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Is caseloading sustainable? The 25-year history of caseloading at King's College Hospital

FINAL AUTHOR VERSION (NB - This was edited & cut before publication – please refer to the final printed version)

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Introduction

Caseload midwifery is defined as follows:

When a midwife carries a caseload she is the primary provider of midwifery care (the named midwife) during pregnancy, birth and the early postnatal days for an agreed number of women. She may be providing care to women wherever they are: at home, in the community or in a maternity unit. She has responsibility for the planning and monitoring of care throughout for the women on her list. She liaises with medical colleagues and social agencies as appropriate.

(National Childbirth Trust 1995)

Caseloading is a relational model of care provided by a small team of midwives who do on-calls in order to provide a 24/7 service. Midwives have autonomy over their workload, allowing them to respond to the individual needs of women and their families. Mixed-risk caseloading has been an important element of maternity care at King's College Hospital for twenty-five years, where currently almost 20% of the 5-6,000 women who give birth there each year receive caseloading care. In this two-part article, we discuss how caseloading was developed at King's, how the model works, the outcomes and what contributes to the sustainability of this model of care.

Background

As we know from *Call the Midwife*, getting to know your midwife was the norm in the UK from the inception of the NHS through to the 1960s. Continuity of carer was one of the casualties of the Peel Report in 1967 which instigated the wholesale movement of births into hospital, with an institutionalised approach which resulting in fractured maternity care. Today only about a third of women receive continuity of carer in the antenatal period, and a mere 15% of women have met the midwife who cares for them in labour (Care Quality Commission 2018).

In 1993, the Department of Health (DH) published *Changing Childbirth*, which built on important work by Sheila Kitzinger and others, for the first time shining a light on the importance of choice, control and continuity of care, emphasising women's psychological as well as physical safety. Chaired by Baroness Julia Cumberlege, *Changing Childbirth*

introduced the challenging idea that hospitals were not always the safest place to give birth. The report had an electric impact on maternity provision in the UK which is still felt today.

Just over twenty years later, Baroness Cumberlege's follow-up report, Better Births (National Maternity Review 2016), embedded 'continuity of carer' as one of its key recommendations, this time strengthened by important evidence from Sandall et al (2016) demonstrating that midwifery-led continuity models have a significant impact on maternal and neonatal outcomes [Table 1] and that women experience greater satisfaction with continuity of carer when compared to other models. Women recall the quality of their relationships with healthcare professionals as the most important aspect of their care, above place of birth or medical interventions (Davis 2013).

Table 1 Benefits of midwife-led continuity models of care

| |
|--|
| <p>Maternal outcomes:</p> <ul style="list-style-type: none">• 7 times more likely to know the midwife attending their birth• 24% less likely to have a preterm birth <37 weeks• 10% less likely to have an instrumental birth• 5% more likely to have a spontaneous vaginal birth• 16% less likely to have an episiotomy• 15% less likely to use an epidural <p>Neonatal outcomes:</p> <ul style="list-style-type: none">• 16% less likely to lose their baby• 19% less likely to lose their baby before 24 weeks <p>No difference in induction of labour or caesarean section. No adverse effects (PPH, perineal trauma, admission to NNU) compared with models of medically-led care and shared care.</p> <p>(Sandall 2017)</p> |
|--|

Delivering continuity:

Following the publication of Better Births, NHS England has set a goal of 20% of women receiving continuity of carer by March 2019, with a 20% increase in continuity year on year thereafter (National Maternity Review 2016). The previous Secretary of State for Health, Jeremy Hunt, went farther, announcing that the majority of pregnant women will have continuity of carer by 2021:

...the next step in my mission to transform safety standards is a drive to give mums dedicated midwives who can get to know them personally and oversee their whole journey from pregnancy to labour to new parent.

(Department of Health & Social Care 2018)

While Trusts across England search for ways to improve continuity, many initiatives have focused on improving antenatal and postnatal continuity. It is important to note that the evidence of benefit of midwifery-led continuity models crucially includes intrapartum continuity (Sandall et al 2016). Baroness Cumberlege has stated that continuity covering the antenatal, intrapartum and postnatal periods should be delivered using small caseloading teams of 4-6 midwives caring for 30-40 women each (National Maternity Review 2016, p96). This is reinforced in Implementing Better Births:

Services that provide continuity over the antenatal and postnatal periods, with the exception of the intrapartum period, cannot be said to deliver continuity of carer

(NHS England 2017, p18)

Who is caseloading for?

In recent years, where caseloading has been developed, the focus has often been on creating low-risk homebirth teams (Cross-Sudworth 2018; Neighbourhood Midwives 2018). These initiatives can struggle to find sufficient low-risk women interested in homebirths to fill their caseload. Although it is undoubtedly true that caseloading is central to the provision of an effective homebirth service, Better Births does not limit its recommendation for continuity of carer to low-risk women or to those seeking homebirths. Interestingly, Sandall et al's Cochrane Review (2016) does not include any trials where homebirth was offered. Implementing Better Births (NHS England 2017) urges us to:

Start with the women who are most likely to benefit (p31)

Women with complex social needs and minority ethnic women, who experience worse outcomes of pregnancy, have been shown to benefit disproportionately from continuity of care (Rayment-Jones et al 2015; McCourt & Pearse 2000). Limiting caseloading to women who are seeking a homebirth and/or are low risk may result in English-speaking women and those in higher socio-economic groups to be being more likely to access continuity of care (Hemmingway 1997).

The cost of caseloading

Caseloading is traditionally perceived of as expensive due to on-call costs and the smaller number of women cared for. Sandall et al's Cochrane review (2016) identified wide variation in how cost of care/cost-effectiveness was calculated, but found a trend towards lower

costs for midwifery-led continuity models (seven studies). Only one caseloading model in the Cochrane review included an economic evaluation, with cost savings of over A\$567 (£315) per woman (Kenny et al 2013).

Modelling undertaken for Better Births suggests that caseloading could be implemented without a significant increase in midwifery numbers, although funding will be required to manage change (National Maternity Review 2016, p96). Despite this, earlier this year Jeremy Hunt announced an increase in midwifery numbers to support the development of continuity of carer (Department of Health & Social Care 2018).

Developing caseloading at King’s College Hospital

When Changing Childbirth was published in 1993, its aims resonated with King’s Director of Midwifery, Janette Brierley, who believed passionately that any new service should address health inequalities. She set up the first caseloading team at King’s in 1994 (named ‘Brierley’ in her honour following her tragic death later on that year). She was succeeded by Cathy Warwick who was appointed Head of Midwifery and Gynaecology Nursing at in 1995. In her fourteen years at King’s, Cathy Warwick continued Janette Brierley’s precedent. Her vision was that as many women as possible should experience continuity of carer and she believed that the best way to achieve this was to gradually evolve caseloading care, taking opportunities to develop the model as they presented themselves.

Whilst I was at King’s I tried to develop a leadership environment that I thought appropriate to our aim of developing and supporting a caseloading model. There had to be trust in the midwives and flexibility around working patterns... The support for caseloading of the obstetric staff was vital and I was lucky over the years to work with at least three obstetricians who positively advocated the model and others who were supportive.

(Warwick 2018)

Cathy Warwick, and later her successor Katie Yiannouzis, supported the development of several caseloading teams [Table 2], ensuring that the caseloading model included women more likely to experience poor pregnancy outcomes. This is the foundation of the mixed-risk model which is still in place at King’s today.

Table 2 History of the development of caseloading teams at King’s

| Year | Name | History |
|------|----------|--|
| 1994 | Brierley | Set up with support from the independent midwives from the South East London Midwifery Practice (SELMP), two thirds of their caseload comprised of women planning a homebirth across the King’s area and one third comprised of women with serious mental health issues (SMI). |

| | | |
|-------------|-----------------|---|
| 1996 | Bessemer | This specialist team was set up to deliver continuity to teenage mothers, providing antenatal, intrapartum and postnatal care across all settings. |
| 1997 | Albany | The SELMP was subcontracted to work for King's, changing its name to the Albany. Based in the community in Peckham, an area of considerable deprivation, the Albany cared for King's women while retaining their self-employed, independent status. Albany's model differed in that midwives were on-call for their own women 24/7, except for when they were on leave. Over 12.5 years, the Albany achieved a 43.5% homebirth rate and 16% caesarean section rate in an all-risk population with a perinatal mortality rate of 5.78:1000 at a time when the national rate was 7.5-8/5:1000 (Homer et al 2017). The Albany's contract was cancelled in 2009 amidst significant controversy (CMACE 2009; Edward & Davies 2010; Yiannouzis 2010). |
| 1999 | Oakwood | Three newly qualified midwives were inspired by Changing Childbirth, Caroline Flint (Flint et al 1989) and the work of Leicester's Birth Under Midwifery Practice (BUMPS) to approach Cathy Warwick about starting another caseloading team in 1999. Oakwood had an 'all risk' caseload, drawing their women from a local GP in East Dulwich. |
| 2008 | Lanes | A fifth case-loading team, the Lanes, was started up by Cathy Warwick and the new Head of Midwifery Katie Yiannouzis in response to increasing local demand in affluent East Dulwich for homebirths. Based at a GP surgery, they also accepted a mixed-risk caseload. |
| 2011 | Aylesham | Following the closure of the Albany practice, protests from local women prompted Katie Yiannouzis to launch a new King's caseloading team in Peckham based at a local Children's Centre, drawing its women from two local GP surgeries. |

It is notable that most of these caseloading teams included (or were instigated by) newly qualified midwives, and a number of the founding members are still working as caseloading midwives today. The caseloading teams at King's operated alongside two other models of community midwifery, both of which also offered some level of continuity including intrapartum care:

- Two large hospital-based traditional community teams (clinic-based care with one 24-hour on-call a week for homebirths only)
- Four group practices (also developed by Cathy Warwick) offering team-based continuity of care including intrapartum care in hospital and homebirth (three GP-based and one specialist team caring for women with medical complexity) (Beckmann 1996). The group practices were slightly larger than the caseloading teams, with bigger caseloads (circa 45:1 FTE). Under this model, antenatal care was mostly clinic-based and midwives had one or two 24-hour on-calls each week to cover intrapartum care. One person would be on-call each 24-hour period and the group practices seconded each other for homebirths.

This approach had a significant impact on King's homebirth rate, which ranged from 7.1-8.7% in the ten years from 1999-2009.

5 Practising Midwife CASELOADING ARTICLE #1

Caseloading at King's today

Although the group practice midwives enjoyed team working, a 33% increase in the number of pregnant women in the area between 2002-2007 led to them struggling to provide continuity and cover their births, with high levels of burn-out from 24-hour on-calls. There were also concerns that three of the caseloading teams were clustered in one small geographical area (Peckham/East Dulwich), leaving most of the King's area to be covered by Brierley, who now had so many homebirths that they only had capacity for 25% of women with SMI at the Trust.

In 2013, a need to streamline midwifery services to ensure equity across the patch prompted a service review using Birthrate Plus (Birthrateplus 2018), led by the Deputy Head of Midwifery for community and antenatal services Tracey MacCormack and Consultant Midwife in Public Health Jill Demilew, supported by the new Director of Midwifery Maxine Spencer. All midwifery services were mapped and audited to explore the strengths and weaknesses of a system whose range of models reflected its organic roots.

An audit of women who had given birth between 2010-2014 at King's showed that outcomes were significantly better for women who had received caseload care when compared to traditional or group practice care. Caseloading also made the greatest contribution to the Trust's overall homebirth rate (which had reduced to 5.0-5.8% after the closer of the Albany and the introduction of a midwifery-led suite). Individual caseloading teams achieved 20-30% homebirths, compared to the group practices whose homebirth rate ranged from 5-10%.

All women who gave birth at King's between 2013-2015 were profiled based on postcode and socio-demographic characteristics to identify areas of greatest need. In a bid to design a more equitable service across the Trust, providing gold-standard care to some of the most vulnerable women while maintaining both the high homebirth rate and other positive outcomes of caseloading, a new structure for community midwifery at the King's Denmark Hill site was proposed:

- The Trust's catchment area would be divided into four equal segments based on geography, numbers of women and profile of need. Each new area would be served by one caseloading team and a partner 'traditional' community team.
- In addition, the Trust would maintain the specialist caseloading team for young parents a specialist team for high-risk/diabetic women (including on-calls) as well as a traditional team caring for out-of-area women.
- The new caseloading teams would take on responsibility for all homebirths, including a rota for attending 'born before arrival' (BBA) births. Staying true to the 'mixed risk' approach which King's had always espoused, the caseloads were broken down as follows:

- 1/3 women with SMI (i.e. schizophrenia, bi-polar disorder, history of serious depression etc.)
- 1/3 women who wanted a homebirth (including some with pre-existing risk factors wanting out-of-guidelines care)
- 1/3 women with other vulnerabilities (i.e. previous traumatic birth) and low-risk women open to home assessment in labour who might go on to choose a homebirth.
- Their sister traditional teams were relieved of on-calls and homebirths but were expected to provide higher levels of antenatal and postnatal continuity, with each midwife having their own dedicated clinic and becoming true 'named midwives'.
- Almost all clinics (caseloading and traditional) were relocated to community venues, so that women across King's would be cared for near home, fitting in with the Better Births agenda of working across boundaries (National Maternity Review 2016).

This change to community services was implemented at King's on the 28th of September 2015. The process was challenging for managers and community midwives alike as familiar teams, geographical areas and ways of working were disrupted, and the overall number of community midwives was reduced. New team names were chosen and the five caseloading teams became **Juniper, Electric, Grove, Birchtree** and **Young Parents Midwifery Practice (YPMP)** with most of the caseloading midwives remaining in this model and most of the group practice midwives being absorbed into the new 'traditional' teams.

Two years on, the dust has begun to settle. In the next article we reflect on how these changes affected one caseloading team, explore how the change in community services has impacted on the outcomes for women and children, and discuss the lessons learned about sustainability from 25 years of caseloading at King's.

PRACTICE CHALLENGES

1. Consider the demographic profile of the women cared for in your trust: which groups of women would benefit most from caseloading care?
2. How could the enthusiasm of newly qualified midwives/preceptors and the experience of senior midwives be harnessed in the development of caseloading at your trust?
3. The RCM have developed an i-learn module on developing midwifery-led continuity models of care: <https://www.rcm.org.uk/system/files/RCM-Can-continuity-work-for-us-2017.pdf>. They have also produced i-learn RCM modules on homebirth, including how to set up a homebirth team.
4. Develop your ideas about caseloading as you would any other service development, by building a business case to present to senior management – you will find useful guidance here: <http://kfh.libraryservices.nhs.uk/high-profile-health-libraries/making-the-case-advocacy/building-a-business-case/>

5. Consider visiting other Trusts where caseloading is well established, and listen to their advice: no need to reinvent the wheel!

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