The SAPlings project: an alternative antenatal care pathway

Abstract

There are increasing demands on the provision of antenatal care. In Oxfordshire, an alternative pathway for women with the most complex socio-economic and obstetric demands on their pregnancies was introduced to meet the needs of these women and reduce community midwives' caseload. A review of this cohort identified that they overaccessed both scheduled and unscheduled antenatal care, but they rarely accessed antenatal education programmes or children's centres. Therefore, an alternative model of antenatal care was planned, based on the Centering model. This aimed to better meet these women's antenatal care and education needs and reduce the impact on the maternity service. Initially, one group was piloted and this has now been expanded to four teams throughout Oxfordshire. The groups have grown and the feedback from women and midwives has been extremely positive.

Keywords

Complex socio-economic needs | Community midwifery | Centering model | Alternative antenatal care pathway | Public health

Antenatal care in Oxfordshire is predominantly a shared-care model based on the National Institute for Health and Care Excellence (NICE) antenatal care pathway. Care is based in GP surgeries or children's centres and each appointment is generally limited to 20 minutes. With increasing demands on the provision of antenatal care, it was important to understand if the needs of women were being met for those with the most complex socio-economic and obstetric demands on their pregnancies, and consider if an alternative pathway may benefit women and community midwives.

Focus groups were set up to generate ideas and gauge reactions to potential changes in service provision (Scottish Health Council, 2019). The groups included community midwives, maternity support workers and children centre staff. The community midwives identified that women with complex socio-economic needs have the biggest impact on the pathway; they were seeing these women more frequently and appointments needed to be longer to enable them to meet their needs. The midwives also identified that they did not always have the knowledge to optimally manage some of the situations, often having to refer elsewhere or spend a significant time after their clinic sorting out problems. Common themes that were the most challenging on their time and knowledge included mental health concerns, housing, domestic violence, relationship issues and child protection.

Women with complex needs, often from disadvantaged or vulnerable families, are identified by a local health and social score rating at booking, and are highlighted to public health midwives and health visitors. To understand the issues faced by these women, a retrospective audit of 27 maternity records was undertaken to review the care that had been provided to women over the previous six months. The audit included background information, lifestyle and social issues, and medical/obstetric history. Consideration was given to whether there was a need for enhanced antenatal care with this group and whether there were enough women for a caseload model of care to be a viable option.

The audit found that these women were seen by their community midwife more frequently than NICE recommendations. On average, they attended 15 antenatal appointments, regardless of parity, and had an additional four episodes of unscheduled antenatal care at the hospital. None of these women had accessed antenatal education classes and few had registered with children's centres.

Therefore, an alternative model of antenatal care was planned, which aimed to better meet the antenatal care and education needs of this group of women and reduce the impact of unscheduled care episodes on the maternity service.

Model of antenatal care

The Centering in pregnancy model of care was

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designed and developed in the US and has been successfully adopted in other countries (Schindler Rising and Jolivet, 2009). The model integrates health assessment, education and support, which are provided in a group facilitated by a care provider. There are 13 elements which define the Centering model of care (*Box 1*).

There is a growing body of evidence reflecting positive results from the Centering model in terms of clinical outcomes, levels of satisfaction with antenatal care, self-efficacy, perceived knowledge, and reductions in social isolation (Gaudion and Yiannouzis, 2011). The groups are described as empowering because they provide support to members and increase individuals' motivation to learn and change; additionally professionals report that groups provide them with renewed satisfaction in delivering quality care (Schindler Rising and Jolivet, 2009). This appeared to be a promising model of antenatal care.

A review of the literature was promising, with a large randomised controlled trial in the US (Ickovics et al, 2007) reporting significant results for this model of care in:

- Reducing the risk of prematurity
- Increasing the mean birth weight
- Increasing breastfeeding initiation rates
- Increasing women's stated knowledge and preparedness for labour and birth
- Higher rates of satisfaction with antenatal care reported by women.

It was important to ascertain how this model would work in the UK. There are publications describing the adoption of the model in the UK (Hatem et al, 2008; Gaudion and Yiannouzis, 2011). Contact was made with a UK provider, as well as a visit to one of their steering group meetings to find out the practicalities of delivering this model of care.

During the meeting, the midwives discussed their availability to take a caseload of women through antenatal care. It became clear that they could only provide this service to 10-12 women once or twice a year. The groups were planned around women who were the same gestation and therefore their babies due within two weeks of each other. They invite 15 women as they have experienced up to 50% drop out rate.

The meeting generated the following concerns about the Centering model:

- It only benefited 8-12 women
- There was a high dropout rate
- The midwives found it difficult to identify women in their caseload with similar due dates
- Dates for the group could be difficult to fit in with the midwives' other work commitments
- It was difficult to organise room availability in centres due to the irregularity of appointments (16, 25, 28, 31, 34, 36, 38 and 40 weeks).

Box 1. Key elements of the Centering model

- Health assessment occurs within the group space
- Participants are involved in self-care activities
- A facilitative leadership style is used
- The group is conducted in a circle
- Each session has an overall plan
- Attention is given to the core content, although emphasis may vary
- There is stability of group leadership
- Group conduct honours the contribution of each member
- The composition of the group is stable, not rigid
- Group size is optimal to promote the process
- Involvement of support people is optional
- Opportunity for socialising with the group is provided
- There is ongoing evaluation of outcomes

Although the Centering model appeared to have limitations, it seemed reasonable to consider a pilot project focusing on women with complex needs in Oxfordshire.

First, it was important to audit the distribution of these families to determine whether we could identify a caseload within a defined area. The public health team had identified between five and seven women per month, and two to three with due dates within two weeks of each other. This made the Centering model difficult to follow because there were insufficient numbers to make it feasible.

Additionally, the audit demonstrated different findings to the US studies (Hollowell et al, 2011). Women who were considered socially high risk in Oxford did not have an increased risk of premature or low birth weight babies, and the breastfeeding rate was similar. However, the women audited did have more antenatal appointments than the recommended number of visits, as well as unscheduled antenatal care visits. It was not clear from the records whether the women had booked the extra antenatal appointments or whether the midwives had deemed them to be necessary. It was also noted that these women did not access antenatal education and few had booked with children's centres.

Developing an antenatal education group

A survey of nearly 1 400 mothers found that mothers on a lower income feel unsupported, and over a quarter feel quite anxious or depressed during their pregnancy (Royal College of Midwives, 2011). Almost three-quarters did not attend antenatal classes and nearly half were not offered them.

In response to concerns raised by Stewart-Brown and Schrader McMillan (2010), the Department of Health published a toolkit, 'Preparation for birth and beyond' (PBB), designed to improve outcomes for babies and parents through a refreshed approach to antenatal education that moves beyond traditional models (Department of Health, 2011). It covers the physiological aspects of pregnancy and birth, but also addresses the emotional transition to parenthood in greater depth, and recognises the need to include fathers and partners in groups and activities. Its overarching goal is to reduce inequalities by supporting disadvantaged parents to give their children the best start in life.

Therefore, our model proposed to amalgamate antenatal care with the PBB antenatal education sessions, so that women would benefit from having regular contact with a named midwife and maternity support worker, along with support from other local women and education that was specific to their needs. The aim is to provide an environment where women learn from each other and the professional can supply further information when required. By taking responsibility for their health and problem-solving with each other, it was hoped that the environment would be creative, supportive and foster friendships among peers (Ireland et al, 2016).

Structure of the group

The key issues from the review process were that these women attended for their antenatal care more than the routine pathway; the majority also had an average of four unscheduled antenatal visits to the hospital. This impacts services and indicates a need that is not being addressed by the standard pathway of care. This suggested a requirement for enhanced antenatal care for this group of women. However, with small numbers, the Centering model would have been difficult to implement.

Taking into consideration the issues raised at the UK steering group with regard to venue, staffing and other commitments, the project team considered that a group that ran every week might be of greater benefit to the women and community midwives. Women want services that are reliable, accessible, sensitive to individual needs and well-coordinated (Anderson et al, 2007).

It was agreed that a midwife and maternity support worker would run a weekly service in a children's centre, enabling women to attend for their routine appointments, but also providing access and opportunity for women to address ad-hoc concerns with the team between their scheduled routine appointments. It was different from the Centering model in that women could attend weekly and at any gestation, but still provided a model of group antenatal care. Caution was applied because the proponents of the Centering model had warned against changing the format. However, given the different circumstances and numbers, the proposed design had the potential to support more than 8-12 women and be of benefit to the community midwives by relieving some of the time pressure in their clinics.

The PBB programme was expanded to a 12-week cycle to include other topics that had been identified during the audit. Different professional groups with experience in these areas were approached, including the county council benefits officer, Oxford parent infant project, smoking cessation service and Oxford talking therapies (TalkingSpace). They were all keen to be involved because they all had a remit for reaching vulnerable families. A one-year plan was prepared and the dates circulated to those who had agreed to facilitate the sessions.

Children and partners were encouraged to attend the majority of sessions. However, because there is a high prevalence of domestic violence in this population, it was decided that there should be women-only sessions once a month. Although the women were encouraged to ask questions in the group so that others would benefit from hearing the answers, they could ask more personal or sensitive questions either before or after the group session commences.

The intention was for women to be given information and be invited to the group by their midwife at their booking appointment. However, some community midwives were reluctant to refer the women from their caseload because they felt they had built a relationship with them, particularly if they had cared for them during a previous pregnancy. It surprised the project team that the midwives could not see the benefit of the group, especially as they had raised concerns in the focus groups about the impact that these women had on their caseload. Therefore, additional focus groups were set up and further explanation of the benefits of the group conveyed to the community midwives; over time referrals increased exponentially.

Naming the group

The group was called SAPlings because it was designed to focus on the social aspects of pregnancy. There was also the connotations of nurturing something fragile and enabling it to grow and flourish. The graphics that we used were nurturing and calming.

The first group in Ozxford was launched in February 2013, with a second group starting in the north of the county six months later. More

recently, two further groups have been established in Oxfordshire.

Each session is structured, with the first hour focusing on health/antenatal checks and the second hour antenatal education; all in a group setting. The midwife and maternity support worker operate in partnership with the children's centre and other professional groups to support the attendees. At the end of each session, there is a brief team meeting to reflect on what had gone well and what could be improved on, as well as a review of the current caseload and any follow-up that is required with the community midwives, GP or other members of the multidisciplinary team.

Findings

The majority of women who come to the SAPlings group have more frequent care episodes than the routine antenatal pathway. On average, they have 13 episodes of antenatal care and approximately two episodes of unscheduled care in hospital, which is a slight reduction from the initial audit. However, the true benefit comes from their engagement in the group and attendance at antenatal education sessions.

> ***'Attending SAPlings was a lifeline for me, a chance to build confidence and relationships. Without the kindness and support of the midwives who run SAPlings, I would have felt very isolated and alone, which would have had a significant impact on my mental health.'***

In 2015, more than half of the women had mental health issues; one-quarter had experienced sexual abuse or domestic violence and one-third of them were known to social services. These vulnerable women have a reduced capacity to think about the developing baby and an increased likelihood of having disengaged or distorted mental images of the baby (Barlow, 2015). This can result in poorer health behaviours in pregnancy, due to a lower level of involvement with the baby, and this can also affect the capacity to care for the baby once it is born. Infants under 12 months make up more than one-tenth of children who are subject to a child protection plan, with neglect (40%) and emotional abuse accounting for nearly three-quarters of these (Department of Education, 2014).

Of the SAPLings women who were known to social services, the majority had prebirth case conferences regarding their ability to parent their baby. The collaboration of the women and their families with social services and the SAPlings team has enabled all but one of these women to keep their babies when they have had previous children taken into care.

> ***'Because of SAPlings, I am happier, stronger and more confident at being the best mother I can be.'***

These groups have provided women and their families with care and education that is more tailored to their needs in a safe and supportive environment.

> ***'I come to the group because I get more information about the pregnancy, it also gets me out the house and is interesting to learn new things.'***

> ***'The dedication and commitment of the midwives speaks for itself. They are wonderful because they listen, support and care for everyone who comes through the doors—from all backgrounds.'***

Women who have previously not engaged with antenatal education are now turning up most weeks to be part of the group discussion around topics that are relevant to them, and not just about labour and birth.

> ***'I have tried baby groups etc previously and they have always been unfriendly, but the openness and inclusiveness of SAPlings has helped me to calm my anxieties, and I feel able to get help when I need it.'***

> ***'SAPlings is knowing you are not alone.'***

The success of this group has been confirmed by the continued attendance at the group, especially when the women attend for more than their required antenatal appointments, and their satisfaction that they have expressed following the sessions that they have attended.

> ***'I love SAPlings—without the group and support from the midwives, I would have had a much more difficult time.'***

> ***'I love coming to SAPlings because they have supported me through everything.'***

The community midwives are very supportive—even those who were initially reluctant to refer women from their caseload:

> ***'SAPlings is fantastic. Being able to identify women in need and being able to refer them to the group really helps those women to receive the care and attention on a one-to-one basis to deal with their personal circumstances. I find the team to be very passionate and dedicated to SAPlings, which allows the women to strike up a trusting relationship.'***

Key points

- Women with the most complex socio-economic needs require additional support and resources throughout their pregnancy
- These women depend upon their community midwife, but also seek further reassurance through unscheduled antenatal care
- The support services in the community (antenatal education classes, children's centres, etc) are rarely accessed by this cohort
- Group antenatal care integrates health assessment, education and support, which are delivered in a group facilitated by a care provider
- Women report high levels of satisfaction with this model because they receive support. They have reported an increased individual motivation to learn and change

'The support offered by the SAPlings team has been life-changing for some women who I know have made big changes in the way they are able to bond with their baby.'

'As a midwife, it has been helpful to know that this is an option for the higher risk public health women, as it is not always possible to have the time to follow up on all the referrals required to offer the best support. Women have really enjoyed the continuity of care that SAPlings is able to provide them.'

'My main problem with the group is getting women to attend in the first place. This is often due to anxiety around meeting new people, and also travelling to the children's centre for low-income women can be a problem. However, the team have made great efforts to encourage women to attend (for example, home visits) and I have found that once the initial contact has been made, most women are happy to attend.'

Two years after the SAPlings groups started, we re-audited the records of the women who attended the group sessions and looked at the same outcomes that we had measured previously. Although there was a marginal improvement in reduced antenatal care, whether scheduled or unscheduled, we felt confident that the group had been successful in reaching vulnerable families and provided them with the opportunity to meet a range of healthcare professionals who worked together to address their complex needs.

Our challenges focused on the needs of the women in the group who were considered high risk due to their complex socio-economic needs, increase in demand for antenatal care that we could not meet with our current pathway, and lack of engagement with antenatal education. There was pressure on the community midwives' clinics and the maternity assessment unit at the hospital where women attended for unscheduled antenatal care.

The aim of SAPlings was to provide a pathway that met the needs of this group; its popularity and expansion reflect its success in achieving these goals. The feedback from those women who attend the group is that it is succeeding in its aim and the community midwives have seen the value in referring women from their caseload to the group.

Although we have found it difficult to statistically measure and quantify the outcomes of this pathway, qualitative evaluation reflects the value placed on the project by women and midwives. The qualitative outcomes will be explored via a joint research collaboration with Oxford University.

Recommendations for future practice

These groups have been incredibly successful, with both the midwives and social services supporting referral and participation in the SAPlings groups in Oxfordshire.

One of the biggest problems the groups face is the transition from antenatal to postnatal support. Many women continue to attend after the birth of their babies because they are comfortable and confident in attending the group. Midwives and health visitors have been working together to establish ways of enabling women to move on from SAPLings to appropriate postnatal groups led by health visitors.

Unfortunately, the majority of the children's centres in Oxford have closed and others have become hubs incorporating social work departments. The presence of the social work department in the hubs has been cited as off-putting by some of the women who would be suitable for SAPlings. Therefore, different venues have been found to ensure that SAPlings can continue with multi-agency support in an environment that is accessible for the women. Although this can be a challenge, we are committed to making it work because these teams are an essential part of our maternity service.

The next phase for this group of women is to expand this model of care to include continuity of care in line with 'Better Births' (National Maternity Review, 2016). We know that this group of women can feel unprepared and unsupported during labour and childbirth (Ireland et al, 2016). Therefore, a natural progression is to incorporate intrapartum care into the pathway for the SAPLings groups. **BJM**

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