

PEER-REVIEWED ARTICLE

Midwives' perceptions of continuity in postnatal care between the specialist health service and primary care

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Background: Midwives in Norway are generally employed in either primary care or the specialist health service. Both service levels provide postnatal care to families, creating a need for continuity between these levels and an understanding of midwives' perception of this continuity.

Objective: To investigate midwives' perceptions of continuity between service levels during the transition from the maternity ward to postnatal primary care.

Method: The study is based on semi-structured interviews in two focus groups with 16 midwives employed in the specialist health service and/or associated primary care services.

Systematic text condensation was used to analyse the data.

Results: The analysis resulted in two main findings: 1) Perception of continuity between different service levels is closely related to the structure and organisation of these services. 2) Perception of continuity depends on formal and informal communication channels between service levels.

Conclusion: Midwives need knowledge about the associated service level in order to experience continuity in the follow-up care of postnatal women during the transition from the maternity ward to postnatal primary care. How services are organised affects the perception of continuity in postnatal care. The same applies to information channels between service levels, both formal and informal. Midwives experienced a discrepancy between current guidelines, collaboration agreements and practice.

Introduction

Midwives provide follow-up for pregnant women, women in labour, postnatal women, neonates and families in both the specialist health service and primary care, which creates a need for continuity and cooperation between service levels. Women should have access to continuous care throughout pregnancy, childbirth and the postpartum period (1–3), which requires close cooperation across maternity services (4).

National guidelines for postnatal care recommend that care for families should be organised to ensure predictability. A prerequisite for this is continuity of care, where the midwife plays an important role. The distribution of responsibilities and tasks between the specialist health service and primary care should be clearly defined, and managers should be aware of midwives' capacity when following up women during the postnatal period (4).

The World Health Organization (WHO) emphasises the importance of strong leadership when implementing continuity models (5). Strong leadership is also crucial for maintaining continuity models within the midwifery profession, which have been shown to improve health outcomes, increase patient satisfaction and provide more cost-effective postnatal care (6).

The specialist health service and primary care have a duty to work together, with the goal of providing comprehensive and seamless health and care services for patients and service users. Legislation provides for continuity between service levels by requiring collaboration agreements between hospital trusts and local authorities (7).

Early discharge after childbirth increases the need for collaboration between service levels, particularly in relation to breastfeeding support, physical and mental health changes, interactions, attachment processes and other aspects of postnatal care (4).

Continuity in postnatal care is important for the women and families using the service and for the healthcare personnel providing it (8). Perceptions of continuity within the health service can have an interpersonal and an organisational dimension (9).

Three types of continuity

Continuity is also described as a sense of coherence in events over a period of time (10). Haggerty et al. (11) describe three types of continuity: informational continuity, management continuity and relational continuity. For continuity to be present, care must be experienced as coherent, both for the service user/patient and for the healthcare personnel.

Informational continuity refers to access to relevant information at the right time, such as the transfer of patient information between healthcare personnel and between service levels.

Management continuity involves communication, coordination and the transfer of knowledge and assessments between colleagues, between service levels and between different job categories.

Relational continuity is continuity over time and relates to the relationship between the service user/patient and the healthcare personnel. The perception of continuity from the healthcare personnel's perspective is related to the sense of having sufficient knowledge and information about the patient to provide the best possible care (11).

The international evidence-based theoretical framework, Quality Maternal and Newborn Care (QMNC), highlights, among other things, interdisciplinary collaboration and continuity of care (12).

There are various care models that facilitate continuity. In the Team Midwifery model, midwives work in a group and provide follow-up care and continuity throughout pregnancy, childbirth and the postnatal period. In the Caseload Midwifery model, one midwife has primary responsibility for the woman throughout pregnancy, childbirth and the postnatal period, with another midwife on standby (13).

The continuity model has been shown to improve job satisfaction among midwives and reduce the risk of burnout (14), but it requires midwives to be flexible, and the boundaries between work and personal life can appear fluid (15).

The Women's Health Committee (16) and the National Health and Coordination Plan (17) outline how poor collaboration between services is a challenge. Priority groups for cooperation within health communities are women during pregnancy, childbirth and the postnatal period. Postnatal women find the support during the perinatal phase to be fragmented (18), and user organisations highlight a failing postnatal care system (19, 20).

Objective of the study

Midwives in Norway are primarily employed in the specialist health service or in primary care and therefore play a central role in ensuring continuity of the patient's journey through the different service levels. To our knowledge, no studies have been conducted on the perceptions of midwives in Norway in terms of continuity between service levels.

The objective of this study was to investigate midwives' perceptions of continuity between the specialist health service and primary care.

Method

Design

The study had a qualitative design, and two focus group interviews were conducted with midwives who had experience from primary care and/or the specialist health service (21, 22).

Recruitment and sample

The study was conducted at a hospital trust with 1629 births in 2022 (23) and collaboration agreements with 16 associated local authorities. Midwives were recruited in May 2023.

The midwives were provided with both written and oral information about the study. Some volunteered to participate in the focus group interviews, while others were recruited through direct invitations from the first author or the senior midwife.

We used an availability sampling method (22), where the inclusion criterion was that the midwife had a permanent position in primary care and/or the specialist health service and had been employed in one of the service levels for at least six months. The focus groups consisted of seven and nine participants, respectively, which is an ideal size for focus groups (24).

Data collection

Ninety minutes were allocated to each focus group interview, and the interviews were held one week apart in May–June 2023. Semi-structured interviews were conducted based on an interview guide with five open-ended questions (Table 1), developed from relevant literature and discussions within the research group. The open-ended questions were designed to encourage reflection and the sharing of experiences, as well as to stimulate interaction and synergy within the focus groups (25).

Table 1. Interview guide

Manin questions
Can you tell us a bit about what comes to mind when you hear the word <i>continuity</i> ? Feel free to give examples.
How do you perceive the continuity between primary care and the hospital trust where you currently work?
What do you think 'continuity between service levels' means?
What do you think might hinder continuity between service levels?
What do you think might promote continuity between service levels?

Group interviews are difficult to standardise and structure, and it is essential that the moderator ensures all participants have the opportunity to share their experiences related to the phenomenon being studied. Follow-up questions were asked in order to explore the experiences in more depth, and we sought to avoid leading formulations. The interview guide served as a useful tool both in the planning and execution of the interviews (25, 21).

Both group interviews were held in suitable meeting rooms at the hospital trust. The first author was the moderator, and the third author was an observer. The second author was also an observer in focus group 2. The interviews were audio recorded and transcribed verbatim. All the authors are midwives; the first and third authors both work in clinical practice. The second and last authors were supervisors in the study.

Step by step data analysis

The first author analysed the data using systematic text condensation (STC) with a thematic cross-sectional analysis that summarised the information gathered from the participants (21). The second, third and last authors provided guidance and quality assurance throughout the analysis. The analysis was a four-step process, in which the first step was to identify preliminary themes from a broad perspective.

In step two of the analysis process, meaning units describing the midwives' perceptions of continuity between service levels were identified and categorised into relevant preliminary themes. This formed the basis for the discussion on code groups. Through an inductive, iterative and dynamic process, we sorted the text into codes and three code groups ([Appendix 1](#) – in Norwegian) (21).

In step three, each code group was reviewed thoroughly, and the material was sorted into two to four subgroups. For each subgroup, we created a text condensate in a constructed first-person narrative, where 'I' represented the voices of the different focus group participants.

The analytical text, created through STC, represents the findings from the study; an anonymised quote was chosen as an illustration for each subgroup (21). Table 2 shows the final code groups and subgroups.

Table 2. Overview of code groups and subgroups

Code group	Subgroups
Continuity depends on structural factors.	Elements of the current structure/organisation hinder continuity.
	The midwives made suggestions for how to foster a sense of continuity.
Continuity depends on formal and informal communication channels between service levels.	Birth discharge summary – the formal link
	Maintaining the link that threads the information together
	Phone and text messages as an aid to the flow of information

The fourth step is recontextualisation, which focuses on presenting the common themes that emerge from the data analysis. At this stage, results categories have been developed (21).

Ethical considerations

The Regional Committee for Medical and Health Research Ethics did not require formal submission of the study (reference number 2023/600631/REK West). The study has been approved by the hospital trust’s data protection officer. Sikt – the Norwegian Agency for Shared Services in Education and Research has assessed that the study has a legal basis for processing personal data (reference number 579941).

Results

A total of 16 midwives participated in the study, nine of whom had experience from both service levels. Their mean years of experience was 13.2 (ranging from 1 to 27 years), and the mean age was 43.9 years (ranging from 27 to 61 years).

The analysis resulted in two main findings. The midwives’ perception of continuity between service levels depends on:

- 1. the structure and organisation of and surrounding the service
- 2. formal and informal communication channels between service levels

Facilitating continuity

The midwives found that structural and organisational factors hindered continuity between service levels. This could include inconvenient timing of events that took place in the service. For example, when mothers were discharged from the maternity ward at the weekend, in the evening or during public holidays, the midwives experienced a breakdown in continuity that could result in delayed follow-up of the mother and her family during the early postnatal period.

Adequate staffing, with familiar personnel, also played a role in the midwives' perceptions of continuity. The midwives pointed out that the flow of information between the specialist health service and primary care could vary and, at times, was inadequate.

The midwives reported limited information flow regarding decisions and topics discussed at collaborative meetings between service levels. They also described different and diffuse systems for obtaining information about the mother and neonate, as well as different systems for cooperation between the hospital trust and the local authorities. Midwives who were only familiar with the daily work in the specialist health service had little knowledge of the systems used by the different local authorities.

The midwives clearly stated that there was a difference between small and large municipalities. In smaller sized municipalities, most pregnant women were followed up by a community midwife throughout their pregnancy, which gave the midwives an overview of 'their' pregnant women. Some of the midwives mentioned that they were always available for the women, while office hours governed the accessibility of others.

Perceptions of continuity could also vary from individual to individual, depending on how they organised their working day. The quote below illustrates a midwife's experience of structural factors that hinder continuity:

'We work in the health service after all, and there's a lack of safety nets. I mean, if women are discharged on a Saturday, we can't reach the community midwife. So the discharge summary is sent on Monday. There's no preparedness for emergencies. It's about facilitating continuity.' (Berit)

The midwives discussed alternative ways of organising the services to improve continuity between service levels. They believed that early home visits by a midwife would be beneficial for continuity in postnatal care. One midwife suggested that all midwives be employed by the hospital trust, as this would improve the continuity between service levels.

This single employer could plan and manage shift rotas across service levels. Working in both service levels, with two employers, was described as challenging, particularly if management did not facilitate the coordination of work between the two levels.

Several of the midwives believed that mutual job shadowing could enhance the continuity. Collaboration is easier when you recognise one another, which also facilitates contact, such as by phone.

Some of the midwives expressed a need for an overview of the key information relevant to the other service level. Joint meetings and professional development days across service levels would make it easier to contact colleagues in the other service level. A few of the midwives felt uncertain about what community midwives needed to know, as one midwife describes here:

'I don't have enough knowledge about what's happening out in the community. Especially when there are so many municipalities we send women to.' (Jenny)

The text in the birth discharge summary is worth its weight in gold

The midwives in primary care considered the birth discharge summary to be the link between the hospital maternity ward and the local authority. The birth discharge summary used in the hospital setting contains mandatory information such as blood loss, date and time of birth, and the sex of the neonate. It also includes an open text field where the midwife can add information in her own words.

The participants described text that community midwives found irrelevant and alien. For example, a phrase like 'white ONEWS' provided little useful information, while other essential information was missing. One midwife referred to an example where it was not mentioned that the birth had taken place during transportation, which would have been useful for the community midwife to know.

The importance of common terminology was highlighted as a factor in strengthening the continuity between service levels. The fact that the mother and neonate have separate medical records and discharge papers was seen as something that hindered effective continuity. Having the birth discharge summary include all relevant information was deemed crucial for the community midwife's perception of continuity in relation to home visits.

One of the midwives mentioned that she chose to 'start with a clean slate' during home visits because she felt the content of the birth discharge summaries was incomplete. This sentiment is clearly expressed in the following quote:

'The text [in the discharge summary] is worth its weight in gold! I think, in terms of continuity: the biggest challenge is the lack of information in the discharge summaries.' (Heidi)

Technical differences in data systems made it challenging for midwives in the hospital setting to know how midwives in primary care received information about the mother and neonate after discharge. The local authorities encompassed by the hospital trust used different digital medical record systems. Midwives in the different municipalities, for example, had varying levels of access to the neonate's medical records.

It was assumed that the technical systems would function, but the midwives were sometimes unsure whether the technology could be trusted; whether the information was received by the correct recipient and at the right time. The thread linking the exchange of information was often missing, with a poor flow of information both within and across service levels.

Information could be missing, delayed or altered, as midwife Gro describes here: 'It's kind of like the Telephone Game, "What did you hear?"' (Gro)

The large number of local authorities encompassed by the hospital trust, along with their diversity and differing organisational structures, was a challenge for the midwives. It was difficult to keep track of how to communicate with each local authority. A lack of contact details about one another, such as information on set phone hours or text services, was a barrier to the exchange of information.

Some midwives felt that making phone calls between service levels could cause tension. Others emphasised that phone calls between service levels were useful when more information was needed, as the following quote illustrates: 'I always feel that if I call, things will get sorted.' (Nora)

Discussion

Continuity between service levels depends on the structure and organisation of and surrounding the service

The midwives' perceptions of continuity in postnatal care are both enhanced and hindered by structural factors in the organisation of services and the information channels between service levels. The findings will be discussed in light of Haggerty et al.'s (11) theory of continuity.

The study revealed geographical differences between local authorities and how they carried out the work. The midwives felt that it was easier to keep track of 'their' women in smaller sized municipalities than in larger ones. The differences between local authorities made cooperation challenging, as confirmed by the national clinical guidelines for postnatal care, which highlight the varied approaches to the work across local authorities (4).

The midwives in the study indicated that they should work in both service levels, but they experienced barriers that prevented this. An Australian study examined the transition between two service levels during the postnatal period and found that a more coordinated and systematic approach should be developed for good collaboration between service levels. Whether this will happen depends on, for example, local factors and interest in such an approach (26).

The Caseload Midwifery and Team Midwifery care models focus on continuity in the relationship between the woman and the midwife throughout pregnancy, childbirth and the postnatal period (13). These models have not been implemented where our study was conducted. However, the findings from the study suggest that relational continuity (11) can occur, particularly if the midwife and the postnatal woman are in a smaller sized municipality.

An Australian study that investigated the implementation of midwife-led care models found a need for flexible working practices to maintain continuity in postnatal care. Homer (27) points

out that a deeper understanding is needed of the barriers to implementing care models with continuity in midwifery services.

The Norwegian White Paper no. 12 (28) proposed that a primary care midwifery service could be anchored in hospital trusts. The national clinical guidelines for postnatal care (4) emphasise that midwives working both in primary care and the specialist health service help ensure continuity of care for women and their families. Our findings show that the current organisation deviates from these guidelines and evidence-based research.

Mutual job shadowing programme

The midwives said that mutual job-shadowing across service levels could enhance continuity. It could also lower the threshold for contacting one another and improve the understanding that information needs to be exchanged about the postnatal woman and her baby in the transition from the hospital setting to primary care. This view is supported by a Norwegian study showing that mandatory mutual job-shadowing programmes strengthen cooperation between service levels (29).

The collaboration agreement between the hospital trust and local authorities states that the parties share responsibility for establishing a job-shadowing programme (30). Nevertheless, the midwives in the study pointed out that it was mostly the primary care midwives who took part in job shadowing.

The midwives in the study stated that a lack of resources could hinder continuity, and that increased staffing could improve the chances of implementing job shadowing. An international framework for quality in midwifery services notes that sufficient resources and continuity across service levels are prerequisites for providing good care for women in the perinatal phase (12).

The midwives' experiences with job shadowing could indicate that this is a shared responsibility, and that resources and organisation are both important for collaboration and continuity.

Continuity between service levels depends on formal and informal communication channels between service levels

In the study, the midwives stated that their perception of continuity depends on receiving sufficient information through an effective communication channel to ensure proper follow-up of the woman and the neonate. The birth discharge summary is a formal information channel between service levels designed to meet documentation requirements (31).

The midwives in the study had different experiences of what information was useful to include in the free-text section of the birth discharge summary. The timing of when the discharge summary was sent and received also impacted on its usefulness.

A systematic literature review examining communication between the specialist health service and primary care in relation to patient discharge shows that delayed and poor communication can have a negative impact on patient care in terms of continuity of care (32).

Information continuity (11), which is an important form of continuity, highlights the role that the discharge summary plays as an information channel between service levels.

Our study identified an area for improvement related to more comprehensive information in the birth discharge summary and pointed out that phone contact, an informal information channel, could help strengthen continuity between service levels.

Midwives from some municipalities in our study reported that they were always available for the women, while midwives in other municipalities were not as accessible. The reasons for this discrepancy are not specified in our findings, but it raises the question of whether midwives' work instructions vary, and whether individual midwives' attitudes and commitment significantly impact on their accessibility to the women.

Legislation and collaboration agreements form the basis for cooperation between service levels (7), alongside the principle of equal access to services (33). However, this study shows that differences between local authorities and varying personal engagement from midwives can impact on continuity during the transition between the specialist health service and primary care.

The perception of continuity was particularly linked to adequate staffing, familiarity with internal procedures, and clear agreements between service levels, in line with the theory of continuity (11).

Strengths and limitations of the study

A large focus group represents a significant strength in this type of study, but it can also introduce challenges. The ages and work experience of our participants varied, and this provided a broad and nuanced picture of their experiences. The sample was therefore considered sufficiently diverse to address the research question. This diversity can help ensure external validity, making the study's findings potentially relevant in other contexts (25).

The study participants were colleagues of the first and third authors. The selection process may be affected if participants feel an expectation to take part in the study. While it cannot be confirmed that this was the case in our study, it should be noted as a potential limitation. The theme and context are closely linked to the first and third authors, which can be a strength, particularly if we challenge our preunderstanding and ask critical questions about our own interpretations throughout the research process (21).

The study was conducted in a single hospital trust, and the findings may therefore reflect a local variant. However, they could still be transferable to other areas of Norway, as midwifery services are largely organised in a two-tier system.

Furthermore, midwifery services are subject to the same national guidelines, regardless of geographic location. If findings from a study can be applied to other contexts, they can be considered to have transferability, even if the study was conducted in a defined area (21).

Conclusion

Midwives in a hospital trust and associated municipalities found that knowledge of the collaborating service levels was needed to achieve continuity in postnatal care between the maternity ward and primary care.

The organisation of services and the information channels between service levels impacted on the midwives' perception of continuity in postnatal care. Insufficient or incomplete information between service levels hindered continuity.

Conversely, job shadowing can promote continuity. Future attention to enhancing collaboration between service levels, quality-assuring the content of the birth discharge summary, and improving the flow of information between service levels may improve continuity between the specialist health service and primary care.

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ORGANISATION: There is a need to improve the flow of information about postnatal women and neonates in the transition from the hospital setting to primary care. *Illustrasjonsfoto: Susan Kirch / Plainpicture / NTB*

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