AUTHOR(S): CROWTHER, S.

TITLE: Who's afraid of working as a continuity of carer midwife?

YEAR: 2017

Publisher citation: CROWTHER, S. 2017. Who's afraid of working as a continuity of carer midwife? The practising midwife [online], 20(5). Available from: http://www.practisingmidwife.co.uk/tpmindex.php?p1=articles&p2=1997

OpenAIR citation: CROWTHER, S. 2017. Who's afraid of working as a continuity of carer midwife? The practising midwife, 20(5). Held on OpenAIR [online]. Available from: https://openair.rgu.ac.uk/

Who's afraid of working as a continuity of carer midwife?

Midwifery continuity of carer (MCoCr) dominates conversations around midwifery. We are told that women want it, evidence supports it and policy is telling us to get on with it. Yet for many midwives, the introduction of MCoCr is an unwelcome pressure on an already over-stretched service. Many midwives may be afraid about what the future will bring when this model of care is imposed on them. While appreciating that barriers to change may lie ahead, this paper encourages us to view these changes as a step towards actualising a model of care that is more aligned with midwifery core values; it is argued that this way of working may afford greater joy in midwifery practice. The emphasis on flexibility, generosity, working together, self-determination and a focus on self-care is crucial. All stakeholders' voices must be recognised as having equal value and local practice change needs to be able to find bespoke solutions for implementing successful MCoCr in a region. One size certainly does not fit all.

Susan Crowther

Professor of Midwifery at Robert Gordon University

2017;20(5): ePub 1 May 2017

CASELOAD

Midwifery continuity of carer (MCoCr) is the buzzphrase nowadays, yet many of us are concerned about how that will affect our personal and professional lives. Even the terminology can cause confusion and invoke concern. The term 'caseload' implies being on call all the time without a break, for a discreet group of women, without support. It speaks of endless hours on call and long, uninterrupted hours of work. As Dr Mary Ross-Davie, RCM Director for Scotland, said in a recent ThinkTank event in Edinburgh: 'First we need to get the elephants in the room on view', so let us name some common concerns:

- I don't have all the skills needed
- I will not get paid for doing the on-calls if not called out - that is not fair
- There are no resources for this: we are stretched enough as it is!
- Women will become too demanding and dependent
- Constant on-calls mean I have no control over my own time
- I'll be solely responsible for a caseload of women
- I'll have to work all the time
- I'll be called in to cover labour ward when not busy and be working constantly
- There will be no-one to cover me if I have to go off for a family emergency; I'll be trapped
- If a colleague calls in sick I'll be twice as busy
- There will be no structure to my working life so I can't plan any personal and family events
- I'll just burn out if I am made to do this - it is not what I signed up for
- My needs will be ignored

Perhaps some or all of these concerns resonate with you? Yet midwifery continuity of carer does not have to be, or need to be, configured in the ways suggested in the above comments. The model adopted by privately employed independent midwives is not feasible across the NHS, nor is that

desirable. So, for the purposes of this article I will refer to MCoCr.

To begin I need to admit my own bias towards this model of providing midwifery care. In my own career I have traversed different ways of working yet all of them have focused on relational care - be that as a group practice midwife in London, as a self-employed independent midwife across the southern counties or as a caseload rural midwife in New Zealand. While working in these ways I have come to see how my passion and joy of midwifery has grown as I experienced what it means to be with women over the childbirth year. In many instances women have returned again and again so I get the honour of travelling with them as they grow their families. It has changed me as a person in ways that are hard to articulate, which I have written about elsewhere (Crowther 2016).

BENEFITS OF MIDWIFERY CONTINUITY OF CARER

So why is MCoCr so compellingly? It is now clearly shown that strategies to reduce maternal and newborn mortality and morbidity globally are focused on the provision of quality of care (Renfrew et al 2014). As we engage with this quality agenda, we can see there is mounting and established robust evidence of positive outcomes for women receiving continuity of midwifery care. Sandall et al (2015) found, in a Cochrane review including over 17,000 women, that MCoCr enables:

MCoCr is associated with:

- More spontaneous vaginal births
- Better successful breastfeeding rates
- Increase in positive maternal experiences
- Helps shorten labour by 30 minutes on average, and

In addition there is considerable health and maternity policy advocating this model of care. The NHS England's Better births review (2016: 9) states:

- 19 per cent less fetal loss before 24 weeks
- 24 per cent fewer births before 37 weeks
- 20 per cent less amniotomy
- 15 per cent fewer epidurals
- 10 per cent fewer instrumental births
- Less frequent induction of labour

“Every woman should have a midwife, who is part of a small team of four-six midwives, based in the community, who knows the woman and family, and can provide continuity throughout the pregnancy, birth and postnatally.”

Likewise, one of the key recommendations of the Scottish Government's (SG) 'Best start' review (2017: 8) is:

“Every woman will have continuity of carer from a primary midwife who will provide the majority of their antenatal, intrapartum and postnatal care and midwives will normally have a caseload of approximately 35 women at any one time.”

CONTINUITY OF CARER CAN WORK

The evidence that women want this kind of care provision continues to grow. MCoCr has been shown to work - we have knowledgeable colleagues at home and abroad who can help us achieve the same here. Other middle-to-high income countries, such as New Zealand, have been successful in introducing MCoCr across the whole of their maternity system, and continue to show how it is sustainable over time (Grigg and Tracy 2013; McAra-Couper et al 2014; Hunter et al 2016; Gilkison et al 2015).

MCoCr also aligns with our midwifery social philosophy of care: it actualises the relational quality of midwifery which lies at the heart of what we do in maternity care (Hunter et al 2008). Relationships matter to us as midwives; it is this relational aspect that inspires and adds quality to our practice.

Without doubt, we have had some failed attempts at implementing continuity of carer in the UK, such as Changing childbirth (Department of Health [DH] 1993); there will be many reading this who could attest to this and feel 'It won't work, we have tried it before'. Yet so much was learnt from those early beginnings. Is the answer to this common rebuke to current policy and evidence to simply continue as we are and not press ahead for change that aligns with midwifery's core values and what women and families need and deserve? Do we not have a moral responsibility to implement this, as a profession that declares itself to be evidence based?

RECRUITMENT AND RETENTION ARE CRUCIAL

We must also change the way midwifery is currently doing things if the profession is to survive. Ensuring optimal recruitment and retention across all regions is crucial, yet this is problematic with the current infrastructure. Many members of our profession have either left or are considering leaving; many decide to go part time, due to stress and the unrealistic demands put on them; many leave because they simply cannot practise in a way that aligns with their vision for quality midwifery. I was alarmed to read, in a recent survey in the Royal College of Midwifery's (RCM) Caring for you campaign, that 48 per cent of members felt stressed every day or most days, due to workload, reporting that they had insufficient time to do their job. In the same survey only 22 per cent of midwives found time to build rapport with the women in their care (RCM 2016). It is unsurprising that many midwives find the current way of working unfulfilling and unsustainable - change is certainly needed.

MANAGING CHANGE

Sustainability and resilience are crucial for any midwifery practice (Crowther et al 2016); this is particularly pertinent when changes to practice are planned. To this end, the RCM acknowledges the concerns of midwives and is actively supporting the changes in practice arrangements. Through the Better births initiative, the RCM is creating various resources at the time of writing this paper. One resource will be an interactive guide/workbook that will address all the concerns stated in this paper; it will be an online resource for all regions to use. The resource is full of practical suggestions based on a wide array of gathered experiential data of midwives already in MCoCr practice. The main thrust of that interactive workbook will not be on generic generalisable solutions, but bespoke solutions that address the contextual realities of our diverse regions (for example, highly complex populations, rural, remote, and urban and Island communities, and the needs of part-time and job-sharing colleagues). The bottom line is that each region will need to be self-determining in how they develop MCoCr into their locality. It is vital to address sustainability and resilience alongside this move to a new model. Figure 1 highlights the qualities inherent in sustainable and resilient practice arrangements, adapted from some collaborative New Zealand and UK re-analysis of regional studies on midwifery (Crowther et al 2016).

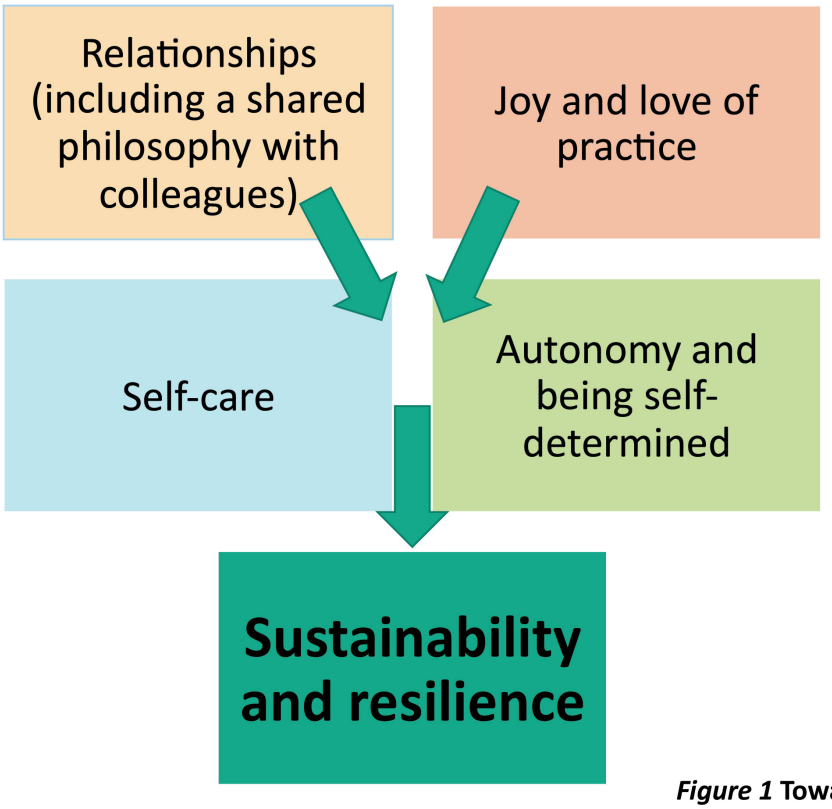

Figure 1 **Towards sustainable and resilient midwifery practice** (adapted from Crowther et al 2016)

REVOLUTION NOT EVOLUTION

For many, developing MCoCr across maternity systems is not about tinkering with the current infrastructure in a process of evolution: for many it will be a revolution. As this takes place, close attention to midwives' self-care, self-determination and autonomy is vital. This requires tact, unity and the equanimity to listen to all stakeholders' voices in non-hierarchical ways, even when views are discordant. It requires a generosity of spirit, open to differing points of view. Collectively we need to ensure that every person's concerns are given the opportunity to be heard. Everyone's voice is of value and leads to greater sustainability of this model of care. Leaving members of our profession behind will simple not work and will only trigger discontent and alienation. The purpose of MCoCr is to improve outcomes for mothers, infants and families and make our practice better, to nurture passion for what we do and give us joy in our practice.

WORKING TOGETHER

As we move towards delivering this new relational model of care throughout our maternity system, it is crucial that this relational quality translates into collaborative and partnership ways of being with one another. Collegiality and mutual respect for each of the diverse roles we take on in the midwifery profession are key. The conflict that can arise when labour wards appear to reign supreme over other aspects of midwifery denies the expertise that permeates throughout all aspects of midwifery. The breaking down of this old way of thinking is important for MCoCr models of care to flourish. To work as a MCoCr midwife or a hospital midwife is a celebration of our profession's ability to adapt to the myriad, at times complex, aspects of the childbirth year. Working together is so important. A MCoCr midwife is unable to work in isolation, s/he works within a team that crosses boundaries, professional groups and communities. Similarly, hospital midwives in this new world will

not be able to work separated from the contextual realities of their MCoCr midwife colleagues, because MCoCr midwives will be working closely together with hospital-based midwives. The traditional community midwife working 'out there in community' will be a thing of the past. This apparent demarcation between hospital and community midwifery is artificial and institutionally driven. It has plagued midwifery for so long, not benefited women and families, and has certainly undermined midwifery as a united profession.

Making midwifery realistic and fair is concerned with basic human rights, that cannot be taken out of the equation. Issues of hierarchical power structures, basic and fair working conditions, remuneration and ensuring adequate leisure time for all midwives have been highlighted in the literature (Filby et al 2016). It is imperative that we all work together to ensure barriers to positive change are not overcome at the expense of individuals, whether they work in hospital facilities or based in primary locations, as MCoCr midwives. We need to find out what we can do proactively in our own regions to overcome the barriers to improving quality midwifery care.

REIGNITING YOUR PASSION FOR MIDWIFERY

Implementation of MCoC across the NHS will revolutionise the care women and families receive. This may seem scary at first. Most of us are afraid of too much change, especially when it feels as if it is imposed on us and we will lose control over our working lives. For MCoCr to work, it needs to work for both users of the service and those delivering that service. I would contend that delivering a service, to women and families, that is underpinned by relationships over time, aligns with midwifery philosophy and may bring you increased job satisfaction. If you are tired and frustrated with how you work, taking on a MCoCr role may re-ignite your love, joy and passion for midwifery. That has certainly been my experience and the experience of many other colleagues who have practised or who continue to practise as MCoCr midwives.

REFERENCES

Crowther S (2016). 'Caseload midwifery is sustainable: personal example". Blog: https://drsusancrowther.com/2016/05/14/caseload-midwifery-is-sustainable-personal-example/

Crowther S, Hunter B, McAra-Couper J et al (2016). 'Sustainability and resilience in midwifery: a discussion paper.' Midwifery, 40: 40-48. doi: 10.1016/j.midw.2016.06.005.

DH (1993). Changing childbirth, London: HMSO.

Filby A, McConville F and Portela A (2016). 'What prevents quality midwifery care? A systematic mapping of barriers in low and middle income countries from the provider perspective'. PLoS ONE, 11(5): e0153391. doi:10.1371/journal.pone.01533923391

Gilkison A, McAra-Couper J, Gunn J et al (2015). 'Midwifery practice arrangements which sustain caseloading Lead Maternity Carer midwives in New Zealand'. NZCOM Journal, 51: 11-16.

Grigg CP and Tracy SK (2013). 'New Zealand's unique maternity system'. Women and Birth, 26(1): e59-e64. doi: http://dx.doi.org/10.1016/j.wombi.2012.09.006.

Hunter B, Berg M, Lundgren I et al (2008). 'Relationships: the hidden threads in the tapestry of maternity care'. Midwifery, 24(2): 132-137. doi: http://dx.doi.org/10.1016/j.midw.2008.02.003.

Hunter M, Crowther S, McAra-Couper J et al (2016). 'Generosity of spirit sustains caseloading Lead Maternity Carer midwives in New Zealand'. NZCOM Journal, 52: 50-55.

McAra-Couper J, Gilkison A, Crowther S et al (2014). 'Partnership and reciprocity with women sustain lead maternity carer midwives in practice'. New Zealand College of Midwives Journal, 49: 27-31. doi:

http://dx.doi/10.1278/nzcomjnl49.2014.5.27-31.

NHS England (2016). National maternity review. Better births, improving the outcomes of maternity services in England, a five year forward view for maternity care, London: NHS England. https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

Renfrew M, Homer C, Downe S et al (2014). 'Midwifery series: Executive summary'. The Lancet, June: 2-8. http://thelancet.com/pb/assets/raw/Lancet/stories/series/midwifery/midwifery_exec_summ.pdf

RCM (2016). Caring for you campaign: survey results, London: RCM. https://www.rcm.org.uk/sites/default/files/Caring%20for%20You%20-%20Survey%20Results%202016%20A5%2084pp_5%20spd.pdf

Sandall J, Soltani H, Gates S et al (2015). 'Midwife-led continuity models versus other models of care for childbearing women'. Cochrane Database of Systematic Reviews, 9: CD004667. DOI: 10.1002/14651858.CD004667.pub4.

SG (2017). The best start: a five-year forward plan for maternity and neonatal care in Scotland, Edinburgh: Crown. http://www.gov.scot/Publications/2017/01/7728/8