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Sustainable birth: caseloading

Jo Killingley

The *Better Births* national maternity review (NHS England 2016) has been gratefully received as a chance to improve maternity services to support women-centred care for better birth experiences. As Baroness Cumberlege stated (NHS England 2016) the commitment, determination and passion from health professionals to improve outcomes for women, babies and their families have been crystal clear. Therefore this is a perfect opportunity to engage and encourage caseloading in maternity units as a sustainable and viable model of care which supports women and promotes midwives' satisfaction.

Thankfully, women still have faith in normality; their desire strengthens their urge to seek external commodities outside of the NHS, such as independent midwifery, the National Childbirth Trust (NCT) and the rise of hypnobirthing to satisfy their need to be supported, and is at the heart of decision making as fulfilled independent mothers. Therefore the demand is clearly apparent and service providers should be encouraged to adopt a caseloading model capable of providing a sustainable approach and meet the needs of the service user.

Caseloading is a model of care where midwives carry their own caseload of women to form trusting relationships and provide care throughout the woman's experience of pregnancy and childbirth up to 28 days' postpartum.

The qualitative rich data continues to reflect important issues in midwifery, such as midwifery-led care (Walsh & Devane 2012), and lack of support and continuity which inevitably contribute to medicalised birth (Caffrey 2011) and despite the propaganda, having a medicalised birth is not the safer option (Downe & McCourt 2004). Lack of choice continues to be an issue in maternity services; choice of birthplace remains a restricted option in many services due to the constraints of maternity staffing, as organisations lack the confidence in providing a home birth option unless it is encapsulated in a caseloading midwifery model, (Mccourt *et al* 2011). Caseloading midwifery supports the transition of women from passive decision maker to the informed decision maker. The midwife seeks to explore the family as a unit, facilitating the complex and sensitive nature of questioning and listening, which is necessary to form trusting relationships or to be a 'professional friend' (Pairman 1998). Additionally, being able to observe behaviours to ensure safety and promote public health issues before finally having the privilege to watch the empowered mother emerge at the end of their journey (Finlay & Sandall 2009). The benefits of caseloading are overwhelmingly clear which is integral to the concept of holistic women-centred care

(McCourt *et al* 2006) and in line with the *Better Births* maternity review (NHS England 2016).

Why is caseloading not the societal norm? From the perspective of a midwife who has successfully set up NHS caseloading and believes it to be high-quality care, commitment issues outside work may influence how the midwife views caseloading. The demands from family or a full social life or simply a need for set hours is an understandable concern. As the midwife's working day is so full and stretched it is not easy to appreciate the flexibility of working as an independent practitioner where work is planned and organised around the woman, the midwife's life and their commitments.

Obviously as babies come when they are ready, some events are not foreseeable, which is why a 'buddy' method can be adopted. This is where midwives work in pairs, as a team to cover each other. This buddy system safeguards time off as protected so midwives gain the well-earned breaks outside work vital for their own mindfulness. I believe midwives are supportive and empowered individuals who value each other and therefore this can easily be facilitated as a supportive working partnership.

From the midwife's perspective, caseloading does not only improve outcomes for women (Benjamin *et al* 2001), it is empowering, satisfying and encourages professional development for the midwife too as she/he can gain knowledge, and reflect and develop with each individual case, which generates an opportunity to review practice and gain a deeper understanding.

The underlying philosophy of the midwifery profession is essentially aligned with sustainability. Midwifery practice is about community-based primary health, strengthening family relationships and promoting empowerment and normal birth (Yanti *et al* 2015) and receiving the best care from midwives throughout the childbirth continuum (International Confederation of Midwives 2014).

As the NHS is one of the UK's most energy intensive organisations and is now focused on financial and environmental sustainability, the NHS's sustainable development strategy (Public Health England 2014) has been developed towards both of these goals. One key pillar of the sustainable development strategy is 'models of care', which aims to support people to have more control over their own well-being. This is essentially the philosophy of midwifery caseloading care as the woman and midwife are at the epicentre of identifying and facilitating primary health care needs which can be built around the requirements of the women.

A more sustainable future will benefit everyone, and midwives are critical influencers

towards this goal. The caseloading model is safe and the trust between a midwife and a woman provide the foundation for empowerment and informed choice (Boyle *et al* 2016). This in turn increases the chance of spontaneous vaginal birth associated with better birth outcomes and greater maternal satisfaction and significantly reduces intervention including episiotomies and assisted birth (Sandall *et al* 2016). Caseloading is also cheaper, for all levels of normality and risk (Tracy *et al* 2013). Consequently, caseloading has a positive impact on our planet with a lower carbon footprint, less pollution and reduced energy use from the lack of intervention.

I am not alone. As an educator, I am regularly asked why caseloading isn't commonplace. Students who are fresh with creativity and free from routine practice want to practise this way, they clearly see that caseloading 'makes sense' from the perspectives of the woman, their family and themselves as a professional, therefore emphasising the demand for a model which suits both women, midwives and the future workforce.

I would encourage you to ask around, see if there are any interested midwives in your departments; you may be surprised. We could create a common denominator of interest and promote caseloading as a leading contender of service provisions for a sustainable future in your Trust.

Jo Killingley, Senior Midwifery Lecturer, Middlesex University, London.

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