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# Is It Possible to Establish a Caseload Model of Midwifery Care Across the United Kingdom?

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## Abstract

Midwife Continuity of Care Model (MCOC) is a model of care designed to provide the best quality of care. Also to find the best structures or patterns of practice according to a woman´s needs, expectations and beliefs. This model was designed with the aim to provide antenatal, intrapartum and postnatal care by a named midwife, or small group of midwives, to women who are healthy or deemed "low risk". Therefore, MCOC enables midwives to act as facilitators, empowering women to use their own capacity of rational to make decisions regarding their pregnancy and childbirth.

**Keywords:** Midwife continuity of care model; Pregnancy; Childbirth

## Introduction

The Changing Childbirth Report was produced in 1993 as a result of the recommendations published in the Winterton Report in 1992. The Winterton Report arose from the need to support women and their families to have choice, control and continuity in their maternity care. This was further supported by the Health Commission´s Review in Maternity Services 2008. From this report caseload holding is a form of midwifery-led care that understands pregnancy and birth as a normal life processes (Flint, 1993). Women under Midwife Continuity of Care models (MCOC) are less likely to have surgical interventions such as instrumental deliveries, episiotomies and caesarean sections. Maternity care in United Kingdom is a medicalised model of care. It comprises of midwifery-led care shared by a multidisciplinary team which includes general practitioners, obstetricians and midwives [1]. By contrast, caseload midwifery is aimed to reduce the discontinuity of care of having several different health professionals for pregnancy and childbirth. Evidence has demonstrated this can reduce costs, increase women´s satisfaction and reduce interventions in childbirth in comparison to other models of care.

This paper aims to review two articles whose methodology was based on a quantitative approach and qualitative approach in order to explore the strengths and limitations of Caseload Midwifery Model. It also explores the possibility of implementing this model of care across the United Kingdom [2]. The quantitative one seeks to study "caseload midwifery care versus standard maternity care for women of any risk: M@NGO, a randomized controlled trial". In contrast, the qualitative one aims to explore "women´s views on partnership working with midwives during pregnancy and childbirth" Furthermore, it explores the role of the midwife as a lead professional in this model of care [3].

In the Tracy paper, researchers used a quantitative method according to the purpose of the study previously stated in the introduction. The authors clearly established the level of the research in the title and in the summary of article. In comparison, Forster et al., (2016) purposed a randomized control trial aiming to demonstrate that continuity of care by a primary midwife increases women´s satisfaction with antenatal, intrapartum and postnatal care. Tracy et al., conducted a Randomized Control Trial (RCT) at two metropolitan teaching hospitals in Australia [4]. Randomized control trials are the gold standard of quantitative research. RCTs are classified as level 3 questions. According to Wood and Ross-Kerr, level three questions are defined as "questions used to test hypotheses based on already established theories about a topic". This randomized control trial evaluated two different primary outcomes: Maternal outcomes identified the proportion of women who had a caesarean section, the proportion of women who had instrumental or unassisted vaginal birth and the proportion who had epidural analgesia in labour. Neonatal outcomes addressed to babies´ Apgar score after birth, preterm babies and babies who were required to be admitted into the Neonatal Intensive Care Unit [5].

## Literature Review

The data collection seemed suitable as medical records allowed the researchers to access information at any time. Data was entered into the hospital IT system by the attending midwife and checked electronically by the research midwives. Ethical considerations are included in this paper as all participants provided written informed consent. Ethical consents were gained from all relevant university and Area Health Service human research ethics committees [6]. According to the Royal College of Midwives (2004), all participants involved in a research study are entitled to expect that the research study accomplishes appropriated standards, and that is adding something to the body of knowledge. In Tracy et al., paper a total of 1748 women were eligible for the study. These were randomly assigned, with 871 to caseload midwifery and 877 to standard care. The inclusion criteria included women aged 18 years and older who were less than 24 whole weeks pregnant at the first booking visit. The exclusion criteria included women who had already planned to have an elective caesarean section, had a multiple pregnancy or were planning to book with another care provider [7].

The sample was collected by using an unblinded, randomized, controlled, parallel- group trial. This type of RCT is aimed to identify which intervention condition will work best. In respect of the sample size and statistical power, the total population subject to eligibility was 1748. Women random selected to receive a new intervention (Caseload Model of Care) are compared to those selected to receive standard practice (Standard Care). However, women who received standard care were well-suited to answer the aim of the study of whether introducing caseloading could improve outcomes over and above the current state of practice. Validity is used to estimate if the data collected, measures what the researcher intends to measure. Random sampling evaluates the external validity of the research. External validity is not guaranteed, as this study was carried at two teaching hospitals in Australia. Further studies should be conducted in

other settings in order to generalize the results. According to Cluett and Bluff, p value is defined as "the level of statistical significance at which researchers deem the chances of obtaining a level of type 1 error, to be small enough for the purposes of their study" [8].

The use of power calculation was reported in Tracy sampling error was minimized as the calculations were based on the basis of the preliminary outcome data after the restructuring of the maternity service and the introduction of the first midwifery group practices for all-risk women. Therefore, type 1 error needs to be considered in order to analyze the data of each group with the aim to accept the null hypothesis as valid. According to the results obtained in the study conducted by Tracy et al. Midwifery Case Model of Care contributed to a significant difference in the overall median cost of birth per woman. This significant difference is represented with p=0.02. This means that the probability is very small, suggesting that the outcome was due to the intervention instead of the chance. Although, there is still a small possibility that the outcome was due by chance. For instance, women in the standard group were more likely to have an elective caesarean section than women who were in the caseload group. The proportion instrumental or unassisted vaginal births and the proportion who had epidural analgesia in labour were less significant in the caseload group [9].

With respect to neonatal outcomes, the number of babies who has an Apgar score of 7 or less at 5 minutes was similar in both groups. Moreover, there were no significant differences between the number of babies born preterm and those admitted to Neonatal Intensive Care Unit. Boyle paper seeks to gather information about women´s views towards partnership working with midwives during pregnancy and childbirth rather than generalize the results to greater level or different settings. For the purpose of this study, the authors did compare their findings between the Caseload Care (midwifery led-units) and Standard Care (shared care guided by community midwives). The process of gathering information was performed by conducting diary-interviews in two district general hospitals in the South East of England. According to the researchers' goals, interviews seemed to be the most suitable tool for data collection on the topic (Richards and Schwartz, 2002). Furthermore, interviews are relevant in midwifery research as they provide an opportunity to carry out a woman-centred approach to issues and situations [10].

Grounded theory is one of the three main approaches to qualitative research and it provides an explanation and insight into the phenomenon that is being studied. A social constructivist approach was used to accomplish the aim of the study. Social constructionism attempts to makes sense of the social world by focusing on behaviour and studies of how phenomena and social reality are constructed. The sample was conducted during the face-to-face booking interviews at approximately ten weeks of gestation by using a purposive sampling approach. Purposive or purposeful approach enables the researchers to provide information to the participants of the phenomenon that is being studied. The sample recruited was 16 women. Although is a small sample, it seemed suitable in qualitative research. Ethical considerations are also included in this paper. Participants were provided with written information and informed consent was signed by them. According to Bowling, any participant involved in research has the right to confidentially, voluntary participation, informed consent and protection against physical or emotional harm [11].

Data analysis was conducted by using a thematic approach. A thematic approach was achieved by reading the transcripts several times and identifying empirical codes. By conducting this analysis researchers try to demonstrate that the individual´s reality is faithful to their experiences. Moreover, the researcher ascribed a memo to each code in order to describe the meaning for each code segment. It was also relevant to acknowledge the influence of the insider perspective due to the direct involvement of the researcher with the research setting [12]. To assess the findings, three categories were identified with the aim of the study. The three main categories identified were organisation of care, relationships and choice. According to Better Births, organisation of care was described as "how maternity services were organised in relation to woman´s contact with the service and subsequent midwifery care and women´s experience of care by the midwife and the factors that impact on the quality of that experience". Women under caseload care reported a reduced scheduled period of time in each antenatal appointment. This was associated with lower levels of satisfaction in relation to the care received.

In addition, women also reported that midwives spent too much time completing midwifery records. Record keeping remains an integral part of midwifery practice as a professional tool to help the process of care (Nursing and Midwifery Council, 2002). As a consequence, women felt that not having time enough to discuss things related to their aspects of care. The authors described partnership relationship as a dynamic relationship that recognises the autonomy of both partners enabling reciprocity and facilitating shared decision making. Two different sub-categories we identified within this theme: women´s perspective and interpersonal categories. This record keeping compromises the importance of building a trusting relationship with their midwives. While building a trusting relationship with their main carer, was demonstrated to ensure a positive childbirth experience. However, women attending the birth centre, did report that they did not see the same midwife in each visit. Subsequently, some women reported lack of emotional support despite achieving continuity of care [13].

Interpersonal interactions were focused on the extent to which the midwives´ style communication met the women´s needs and expectations in regards choices of care. A Hailey et al., (1998) conducted a study to describe the effects of how communication style can influence women´s satisfaction [14]. The results of this study suggested that women who were allowed to make informed choices were more likely to achieve higher levels of satisfaction. Boyle et al. paper, women who received midwifery led care were generally allocated longer appointments than women received standard care. Maternity Matters (2007) described the concept of choice as "the extent to which women either wanted to be involved in decisions, or contributed to decision making during their pregnancy and birth". Women who had received standard care described that physical care undertaken by community midwives as medical. By contrast, women who had caseload care reported that they felt empowered by their midwives to make decisions as the midwife acted as a facilitator [15].

## Discussion

Clinical leadership remains a key concept of a midwife´s role. Therefore, leadership is the responsibility of all healthcare professionals whether or not they occupy a formal leadership role. Subsequently, leadership has been defined as "the influence with a purposeful intent to generate positive change; that it is a highly social and relational process that requires engagement, integrity and authenticity; and finally that it is heavily contextualised and pragmatic in order to suit the identified purposed and desired outcomes". This new conception of leadership compromises three main aspects:

pragmatic and contextual leadership, relational and authentic leadership and the importance of the influence [16]. Nonetheless, this model of leadership was first described by Lewin in 1950s´ and is still used nowadays. Lewin explained organisational change by identifying three different stages. The first identified stage was "unfreeze", which requires changing attitudes in order to propose a change. Communication remains an important aspect to propose change. The following step implies "change" that will enable effective communication by developing new ways of working and by learning new attitudes, values and behaviours. The final stage was identified as "refreeze" due to the establishment of the benefits of change. In this step, reinforcement by managers is required with the aim to accomplish an effective performance at an organisational level [17].

Leadership in midwifery practice remains essential as it is aimed to maintain autonomy and responsibility, develop strategic thinking, ensure high standards of care, acquire management experiences and introduce new approaches to practice. The Changing Childbirth, introduces successful strategies to support the change. Furthermore, it also needs to be considered the limited resources available to sustain professional development. As a consequence, it remains essential to identify the qualities and skills to become a effective leader. According to Kouzes and Posner these qualities and skills will address different aspects such as thought, language and action. This will enable midwifery leaders to effect change in practice. However, effective management is required in order to achieve the processes of planning, implementation and control. As discussed before, The Changing Childbirth (1993) focused on three themes choice, control and continuity with the purpose to introduce a change. Transactional leadership emerged with the aim to build the exchange of valued services in order to enhance woman´s satisfaction. By contrast, transformational leadership was expressed by feminine principles that enable midwives to learn from women [18].

Nowadays, maternity services in the United Kingdom are facing a great challenge (implementation of Caseload Model of Care). For this reason, leadership becomes an important tool to enable the change in the culture of care. Caseload Midwifery Care recognises the midwife as the leader to initiate, guide and facilitate continuity of care during pregnancy and childbirth. The role of the Supervisor of Midwives (SOM) provides a framework to support this change as supervision includes a leadership role to develop midwifery education and ensure that midwives are fit to practice (Nursing and Midwifery Council, 2004). This leadership style will promote women and family-centred care which improves professional standards for contemporary pre- and post- midwifery education. According to Yearley, leadership through supervision will commit to achieve excellence in midwifery education and practice. Kay conducted an ethnographic research with the purpose to describe the experience of midwife team leaders. The study was performed in a community midwifery service made up of four midwifery teams. All midwifery leaders were invited to participate in the study and only five out of twelve agreed to participate. Data was gathered through observation, records and interviews. Findings highlighted the importance of recognising a good leader at the level of midwifery team leader to achieve the best outcomes for both midwives and women under their care.

## Conclusion

After critically analyze both articles, appears fundamental to emphasize the importance of evaluating the topic from two different approaches in order to explore and understand the information gathered from different pathways enhancing the results. As discussed above, the articles examined midwifery case model of care as an important change in the maternity services of Australia. Case Model of Care would imply benefits for both Australian Health Care System and women who plan to have a baby. To generalise the results from these studies, further research should be undertaken in the United Kingdom. Integrating caseloading in this way has shown to have favourable clinical outcomes such as women´s satisfaction due to continuity of care and reduced rate of interventions during labour. This has led to demonstrate cost- effectiveness with an important difference in the overall median cost for woman. Furthermore, women working in partnership with midwives have reported that knowing their midwives enabled them to build a trusting relationship with them. This trusting relationship facilitated them to achieve a positive childbirth experience.

Leadership remains crucial in caseload model as midwives working in this model of care should be able to manage their time according to their client´s needs. Midwives integrating caseload models of care will be recognised as leaders enabling the change to achieve high standards of care. Limitations addressed to Caseload Model of Care are related to either midwives or women. Evidence has demonstrated that women under this model of care may influence staff attitudes to become more stereotyped or unsupportive. It also need to be considered the shortage of staff which remains an actual problem in the National Health System. On the other hand, it has also been demonstrated certain levels of burnout due to working hours and anxiety regarding problems resolution (Smith et al., 2008 and Yukiko et al., 2013). Furthermore, the implementation of caseloading will imply challenges to change the culture adopted by senior midwives and to introduce newly qualified midwives. Midwifery 2020 acknowledges all the limitations stated above with the purpose to achieve high quality of care in the maternity services of the United Kingdom. Therefore, a consistent leadership framework orientated to both midwives and supervisors of midwives needs to be developed in order to establish this model of care across the United Kingdom.

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