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PRE-PRINT VERSION

**Is caseloading sustainable? Lessons from the front line at King's College Hospital
Sadie Holland & Octavia Wiseman (2018)**

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At King's College Hospital in Camberwell, south London, we have a 25 year tradition of NHS caseloading, with named midwives providing continuity for all antenatal, intrapartum and postnatal care for women and their families (Wiseman & Holland 2018). Caseloading midwives care for 900-1,000 mixed-risk women each year, about 18% of King's 5000-5,500 births.

In this article we describe the experience of caseloading from the perspective of the 30 midwives at King's working in this way, and we have included their voices here, as well as those of local women who have received caseloading care. We discuss how we organise our teams and how we coped with the challenge of major organisational change. Finally, we reflect on our outcomes and what contributes to the sustainability of the caseloading model.

Why work as a caseloading midwife?

Our experience of caseloading has been one of deep personal and professional satisfaction. We have close relationships with our families and feel happily entwined with them while they are in our care. We are proud to see them do well, and feel that we can provide good support to those for whom the journey is not straightforward. Watching women and their partners develop into families is absorbing and enriching:

I have worked in antenatal clinic, labour ward, postnatal ward and GP surgery but I've found the last ten years working as a caseload midwife the most rewarding.

[Caseloading] has empowered me to empower women at a time when they need it. It's hard and needs a massive amount of commitment to do it and keep the focus on the woman and her family, rather than the hospital being the centre of it all. I think it is fulfilling and ensures you as a midwife have a broad understanding of midwifery.

We are proud of the breadth of our skills, from booking right through to postnatal care. We manage every kind of birth, from homebirth to high-risk intrapartum care, following our women to the setting where they choose to give birth.

Clinically there are great benefits in seeing the effects of what you have done and what you have failed or decided not to do for the women. Learning from the women's experience is incredibly valuable and these are lessons never forgotten.

Providing continuity

Each caseloading midwife takes on three new women every month; a personal caseload of 36 women per year. The relationship with the family starts at booking, usually at home, and lasts through to discharge up to 28 days postpartum. There can be flux in the caseload: some women will move away or develop medical complexities which can mean they are better served by another team. They are replaced by women we are asked to care for because of mental health or social concerns; because they have chosen homebirth or birth outside King's guidelines. Women appreciate this kind of continuity:

I don't think I would have been able to do it without the amazing support you provided. Even though it was a little difficult after K was born and I was rushed away I never felt worried or scared and that was because of you.

I feel we got to know and trust each other and this I think is one of the most valuable and challenging skills to master in healthcare

Each midwife hopes to attend the births of 'her' women, but it is also important for midwives to have protected time off and this means that we can miss some of the births we have prepared for. We attended 88% of our births in 2017, missing the others because of simultaneous labours, not enough staff or not being called by Labour Ward. Midwives usually have a 'buddy' in the team who will meet the woman once or twice, and the teams arrange gatherings where women meet the other midwives, hear birth stories and talk through birth preparation so women are highly likely to know the midwife who cares for them in labour.

Challenges

The downside of caseloading is, of course, living with the pager. The demands of

being on-call three nights a week and working every other weekend are onerous and can be difficult. However, at King's we have seen caseloading work, even for those with small children.

Each team usually has three or four midwives working each day (three at weekends), with two of those midwives on-call between 5pm-9am. The advantage of having two midwives on-call is that for homebirth we provide both first and second midwife from our team. We can divide the night so that one midwife works until around midnight with the other, fresher, colleague able to take over until morning. Although this means that a woman may have more than one midwife caring for her, having a safe practitioner is paramount. We 'preserve' the on-call midwives by ensuring they do not do labour care during the day. Because of this it is only in very rare situations that the on-call midwife would work up to 24 hours. Midwives take as much of the next day to sleep as required.

A work patterns analysis of caseload midwives working with a similar model to ours (McCourt 1998) found that midwives' actual work hours conformed closely to 37.5 hours a week and they spent on average 6.5 hours per week working out-of-hours, demonstrating that that midwives are not working unacceptably long hours. If there are simultaneous labours, we prioritise homebirths, which our women understand, and occasionally some women will be looked after by Labour Ward colleagues. In the case of two homebirths, or if only one midwife is on call, we call our 'sister' teams for support.

The caseloading model is widely assumed to lead to burnout and it can involve a lot of emotional work:

Caseloading is not just a job to us. Most of us have had spells of finding it difficult to switch off. I know I am not the only caseloading midwife to have checked on holiday whether 'my' women have given birth, and how they are coping.

However, research has found that control over workload and continuity of care contribute to wellbeing for midwives. Caseloading may actually lead to *less* burnout and provide a sense of greater personal accomplishment than other models of care (Sandall 1997). This has certainly been our experience.

The appreciation from women and their families can be truly heartfelt and we all know families to whom we have made an enormous difference. That's what makes me carry on in caseloading. I wouldn't like to work any other way.

The challenges which cause most dismay come from outside our caseloading responsibilities:

Getting up in the middle of the night to attend a labour is never exactly fun, but when you know the woman and her story, it is relatively easy to throw on your clothes and head out into the night. Being called in to help out on an understaffed labour ward is not the same at all.

Better Births states that caseloading midwives must be protected from filling in gaps in staffing on labour ward (NHS England 2017). At King's there have been periods when we have been asked to do this regularly. It has had a measurable impact on our wellbeing and the care we can provide: for example, a night helping on labour ward can lead to missing one of our own women's births the next day.

Cathy Warwick, who was largely responsible for developing caseloading at King's, commented

If I were to have my time again I think I would set my expectations of the caseloading teams a little more clearly. It was perhaps too easy, at times, for midwives working in these models to be required to cover service gaps or equally not always to take responsibility for working together to manage their own caseload. The former situation can lead to burn out and the latter to resentment. Neither seems necessary or productive.
(Warwick, 2018)

Team working

Each caseloading team is made up of a Band 7 team leader, five FTE Band 6 midwives and one maternity support worker. There is something wonderful about working with supportive colleagues who understand your strengths and weaknesses, who will provide advice, step in if you are tired and support you in challenging situations. Occasionally we will do home visits in pairs, or make ourselves available for a junior member of the team. Five King's midwives have been caseloading for between 10-20 years, bringing huge depths of skill and experience to our service:

We received amazing support from the senior members of the team while we developed the all-round skills needed by caseloading midwives

Midwives manage the care of their personal caseload and control their own diaries, giving them the flexibility to pursue their personal, clinical and administrative interests i.e. Newborn and Infant Physical Examination (NIPE), audit or parent education. Mutual support and daily discussion over cups of tea and lunch create team cohesion. We listen and learn from each member of the team. Talking through a difficult situation allows us to consider both experience and evidence, and our closeness as colleagues and friends enables us to do this in a challenging but friendly way. This kind of support is not so much a bonus as an essential element of the model to avoid burnout:

Caseloading is not just great care for the women, but also for midwives. To work in a supportive, non-judgmental environment where you can really rely on your colleagues was the main reason I've been able to work that way for almost 20 years.

Developing close relationships with our 'sister' teams, consultant midwives, linked obstetrician and perinatal psychiatry is also essential for our sustainability.

Establishing a caseloading team in a new area

A major reorganisation of community services at King's in 2015 seeking to ensure parity across the whole King's area (Wiseman & Holland, 2018) involved moving caseloading teams to areas of significant socio-economic and ethnic diversity. The Lanes team moved from affluent East Dulwich to Brixton/Camberwell, becoming 'Electric' (after the famous Electric Avenue in Brixton). Electric, like all the new caseloading teams at King's, now took on all local women with serious mental illness (SMI), making up about a third of our caseload. Another third of our caseload have other vulnerabilities; the final third seek homebirth.

With the move, we lost loved and respected colleagues who went to work elsewhere. We had had stability of staff for three years; suddenly only two of six were left and we had to get used to new team members at the same time as learning new streets and engaging with a very different demographic. We also became 'homeless', losing our base, and realised just how important it was to have a space of our own to have free discussions about our women, do our administration and store our equipment. Electric midwives had to work a lot harder to explain the benefits of caseloading and of out-of-hospital birth to our new women. In East Dulwich, almost everyone knew someone who had had Lanes midwives and our care was understood and prized. Word of mouth made it easy to talk about the benefits

of homebirth. Even after two years in our new area, which is much larger geographically, we often have to explain that homebirth is even possible, and many women are astonished that we can see them at home. Simply getting around a super-urban area is challenging; parking is difficult, cycling dangerous (yes, some community midwives still cycle!) and there are areas in which we don't feel safe at night.

Nevertheless, it was not long before we were looking after women who were amazed and delighted by the care we offer. Some families who had never considered homebirth ended up choosing one. Our 'Electric' women are generally younger and more ethnically diverse; we have met many fabulous grandmothers and sisters who have helped with the care in ways we never imagined when we were working in a largely white affluent area.

We are equally proud of our care for women with SMI which was one of the greatest challenges we faced, requiring us to increase our knowledge and skills. We regularly attend Perinatal Mental Health and Safeguarding meetings, we have managed admissions to Mother and Baby Units and supported pregnant women in the Maudsley Hospital. We have been very frightened for the wellbeing of a few mothers and their babies, but the continuity we provide has made a crucial difference to the levels of trust, as well as recognition of change in mental health. One mother acknowledged:

We simply wouldn't have had the joyful beginning we have had without you; nor felt so able to be honest about the anxieties and strains

Outcomes

Change has been really hard, but so worth it! I really know what 'making a difference' means now.

KCH caseloading midwives are very proud of our outcomes. Rates of spontaneous vaginal birth range from 68-78%. At Electric in 2017, 39% of women were high-risk at booking, and 59% were high-risk at onset of labour. Nevertheless, Electric's caesarean section rate was only 14%, and 9% instrumental birth, while 31% of women not receiving caseload care had a caesarean and 15% had instrumental births.

Homebirth has been well established at King's for many years, enabled by experienced and confident midwives, and reaching a peak of 8.7% in 2004. The

homebirth rate dropped to 5-5.8% in 2010-2015 after the loss of the Albany and the introduction of a co-located Midwifery-led birthcentre. Since the reorganisation of community teams, the new caseload teams have attended about 250 homebirths a year (2016 and 2017) sustaining a 5% homebirth rate which is two-and-a-half times the national average of 2.1% (Office for National Statistics 2017). This is a significant achievement given that, after the reorganisation, all homebirths were facilitated by the caseloading teams, two of which moved to geographical areas new to homebirth (previously five group practices and two traditional teams had also attended homebirths). Electric's homebirth rate in 2017 was 24%, up from 20% in 2016. Transfer rate was 15%. Some of the other teams, located in areas where there is a greater tradition of homebirth, attend around 40% of their births at home.

Several factors are crucial in maintaining and increasing our homebirth rate:

- We take time and care over a 'birth talk' at 36 weeks in which we formally discuss place of birth, having seeded the idea of out-of-hospital birth right from booking. Clear documentation of these discussions is crucial.
- We offer home assessments in labour, and each team carries out about 100 each year. Home assessment helps to keep women out of hospital until they are in active labour, and to provide reassurance and support when it is needed. Because caseloading midwives carry their homebirth kit at all times, they can give women a choice of place of birth when they are actually in labour: quite a few women who planned hospital birth decide in labour to remain at home.
- We have clear homebirth guidelines which support our practice and standardise transfer and emergency procedures.

Sustaining caseloading

One of the great challenges for caseloading is staff recruitment. An audit of Better Births early adopter sites found that only 35% of midwives were willing to work in caseloading including intrapartum care across all settings. A larger portion (45%) were prepared to do intrapartum care for homebirths only and 50% of midwives said they felt confident to be the first midwife at a homebirth (Taylor et al 2018). In the same study, the three main things midwives said would help them work in a different setting were: shadowing opportunities (52%); more flexibility to organise their own work (47%) and training/updates (46%). A summary of the elements which we believe have helped sustain caseloading at King's over the last quarter of a century are outlined in Table 1.

At King's, we have found that once they have tried caseloading (for example as students or as part of their preceptorship rotation), many midwives choose to stay. For some, caseloading is for life.

Caseloading is the only model of care which has allowed me to feel that I can do a really good job for women as a midwife and this is because you have the time to get to know the women, time to reflect and people who support you.

Table 1 Elements which help sustain caseloading at King's

What has helped sustain caseloading at King's over the last 25 years?

- Management support and a shared vision of gold-standard woman-centred care
- Team working & mutual support within the team
- Respect for time off
- A dedicated team base
- Autonomy over workload and the flexibility for teams to decide how they want to work together
- Respect for professional boundaries (not being diverted into understaffed labour ward)
- No more than three on-calls a week, and no 24-hour on-calls
- A good working relationship with the inter-professional team, ensuring that transfers of care are smooth and mutually respectful
- Being able to recruit students with experience of caseloading during training
- Accepting preceptees into caseloading teams

Conclusion

The experience at King's reflects research findings that midwifery-led continuity of care is satisfying for both women and midwives and delivers better maternal and neonatal outcomes than standard care. Having explored a range of models, King's found that caseloading is the most effective model to deliver consistent intrapartum continuity and a high homebirth rate, even within a mixed-risk model.

To our knowledge, despite Jeremy Hunt's aspiration for the majority of women to receive continuity of carer by 2021, there has been little work conceptualising what such a service might look like. Important lessons for the future will be learned from King's and other Trusts who have experience of mixed-risk caseloading, as well as

from Better Births initiatives which are extending caseloading to vulnerable groups such as in Lewisham (the POPPIE project for women at risk of pre-term birth), Croydon (asylum seekers) and Guy's & St Thomas' (socially vulnerable women including non-English speakers).

A larger challenge may be whether the majority of midwives will agree to practise in this model. If it becomes the dominant model, midwives may have little choice, but such a wholesale change is likely to take more time than currently anticipated. At King's we found that engaging midwives in caseload working needs to be addressed in the culture of the unit, during midwifery training and preceptorship. Any Trust wanting to deliver continuity of carer will need to do so in a way that recognises that midwives need reasonable working patterns (Warwick, 2018). Because of this, research is also needed to explore the effectiveness of models of continuity which do not include intrapartum care.

References

McCourt C (1998) Working patterns of caseload midwives: a diary analysis. *British Journal of Midwifery* 6(9):580-585

NHS England (2017) Implementing Better Births: Continuity of Carer. Available: <https://www.england.nhs.uk/wp-content/uploads/2017/12/implementing-better-births.pdf>

Office for National Statistics (2017). Birth characteristics in England and Wales: 2016. Available: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriage/livebirths/bulletins/birthcharacteristicsinenglandandwales/2016> (accessed 15.3.18)

Sandall J (1997) Midwives' burnout and continuity of care. *British Journal of Midwifery* 5(2):106-111

Taylor B, Cross-Sudworth F & McArthur C (2018). Better Births and continuity: Midwifery survey results. University of Birmingham, Birmingham

Warwick C (2018) Personal email, March 2018.

Wiseman O & Holland S (2018) Is caseloading sustainable? Lessons from the history of King's College Hospital (REF t/c)

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KCH Caseloading model
Staffing: One Band 7 team leader, five Band 6 FTE midwives and a maternity support worker. Some teams have midwives who job-share or work part-time. Student midwives and preceptees on their final rotation are welcomed.
Ratio: Each caseloading team provides comprehensive care to 210 women p/a from booking through to discharge. Each midwife books 3 women a month onto her caseload (1:36 ratio: the team leader booking fewer women to allow time for administration).
Community-based: Caseloading midwives are usually based in Children's Centres with access to a clinical room but many appointments take place in women's homes.
Continuity: Each woman has a named midwife who provides all or most of her care, with support from a 'buddy' midwife to cover annual leave/days off. Regular events are held so that women get to know the team, increasing the likelihood that they will have met the midwife attending their labour.
On calls: Each FTE midwife works five days across the week, including every other weekend, and is on-call three nights a week (women understand that they may be attended in labour by another midwife in the team if their midwife is not working). This enables a 24/7 service with two midwives on-call every night. Midwives are paid a basic out of hours on-call payment, and then normal unsocial rates for any work done.
Autonomy: Midwives have high levels of autonomy, allowing them to manage their workload in order to be responsive to women's needs and the needs of their team.
Home assessments: Midwives carry out home assessments for women in labour, allowing them to choose at that point where they would like to give birth (home, MLU, OU). The midwife remains with the woman whatever her place of birth, including theatre if CS is indicated.
Homebirths: At homebirths a second midwife is called for second stage. If there is more than one homebirth, or if staffing is low with only one midwife is on call, other caseloading teams will offer support.
Covering gaps in ward staffing: Caseloading midwives are not expected to regularly cover gaps in ward staffing as it is understood that their own work is their priority. At times of great acuity on the wards the caseload teams are asked if they can help. Depending on the teams' workload, caseloading midwives decide how much help they can offer.
Governance: Midwives follow Trust guidelines, which take into account out of hospital care (i.e. homebirth guidelines address handling emergencies in a community setting)

