
This report sets out to evaluate the impact of the Enhanced Midwifery team in Liverpool over a 12 month period.

It aims to:

- Assist local commissioners to identify the women cared for by the EMT and their demographics and health needs
- Assist commissioners to understand the outcomes provided by the EMT
- Make recommendations to improve the EMT service

This will be done, firstly by giving a brief background to social vulnerability and pregnancy, then to the interventions and policies that are currently in place in the UK. The local needs will be described to allow a picture to be developed of the current situation in which the EMT work.

The report will then go on to present commentary and analysis from a variety of sources; from the team that makes up the Enhanced midwifery service, to their colleagues in the Liverpool Women’s hospital foundation trust and other outside colleagues from council led and third sector organisations.

The report also includes:

- A quantitative analysis of the caseload of women that the team cared for over the period of one year (Sept 2011 - Sept 2012)
- Responses from a user satisfaction survey

* Please note all references for the executive summary and recommendations can be found in the main body of the report. A complete numbered list of recommendations can be found in the appendices
1.3 Background to Vulnerable Pregnant Women

Socially vulnerable women and families that experience multiple problems, often with subsequent health problems in pregnancy, may then go on to have difficulty in giving their baby adequate care.

Domestic abuse, alcohol and substance misuse and mental health problems are frequent factors in the backgrounds of families that are the subject of serious case reviews and are often found occurring together as co-morbidities.

Early intervention is necessary to prevent harm to unborn babies and in the first year of life as babies are especially vulnerable to maltreatment and neglect that affects the developing brain and causes irreversible harm.

Deprivation underlies all the vulnerabilities families may experience and babies born in the most deprived areas are up to six times more likely to die in infancy.

One reason these women are more at-risk is because they often do not seek antenatal care or stay in regular contact with maternity services.

The coalition government have introduced the ‘Think family’ approach and the Healthy Child (HCP) public health programme. One of the HCP’s key roles is to identify children with high risk and low protective factors, and to ensure that these families receive a personalised service.

1.4 The Role of Midwives

Pregnancy is a time at which many women first come into contact with health services and can be identified as needing additional support. Pregnancy is a time associated with positive changes in lifestyle behaviours but can also put women at higher risk of experiencing domestic violence and mental health disorders.

Midwives play a vital role in encouraging women to access screening and maternity care and proving positive support, encouragement, information and signposting to specialist help for those that need it. NICE guidance on service provision for pregnant women with complex social factors was published in 2010. The guidance advised that women with risk factors should be offered a named midwife, who should take responsibility for and provide the majority of her antenatal care.

1.5 Vulnerable Pregnant Women in Liverpool

As the most deprived local authority in the country, Liverpool faces significant challenges. 65% of Liverpool residents live in the most deprived national quintile.

Women are more likely to smoke in pregnancy and less likely to breastfeed and babies are more likely to be born with a low birth weight (<2500g) and die in their first year than in the North West or England and Wales.

The Liverpool Women’s hospital has seen a sharp rise in safeguarding activity (numbers of referrals and health professional letters written) in 2011/12 compared to the 2010/11 period.

Domestic abuse is increasingly a concern with 70% of cases going to MARAC (Multi Agency Risk Assessment Committee) being patients who have been known to Liverpool Women’s NHS Foundation Trust. Incidents have been increasing in terms of complexity and severity.
1.6 Program Objective Reports - Potential Impact

1.6.1 Are The Right People Being Reached?

Each of the six enhanced midwives was expected to carry a caseload of between 35 – 50 families. (A yearly total of between 210-300 women).

Total caseload in Sept 2011-2012 was 327 women.

27% of the EMT caseload lived in the top 1% of deprivation in Liverpool.

Overall 73% of the EMT caseload lived in the ten percent most deprived areas of Liverpool.

Currently 24.3% of all referrals are inappropriate and not accepted by the EMT.

Each woman received an average of 13 visits. Each midwife made an average of 700 face to face contacts in Sept 2011/2012.

<table>
<thead>
<tr>
<th>Community Care</th>
<th>Enhanced Care</th>
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<tbody>
<tr>
<td>Antenatal appointment location</td>
<td>At a GP clinic</td>
</tr>
<tr>
<td>Antenatal appointment number of visits</td>
<td>First baby 10</td>
</tr>
<tr>
<td></td>
<td>Subsequent baby 7</td>
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<tr>
<td>Face to face time</td>
<td>1st baby (10 x 15 mins ; 2.5 hrs (7 x 15) ; 1 hr 45 mins</td>
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Safeguarding (at level 3 or 4) was the most common reason (50%) given as a reason for referral to the EMT, then Mental health.

Most of those listed under safeguarding had other co morbidities (mental health, drugs and alcohol or domestic violence).

Recommendations

R1 Referral pathways and dissemination of referral criteria for the EMT should be distributed to all relevant stakeholders to reduce the number of inappropriate referrals.

R2 Midwives on the EMT should initiate pre CAF or CAF for women who require one, this should be audited regularly.

1.6.2 Demographics

Women in the caseload were predominantly white British (90%), under 35 (85%), had an average of three previous pregnancies and 1.5 previous births.

Women were more likely than other women in Liverpool to book antenatal care late (26%) be underweight or obese (25%), smoke in pregnancy (50%) and, be anxious and/or depressed (30%). Women were less likely to intend to breastfeed (30%)

Their babies were more likely to be born early (11%), have a low birth weight (15%) require resuscitation after birth (16%) and need time in intensive care (15%).
Recommendation

R3 The reasons for some of these health disparities are discussed in the following sections of the report, however some of these levels are higher than could be expected and a more detailed audit of baby outcomes should be considered to look at ways to improve outcomes in this cohort of women.

1.6.3 Safeguarding

Babies under one are disproportionately at risk from maltreatment and neglect, both by its increased prevalence and the on-going and irreversible nature of harm caused. Parents that are a risk to their children often make the changes necessary to keep them safe during pregnancy.

The EMT is able to build a close, stable and on-going relationship with vulnerable, hard to reach and hard to engage women that can reduce the risk to women and babies by:

- Attending all multi-agency meetings
- Looking for early signs of unhealthy, unhelpful and potentially abusive interactions
- Supporting those parents that want to, to make changes
- Help avoid children being harmed from being left too long in abusive/neglectful situations

LWH is now almost meeting its KPI (95%) on safeguarding attendance (going from 50 to 90% attendance since the EMT was reconfigured).

The EMT are able to support their clients before, during and after case conferences and this was especially important in situations where babies were to be removed when women are at high risk of committing suicide.

Recommendations

R4 Safeguarding should be seen as the focus of the EMT work and therefore it is a priority that the midwives are enabled to attend their client’s case conferences and other professional meetings (over and above a 24 hour service)

R5 A plan of care for ongoing multi-agency support should be put in place for women who have babies removed, including access to the Kensington Children’s Centre ‘Together group’ or a similar scheme

R6 Safeguarding outcomes should be recorded and reviewed to look at themes and trends, if possible women should be followed up (linking data collection with health visitors/children’s services) after discharge to look at longer term outcomes

1.6.4 Domestic Abuse

CEMACH estimated that 30% of domestic abuse commenced during pregnancy

Domestic abuse during pregnancy, and the first six months of child rearing, is significantly related to all three types of child maltreatment.

Living with or witnessing domestic abuse is identified as a source of “significant harm” for children by the Adoption and Children Act 2004.

There were over 3000 Police notifications of incidents involving Domestic Abuse of women known to the Liverpool Women’s Hospital.

Of those 1660 cases were taken to MARAC (were thought to be at risk of serious harm or death)
NICE Guidance for Women with Complex needs, in relation to domestic abuse suggests:

- Commissioners and those responsible for the organisation of local antenatal services should provide for flexibility in the length and frequency of antenatal appointments, over and above those outlined in national guidance.
- Offer the woman a named midwife, who should take responsibility for and provide the majority of her antenatal care. To allow more time for women to discuss the domestic abuse they are experiencing.

If a woman will not admit that she is experiencing domestic abuse then her case is closed to social services but the EMT can usually see borderline cases to try to prevent covered up abuse.

The EMT has the flexibility to see women in crisis situations very quickly.

**Recommendations**

R7  Serious domestic abuse should be a criteria for referral to the EMT

R8  Geographical ‘Hot spots’ may require additional support from the EMT and consideration should be taken when planning caseloads

**1.6.5 Mental Health**

Increasing research interest is being shown in antenatal depression and anxiety which have been linked to altered immune functioning in the baby after birth and behavioural and emotional problems in the child.

Serious Mental illnesses (such as schizophrenia and related psychoses, and affective disorders) can have serious effects on a mother’s ability to care for her children.

Significant mental illness accounted as a reason for referral to the EMT for 31% of the caseload (not including those associated with Safeguarding).

**Recommendations**

R9  Each member of the EMT should regularly discuss her caseload and assess whether they are taking inappropriate referrals. Midwives should be able to use their discretion about borderline cases that require additional support however the caseload should not include a large number of women that do not fit the referral criteria.

R10  EMT should ensure that they refer all women that are in need of support during their birth to the Volunteer doula program.

R11  EMT Liverpool Midwives should liase with PSS and PERC to establish easier and faster access to support groups for women on their caseload.

R12  Commissioners should consider establishing more support for women with anxiety and depression in pregnancy (for example peer support like ‘Bump buddies’ in Hackney http://www.shoreditchtrust.org.uk/Bump-Buddies/About-Bump-Buddies)

R13  EMT midwives should be trained to deliver evidenced based interventions to increase wellbeing and reduce anxiety and depression in their caseload (for example CBT or Human Givens therapy (http://blog.humangivens.com/2012/10/hg-library-expecting-best-midwifery-and.html) and increase antenatal attachment/mindfulness in their clients, for example the ‘Mellow bumps’ program http://www.mellowparenting.org/images/uploads/events/Mellow_WAIMH_Poster.pdf
1.6.6 Substance Misuse

Consequences associated with drug use in pregnancy depend on the drug being used and the frequency of use but can include:

- Increased risk of mortality for both mothers and their babies
- Spontaneous abortion
- Congenital malformations (especially in Benzodiazepine misuse)
- Placental abruption (usually cocaine use)
- Low birth weight,
- Premature delivery
- Mothers passing HIV or Hepatitis C or B to their baby in utero

After birth, the child may be exposed to many sustained or intermittent hazards as a result of parental problem drug use. These include:

- Physical and emotional abuse or neglect;
- Dangerously inadequate supervision;
- Inadequate accommodation and frequent changes in residence;
- Toxic substances in the home
- Exposure to criminal or other inappropriate adult behaviour

Substance misuse was cited as the reason for referral for 4% of the caseload but was co-morbidity in many of the safeguarding referrals so this does not reflect the true level of substance misuse in the caseload.

Recommendations

R14 EMT Midwives should use therapeutic approaches that target stress regulation and interventions to improve mother: child attachment/bonding and interaction as this may be important for the capacity to parent, maintaining abstinence in addiction programs, and decreasing the incidence of child abuse and neglect (for example, the use of a stretchy sling, a study by Anisfield found that 83% of infants held in baby carriers were securely attached compared to 38% in the control group at 13 months of age)

1.6.7 Smoking

Smoking in pregnancy is strongly associated with a number of negative health outcomes. Most of these are increased as smoking level increases. Smoking in pregnancy is also strongly associated with poverty and deprivation.

Socio economic status (SES), young age and mental health problems are the main predictors of smoking in pregnancy. People with severe mental illnesses even more likely to smoke; >80%

Women are more likely to stop smoking during pregnancy than at other times in their lives. Smoking cessation during early pregnancy has been found to ameliorate many associated negative health outcomes and to eliminate differences in birth weight and growth restriction.

People with mental disorders are just as likely to want to quit but are more likely to think they will find quitting difficult. Health professionals and smokers with mental health problems may believe nicotine helps patients to cope with the symptoms of their illness or with the side effects of medication. Health professionals can give conflicting advice, and some studies have shown that while GPs are more likely to advocate quitting completely, midwives were more likely to advocate harm reduction during pregnancy.
The new NICE guidance recommends that advice that should be given to all pregnant women is to stop, not just to cut down, and to avoid any second-hand smoke.

According to the quarterly data the midwives submit to the children’s centres, there were 226 women smoking (out of a caseload total of 327) which is 69% of the caseload.

Of these 62 women were prescribed NRT (nicotine replacement products) which is 27% of those that smoked. They recorded that 20 women gave up smoking during the pregnancy (9% quit rate)

Recommendations

R15   EMT Midwives should look at supporting the whole family to quit smoking during pregnancy

R16   EMT Midwives should not assume that because a woman has other issues (mental health or domestic abuse) that they do not want to quit or should not try to quit smoking (Don’t collude – stopping smoking is not “bad” for women with mental health problems or their babies)

R17   EMT Midwives should link women in their caseload to existing services and incentive schemes. Other effective interventions that they could use with women include Cognitive Behavioural Therapy (CBT) and Motivational Interviewing.

1.6.8 Diet, Obesity and Underweight

Women that are underweight or obese in pregnancy tend to have more complicated pregnancies, and their babies have worse health outcomes. Both underweight and obese women can be at risk of reduced or inadequate micronutrients in their diet.

Deprivation is associated with diets low in protein, fibre, minerals and vitamins.

Underweight and obese women also have significantly lower rates of breastfeeding initiation and duration compared to women with normal pre-pregnancy BMI.

Experiencing domestic abuse, substance misuse and mental health problems are associated with poor diet and nutrition

25% of the EMT caseload was either underweight or obese

Women on the user survey scored the EMT lower on helping them to be healthier and being supported to make healthier choices

EMT Midwives were not referring obese women to the Aintree loss service.

Outcomes for babies in the EMT caseload could be linked to poor diet and nutrition and this is an area the EMT could improve their input

Recommendations

R18   EMT Midwives could give out vitamin and mineral supplements to women in the caseload who are assessed as under/over weight at booking (to ensure women are obtaining adequate micro nutrition in the early stages of their babies development before they would access healthy start)

R19   EMT Midwives should refer eligible women to Aintree loss antenatally and to Mamafit classes at Children’s centres
1.6.9 Breastfeeding

Breastfeeding is a major contributor to public health and has an important role to play in reducing health inequalities. Breastfeeding reduces the risk of numerous negative health consequences for Mothers and babies.

There is a strong economic argument for investing in measures to increase the prevalence of breastfeeding.

Breastfeeding has a positive association with good parenting and breastfeeding, may help to protect children against maltreatment by their mother, particularly child neglect by enabling a greater response to infant cues in brain regions implicated in maternal-infant bonding and empathy.

Breastfeeding rates among opioid-dependent women have been found to be low, with up to three-quarters electing not to breastfeed, but breastfeeding by women that use methadone and heroin in pregnancy may reduce the need for their baby to require treatment for Neonatal abstinence syndrome.

Breastfeeding is considered protective of PND and is thought to lower stress responses and increase maternal attachment and responsiveness.

Whilst there is a tendency to discourage women with SMI’s to breastfeed due to the risk of the medication they are prescribed being passed through breast milk to the infant, there are also many positive reasons to encourage breastfeeding and it may be that for women that want to breastfeed the risk of not treating the maternal medical condition may greatly outweigh the potential risk to the breastfed infant.

Women that have significant drug and alcohol problems, mental health conditions or whose children may be in need of state protection may need additional support when planning and initiating breastfeeding.

The breastfeeding initiation rate of the EMT caseload was 21.4% which is significantly lower than that of Liverpool (52%) and England (73%). However the 6-8 week continuation rate of those that initiated breastfeeding was 33.3% which is higher than the overall city-wide target for 2011/12 of 31.2%

Recommendations

R20 Women should be counselled about the positive effects of breastfeeding for them and their babies, they should be reassured that breastfeeding does not equate with less sleep and may promote wellbeing and reduce the risk of depression.

R21 Women who use heroin or other opioid drugs or substitution therapy (methadone) should be encouraged to breastfeed as this may protect their baby from NAS and help lower stress levels in mother and baby, increasing attachment and responsive parenting.

R22 Women with SMI’s should be supported to breastfeed and reassured that current guidelines suggest most medications, are probably quite safe when used in standard dosages and do not have documented long-term complications for the child.

R23 Evidence suggests that breastfeeding should not be discouraged in women using SSRIs.

R24 Women with severe mental health conditions may benefit from staying in a Mother and baby unit where they can be supported to establish breastfeeding and be receive interventions to increase positive mother/baby interaction.

R25 Women experiencing domestic violence or who have a previous history of trauma may have PTSD and find birth and breastfeeding difficult and distressing. These women may benefit from additional counselling and support (including CBT or human givens rewind therapy).

R26 Women that choose not to breastfeed or who have to give up before they wanted to may need support to alleviate feelings of guilt.

R27 Women whose babies are removed after birth that are breastfeeding will need additional support and should be supported to pump and transfer milk for their babies if they wish to
1.6.10 Maternal Anxiety, Depression and Attachment

Midwives recorded the number of women who were diagnosed with anxiety or depression during the intervention as 298 (out of 327) so 91% of the caseload

Women gave many examples of ways the EMT midwives had helped them cope with their anxiety and distress, both in pregnancy and postnatally. They expressed that their midwives were caring, non judgemental and supportive and gave them advice they could use in their individual circumstances.

Postnatally mother’s current life circumstances and previous experience of trauma can affect their ability to bond and provide good enough care to their babies.

Infants that are born prematurely or are withdrawing from their mothers substance misuse or psychotropic medication may be irritable, cry often and be hard to care for.

Women that have difficulty in bonding and caring for their baby, and perceive their baby negatively are at higher risk of developing postnatal depression. This can be exacerbated by living in poverty and experiencing difficulties like homelessness and domestic violence, women in these circumstances are less likely to breastfeed and more likely to use drugs and alcohol, they can exhibit hostile parenting which could lead to maltreatment or neglect of their baby.

Recommendations

R28 Mental representations of the (unborn) infant are important for the emerging parent-infant relationship; interventions to increase prenatal bonding may be of benefit. (As presented by Dr Angela Underdown http://www.nspcc.org.uk/Inform/newsandevents/cpconferences/abc-baby-in-mind_wdf88274.pdf) therefore EMT midwives should consider interventions to increase antenatal bonding.

In a study by Nishikawa (2013) midwives performed an abdominal examination of Leopold’s Manoeuvres, guiding mother’s hands to find foetal position and then discussing their experience and their thoughts toward the foetus. The intervention group showed higher Prenatal Attachment Inventory (PAI) scores as well as a higher frequency of talking to the foetus.

R29 Women who experience early separation from their baby due to illness or time in NICU may experience difficulty with bonding and attachment and should be encouraged to breastfeed. Have time with their baby skin to skin not just in the first 24 hours but as an ongoing process and support to give ‘kangaroo care’ to reduce stress in herself and her baby and increase attachment.

R30 Midwives should be trained to use interventions to increase parents self efficacy in understanding their newborns behaviour, for example Brazelton Neonatal behavioural score (NBAS) or the Behavioural Observation of the Newborn Educational Trainer (BONET), or video interaction therapy (this had been trialled with the EMT in Liverpool historically with psychotherapy support but was discontinued)


1.7 How Does The EMT Spend Their Time?

The EMT Midwives felt that their role was not always understood by other midwives. The biggest motivator for the team was building up a rapport with their clients.

They enjoyed the flexibility of the role to meet vulnerable women’s needs and felt early referral was important to enable them to have the best chance of making a difference to outcomes.

EMT midwives felt it was more important for them to be able to attend conference and professional meetings than provide a homebirth or 24 hour service.

Midwives attended a number of different types of meetings; the majority of these were professional meetings, case conferences or core groups.
Recommendations

R32  A diary data collection exercise could be used to look at allocation of time by midwives
- Hours per week worker
- Type of Work
- Direct contact with clients
- Tasks associated with contacts (unsuccessful visits, preparation, travel and notes)
- Attending safeguarding meetings
- Activities that are specific to the EMT (team meetings, training, supervision, promotion of the programme and data collection).

Other (e.g. administration, liaison with other organisations and professionals and other work, including time that was not allocated to other headings in the diaries)

1.8 Is The EMT Acceptable in Liverpool?

1.8.1 To Women

A user satisfaction survey designed by researcher to measure women’s opinions and attitudes regarding the impact of the service on themselves and whether the service met their needs.

8% of the caseload (26/327 women) returned the questionnaire.

More than 50% of the sample strongly agreed with every positive statement.
Women were felt their care by the EMT was better than care they had received with previous babies and 100% very satisfied or satisfied with the service overall.

Women felt that the EMT had made a positive contribution to their access services and were able to describe ways their midwife had facilitated this.

Many of the women who answered the survey were heartfelt and eloquent about the care they had received from their enhanced midwife and the difference it had made to their life.

“My enhanced midwife was one of the best midwives I have had (4th pregnancy) I wouldn’t have got through my pregnancy as smoothly and confidently due to her help and understanding as I had domestic violence issues and agoraphobia. She also saved my child’s life at 4 days old! I couldn’t praise her enough.”

Other women also talked about the how much they valued the inclusion of their family by their midwife and had a sense that their needs were met holistically and as a family unit.

“My whole family were included in the visits and made to feel part of all the decisions made and were included in all decisions and meetings. I felt that things were happening rather than a feeling of being passed on to different providers”

The level of input and commitment of the EMT was highlighted:

“She was here every single week, which was great, she’s answer the phone to me regardless of time to reassure me or answer any questions which I had. Although she wasn’t, I really felt like I had a friend throughout my pregnancy. I am very grateful to her”

Recommendations

R33 Women should all be asked for feedback on the service at discharge to ensure the service continues to meet their needs

R34 EMT midwives should record the gestation at which they begin work with a woman

R35 Ways in which the EMT could get earlier access should be explored

R36 The EMT should make parents aware of the conditions that promote early brain development including sensitive and responsive parenting by learning babies physical and emotional cues and encouraging women to join Children’s centre groups that promote early learning

1.8.2 To other service providers and local stakeholders

The EMT are visible and well known within LWH and by outside agencies although this varied geographically by midwife. Some members of the team were more proactive about going to other services meetings and letting stakeholders know about their work.

Some of the strengths of the EMT that LWH stakeholders talked about included:

- Skilled risk assessment
- ‘Word of Mouth’ (about the team)
- Recommendations from local people
- Honesty, challenge, no false hope
- Continuity reduces the need for constant repetition of women’s difficult story
- They are not afraid to discuss issues with women
- Reduction of DNA rates at clinics
- Relapse of illness is identified quickly by EMT
- Very quickly make contact after referral
Outside of LWH different stakeholders had different experiences of working with the EMT.

Case conference chairs were not aware of the work of the EMT but did recognise the individuals when prompted and were interested to work more closely with the team.

Children’s centre managers had mixed experiences, some talked about very strong links with lots of interaction and joint working, and others felt they never saw the midwife assigned to them.

This seemed to be due in part to the EMT being relocated out of Children’s centres and into community teams and also by the change in criteria for referral which was not understood by the managers.

All the health visitors that were interviewed (approximately 20 from two teams) knew about the EMT and personally knew the two midwives that covered their area. They stated that they have their mobile numbers and that they are easy to contact.

They felt the team were an example of innovative joint working, they did shared visits with them, shared information and ensured a smooth transition of care.

**Stakeholder reported issues**

Some people interviewed expressed frustration of the criteria for referral and felt it should be wider so they could refer other women with serious problems that needed support and that they couldn’t currently refer.

It was also felt the team should also cover Sefton

All stakeholders felt there could be serious repercussions if the EMT were not recommissioned.

“I would feel devastated if we lost the team.” The safeguarding problems are only increasing and attendance at case conferences just cannot be assured with community midwives who are already under a strain, with caseloads of 80-120 women. If we had to absorb all the case loading workload on top that would be a big risk”

“In the short term we couldn’t offer women support and continuity, we would have to refer them back to primary care. I would be worried women would fall through the gap. There is a very high potential risk, this is a small but very vulnerable client group and we could potentially see suicides or infant deaths”

**Recommendations**

R37 Audits should be conducted to look at how often the EMT are drawn into covering ‘normal birth’ related work which might detract from their specialised role.

R38 Midwives should meet with the Children’s centres management clusters ASAP to reiterate the team’s new remit and make the datasheet more useful for both parties and show evidence of the work the team are doing.

R39 Stakeholder’s views could be sought when planning changes in referral criteria for the EMT

R40 The EMT should provide feedback after a referral is made to confirm if they will be taking on the care of the woman referred this could be put on the bulletin board of Meditech or phoned through to the referring individual

R41 The EMT should build links with other stakeholders in the area to increase their visibility and ability to provide joint working, this could include presenting their work at meetings, and should include case conference chairs and GP’ consortia

R42 The EMT should collaborate with health visitors to link up data collection looking at longer term outcomes of their caseload.
1.9 Management and Existing Structures

1.9.1 Project Leadership and Management

The team felt that they had leadership input from a variety of people (Community team leaders, Consultant midwife in Normality) but that no-one had a really good understanding of their role or was able to be a ‘champion’ for the team.

The EMT came across as a very close and supportive team that provide each other with feedback and empathy.

The team have started to receive specific supervision in safeguarding and there was a sense that having a dispassionate and formal review of a difficult case was very helpful when working with complex situations.

Some members of the team show strong leadership skills and are proactive about moving the team forward but the role is time consuming and challenging and there was a sense that they felt unable or unwilling to be the one that acted as an informal leader for the team as they then might be expected to carry on doing so, which would be unsustainable with the same caseload.

Recommendations

R43  Leadership qualities within the team should be recognised and encouraged. Consideration should be given to whether one member should have a reduced caseload in order to have time to plan the team’s training needs, present their work to stakeholders and use the data intelligently to plan changes in care.

R44  The EMT should be encouraged to consider further education including becoming supervisors and also involvement with planning and conducting research and writing care pathways and presenting at conferences to disseminate good practice more widely.

1.9.2 Partnership Working

The EMT are experienced in working with a wide range of stakeholders both within and outside LWH including the third sector.

Recommendations

R45  The EMT should keep a record of joint working/visits to provide evidence of engagement with services

R46  EMT midwives should share best practice with the team on engaging with Children’s Centres and make sure that those they work with less often are kept ‘in the loop’ with their progress

R47  The EMT should build links with GP’s to look at a source of early access of referral

R48  Consideration to team branding and publicity should be considered, ideas included a different coloured badge or lanyard to identify the team. The team felt they could also have a stall at open days, and up to date posters/leaflets should be distributed

1.9.4 Data Collection and Analysis

Current data collection is not fit for purpose.

The Meditech system does not currently record referral to the EMT so data cannot be pulled as a report from the hospital system.

The EMT felt the Children’s Centre data returns were time consuming, did not demonstrate the work they were putting in and did not understand what was done with the information and how it was used to improve outcomes for the women.
Recommendations

R49 The Meditech system must be used to make referrals to the EMT so these are recorded and the EMT should have a page where they can record information relevant to their caseload so this can be easily collated and analysed to look at individual progress, and observe themes and trends.

R50 Data collected should tie in with NICE guidance on ‘Pregnancy and complex social factors’, which states that commissioners should assess:
- The number of women presenting for antenatal care with complex social factors
- The number of women within each complex social factor grouping

R51 Midwives should meet with the CC managers to plan an easy to collect, intelligent and ‘fit for purpose’ data collection tool to record day to day contacts and link up with the children’s centre’s.

R52 Other services (health visitors and children’s services in particular) should record which women are cared for by the EMT so longer term outcomes of women and babies can be followed.

R53 Midwives should involve women in making patient direct outcome plans in the early stages of their care. These can used throughout their care as measures of patient achieved change and down or up scaled by women as necessary. (These will need to be considered in relation to the legal, ethical and financial frameworks practitioners must operate within. Therefore, it may often be necessary to negotiate with the person to find a compromise and manage their expectations) and should be focused on improving the health and safety of their unborn baby or infant.

R54 Midwives should be:
- Locally and nationally relevant
- Based on the best, most comprehensive and up to date evidence
- Cost effective
- Involve hard (outputs) soft and user defined outcomes
- Recorded at set intervals on a patients journey to monitor progress
- Defined using a modified or bespoke outcomes tool (linked in to LWH systems, Children’s centres and other services so women’s longer term outcomes can be followed up after discharge)

R55 Midwives should then be involved with the ongoing analysis of their routinely collected data and outcomes and presenting both their individual and team themes and trends both to managers in the trust and within Children’s centres.
1.10 Cost Issues

Based on the 2011/12 patient case mix, and the application of the intermediate tariff it is envisaged the Enhanced Midwifery service caseload will cost the local economy c£543k. If this service was not provided conservative estimates suggest 50% of the patients seen would shift into the Intensive pathway which would cost an additional £178k. The rationale behind this is that interventions enacted prospectively rather than action retrospectively will result in better outcomes.

Therefore, using this model the cost to the local economy of not providing this cohort of women with the EMT would be £721k

In addition it has to be noted that patients falling into the intensive category will be more likely subsequently to have babies requiring neonatal care at a cost of:

£1,262 per ITU bed day
£753 per HDU bed day
£382 per SCBU bed day

The evidence that has been presented in this report has shown that the experiences from conception to the first couple of years of a child’s life are of critical importance as they shape that child’s future physical, mental and emotional health and ability to function into adulthood.

If children are not protected from maltreatment and neglect when living in circumstances involving multiple vulnerabilities and complex social and material deprivation it is not unlikely that many will grow up in what the coalition government has termed ‘Troubled families’

Recommendations

R56 Commissioners should consider funding the EMT into the longer term, this would increase job security for midwives and reduce the likelihood of the loss of experienced staff whose value is partly due to their historical interaction with the geographical community they work with and therefore would be difficult to replace. A longer term strategy could also allow more intelligent planning for using innovative interventions, data collection and evaluation and looking at longer term outcomes of the caseload

R57 One potential source of funding for the EMT is the ‘Troubled families fund’ as the council have flexibility in the criteria for family inclusion and as we have argued, multiple documents have shown that Early Intervention is both inherently better and inherently cheaper than late intervention
1.11 Nature of the work and best practice

1.11.1 Benefits of The EMT for Practitioners

Benefits to the midwives that were raised included:

- Having time and flexibility to be able to support the most vulnerable
- Feeling known and respected in their area
- Close interagency joint working to improve outcomes
- Being able to provide good care (showing empathy, consistency, reliability, honesty, respect, dignity)
- Working with the whole family and community
- Making a difference

Challenges to the midwives included:

- Long hours
- Stressful and upsetting experience
- Having an unpredictable and changeable schedule and sometimes long hours
- Feeling able to take time off and turn off from the work without causing additional pressure on the rest of the team
- Having to turn down borderline cases
- Feeling like they are collecting data for the sake of it without understanding its purpose and direction
- Feeling removed from the team decision making
- Uncertainty if the role will continue, short term contracts

CONCLUSION

The EMT act as an additional safety net to very vulnerable women and babies, they can access women when many other services find engagement difficult and their close involvement with families can uncover hidden risks and dangers that could prevent tragic consequences for mothers and babies. The EMT are an innovative service which show dedication and highly evolved practitioner skills and qualities which enable them to engage with and improve outcomes for women who are highly at risk of adverse outcomes.

The Service has been highly praised by users of the service and stakeholders who work with the team and the potential risks if the service was discontinued have been expressed.

Liverpool should be proud of leading the way with their integrated care for vulnerable women and babies by the enhanced midwifery team. Further work which would enhance this report include a needs assessment of parents with Learning difficulties, these make up 10% of the EMT caseload and have unique difficulties and issues that we were unable to explore here.

Summary QIPP points for EMT:

Q Quality of maternity services for vulnerable women demonstrably improved
I Innovative use of partnership working and individualised care
P EMT reduce DNA rates and time lost for Community midwives looking into DNA
P Prevention through reduced risk of adverse outcome by engaging vulnerable women in maternity care
About the Author

Selina Wallis has worked in Public Health for the past seven years after completing a Masters degree in Public health analysis at Liverpool John Moores University. She currently works as a Public health Masters dissertation advisor for Laureate online education.

She held a public office as a lay auditor for the NMC for four years until 2012.

She has co-authored a chapter in Working with partners: Forming the Future, book chapter in ‘Partnership working’ in: Essential Midwifery Practice: Postnatal Care (Editors: Sheena Byrom, Grace Edwards and Debra Bick) Published October 2009 and given lectures to the public at the Normal birth and Northampton Arts and Health Conferences.

She has worked as a doula (lay birth supporter) for nine years and is a doula mentor for Doula UK. She runs a homebirth support group for women in Liverpool and is involved with the research users group at the Liverpool Women’s hospital.

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14. Appendices

Recommendations

R1 Referral pathways and dissemination of referral criteria for the EMT should be distributed to all relevant stakeholders to reduce the number of inappropriate referrals

R2 Midwives on the EMT should initiate pre CAF or CAF for women who require one, this should be audited regularly

R3 The reasons for some of these health disparities are discussed in the following sections of the report, however some of these levels are higher than could be expected and a more detailed audit of baby outcomes should be considered to look at ways to improve outcomes in this cohort of women

R4 Safeguarding should be seen as the focus of the EMT work and therefore it is a priority that the midwives are enabled to attend their client’s case conferences and other professional meetings (over and above a 24 hour service)

R5 A plan of care for ongoing multi-agency support should be put in place for women who have babies removed, including access to the Kensington Children’s Centre ‘Together group’ or a similar scheme

R6 Safeguarding outcomes should be recorded and reviewed to look at themes and trends, if possible women should be followed up (linking data collection with health visitors/children’s services) after discharge to look at longer term outcomes

R7 Serious domestic abuse should be a criteria for referral to the EMT

R8 Geographical ‘Hot spots’ may require additional support from the EMT and consideration should be taken when planning caseloads

R9 Each member of the EMT should regularly discuss her caseload and assess whether they are taking inappropriate referrals. Midwives should be able to use their discretion about borderline cases that require additional support however the caseload should not include a large number of women that do not fit the referral criteria.

R10 EMT should ensure that they refer all women that are in need of support during their birth to the Volunteer doula program.

R11 EMT Midwives should, liaise with PSS and PERC to establish easier and faster access to support groups for women on their caseload.

R12 Commissioners should consider establishing more support for women with anxiety and depression in pregnancy (for example peer support like ‘Bump buddies’ in Hackney http://www.shoreditchtrust.org.uk/Bump-Buddies/About-Bump-Buddies)

R13 EMT midwives should be trained to deliver evidenced based interventions to increase wellbeing and reduce anxiety and depression in their caseload (for example CBT or Human Givens therapy http://blog.humangivens.com/2012/10/hg-library-expecting-best-midwifery-and.html) and increase antenatal attachment/mindfulness in their clients, for example the ‘Mellow bumps’ program http://www.mellowparenting.org/images/uploads/events/Mellow_WAIMH_Poster.pdf

R14 EMT Midwives should use therapeutic approaches that target stress regulation and interventions to improve mother-child attachment/bonding and interaction as this may be important for the capacity to parent, maintaining abstinence in addiction programs, and decreasing the incidence of child abuse and neglect (for example, the use of a stretchy sling, a study by Anisfield found that 83% of infants held in baby carriers were securely attached compared to 38% in the control group at 13 months of age)

R15 EMT Midwives should look at supporting the whole family to quit smoking during pregnancy

R16 EMT Midwives should not assume that because a woman has other issues (mental health or domestic abuse) that they do not want to quit or should not try to quit smoking (Don’t collude – stopping smoking is not “bad” for women with mental health problems or their babies)

R17 EMT Midwives should link women in their caseload to existing services and incentive schemes. Other effective interventions that they could use with women include Cognitive Behavioural Therapy (CBT) and Motivational Interviewing

R18 EMT Midwives could give out vitamin and mineral supplements to women in the caseload who are assessed as under/over weight at booking (to ensure women are obtaining adequate micro nutrition in the early stages of their babies development before they would access healthy start)

R19 EMT Midwives should refer eligible women to Aintree loss antenatally and to Mamafit classes at Children’s centres

R20 Women should be counselled about the positive effects of breastfeeding for them and their babies, they should be reassured that breastfeeding does not equate with less sleep and may promote wellbeing and reduce the risk of depression.

R21 Women who use heroin or other opioid drugs or substitution therapy (methadone) should be encouraged to breastfeed as this may protect their baby from NAS and help lower stress levels in mother and baby, increasing attachment and responsive parenting.

R22 Women with SMI’s should be supported to breastfeed and reassured that current guidelines suggest most medications, are probably quite safe when used in standard dosages and do not have documented long-term complications for the child.

R23 Evidence suggests that breastfeeding should not be discouraged in women using SSRIs.
Women with severe mental health conditions may benefit from staying in a Mother and baby unit where they can be supported to establish breastfeeding and be receive interventions to increase positive mother/baby interaction.

Women experiencing domestic violence or who have a previous history of trauma may have PTSD and find birth and breastfeeding difficult and distressing. These women may benefit from additional counselling and support (including CBT or human givens re-wood therapy)

Women that choose not to breastfeed or who have to give up before they wanted to may need support to alleviate feelings of guilt

Women whose babies are removed after birth that are breastfeeding will need additional support and should be supported to pump and transfer milk for their babies if they wish to

Mental representations of the (unborn) infant are important for the emerging parent-infant relationship; interventions to increase prenatal bonding may be of benefit. (As presented by Dr Angela Underwood http://www.nspcc.org.uk/Inform/newsandevents/cpconference/abc-baby-in-mind_wdf88274.pdf) therefore EMT midwives should consider interventions to increase antenatal bonding.

In a study by Nishikawa (2013) midwives performed an abdominal examination of Leopold’s Manoeuvres, guiding mother’s hands to find foetal position and then discussing their experience and their thoughts toward the foetus. The intervention group showed higher Prenatal Attachment Inventory (PAI) scores as well as a higher frequency of talking to the foetus.

Women who experience early separation from their baby due to illness or time in NICU may experience difficulty with bonding and attachment and should be encouraged to breastfeed. Have time with their baby skin to skin not just in the first 24 hours but as an ongoing process and support to give ‘kangaroo care’ to reduce stress in herself and her baby and increase attachment.

Midwives should be trained to use interventions to increase parents self efficacy in understanding their newborns behaviour, for example Brazelton Neonatal Behavioural score (NBAS) or the Behavioural Observation of the Newborn Educational Trainer (BONET), or video interaction therapy (this had been trialled with the EMT in Liverpool historically with psychotherapy support but was discontinued)


A diary data collection exercise could be used to look at allocation of time by midwives

- Hours per week worker

Type of Work
- Direct contact with clients
- Tasks associated with contacts (unsuccessful visits, preparation, travel and notes) attending safeguarding meetings
- Activities that are specific to the EMT (team meetings, training, and supervision, promotion of the programme and data collection).

Other (e.g. administration, liaison with other organisations and professionals and other work, including time that was not allocated to other headings in the diaries)

Women should all be asked for feedback on the service at discharge to ensure the service continues to meet their needs

EMT midwives should record the gestation at which they begin work with a woman

Ways in which the EMT could get earlier access should be explored

The EMT should make parents aware of the conditions that promote early brain development including sensitive and responsive parenting by learning babies physical and emotional cues and encouraging women to join Children’s centre groups that promote early learning

Audits should be conducted to look at how often the EMT is drawn into covering ‘normal birth’ related work which might detract from their specialised role.

Midwives should meet with the Children’s centres management clusters ASAP to reiterate the team’s new remit and make the datasheet more useful for both parties and show evidence of the work the team are doing.

Stakeholder’s views could be sought when planning changes in referral criteria for the EMT

The EMT should provide feedback after a referral is made to confirm if they will be taking on the care of the woman referred this could be put on the bulletin board of Meditech or phoned through to the referring individual

The EMT should build links with other stakeholders in the area to increase their visibility and ability to provide joint working, this could include presenting their work at meetings, and should include case conference chairs and GP’ consortia.

The EMT should collaborate with health visitors to link up data collection looking at longer term outcomes of their caseload

Leadership qualities within the team should be recognised and encouraged. Consideration should be given to whether one member should have a reduced caseload in order to have time to plan the team’s training needs, present their work to stakeholders and use the data intelligently to plan changes in care.

The EMT should be encouraged to consider further education including becoming supervisors and also involvement
with planning and conducting research and writing care pathways and presenting at conferences to disseminate good practice more widely

R45 The EMT should keep a record of joint working/visits to provide evidence of engagement with services

R46 EMT midwives should share best practice with the team on engaging with Children’s Centres and make sure that those they work with less often are kept ‘in the loop’ with their progress

R47 The EMT should build links with GP’s to look at a source of early access of referral

R48 Team branding and publicity should be considered; ideas included a different coloured badge or lanyard to identify the team. The team felt they could also have a stall at open days, and up to date posters/leaflets should be distributed

R49 The Meditech system must be used to make referrals to the EMT so these are recorded and the EMT should have a page where they can record information relevant to their caseload so this can be easily collated and analysed to look at individual progress, and observe themes and trends

R50 Data collected should tie in with NICE guidance on ‘Pregnancy and complex social factors’, which states that commissioners should assess:

- The number of women presenting for antenatal care with complex social factors;
- The number of women within each complex social factor grouping

R51 Midwives should meet with the CC managers to plan an easy to collect, intelligent and ‘fit for purpose’ data collection tool to record day to day contacts and link up with the children’s centre’s

R52 Other services (health visitors and children’s services in particular) should record which women are cared for by the EMT so longer term outcomes of women and babies can be followed.

R53 Midwives should involve women in making patient direct outcome plans in the early stages of their care. These can used throughout their care as measures of patient achieved change and down or up scaled by women as necessary. (These will need to be considered in relation to the legal, ethical and financial frameworks practitioners must operate within. Therefore, it may often be necessary to negotiate with the person to find a compromise and manage their expectations) and should be focused on improving the health and safety of their unborn baby or infant.

R54 Midwives should be should be part of meetings to plan service outcomes and targets, and these should be:

- Locally and nationally relevant
- Based on the best, most comprehensive and up to date evidence
- Cost effective
- Involve hard (outputs) soft and user defined outcomes
- Recorded at set intervals on a patients journey to monitor progress
- Defined using a modified or bespoke outcomes tool (linked in to LWH systems, Children’s centres and other services so women’s longer term outcomes can be followed up after discharge)

R55 Midwives should then be involved with the ongoing analysis of their routinely collected data and outcomes and presenting both their individual and team themes and trends both to managers in the trust and within Children’s centres.

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