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Caseload midwifery in a multi-ethnic community: The women's experiences

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ABSTRACT

Objective: to evaluate caseload midwifery in a relatively deprived and ethnically diverse inner-city area.
Design and setting: semi-structured interviews were undertaken with 24 women from diverse ethnic backgrounds, 12 of whom had received caseload care and 12 women from an adjacent area who had received conventional maternity care in a large inner-city maternity unit. Framework analysis was adopted drawing on links with the authors' previous work on women's views of caseload midwifery.
Findings: key themes from previous work fitted well with the themes that emerged from this study. Themes included 'knowing and being known', 'person-centred care', 'social support', 'gaining trust and confidence', 'quality and sensitivity of care' and 'communication'.
Key conclusions and implications: women from this socially and ethnically diverse group of women had similar views and wanted similar care to those in previous studies of caseload midwifery. Many of the women receiving caseload care highlighted the close relationship they had with the midwives and as a result of this felt more able to discuss their concerns with them. This has the potential not only for improved quality of care but also improved safety.

Introduction

Individual caseload midwifery is an approach to care that offers an increase in continuity for women who are cared for by a known midwife throughout pregnancy, birth and the postnatal period. Caseload midwives generally carry a personal caseload of women with both high and low risk pregnancies, working across hospital and community service boundaries. They provide midwife-led care for women at low risk on their caseload and collaborate with maternity team members in co-ordinating and providing care for women at higher levels of clinical risk. They attend births in women's homes, midwife-led or obstetric units, depending on the woman's choice and eligibility. In most services they work in partnerships and group practices to provide cover for their caseloads, for mutual support and peer review of care. Caseload schemes have been introduced particularly in the UK and Australia, as part of an integrated maternity system, whereas in countries such as Canada, most midwife care conforms to the caseload model, but midwives do not yet form a fully integrated part of the public health-care system. Research to date indicates that caseload midwifery increases women's satisfaction when compared with traditional midwifery practice (McCourt et al., 1998; Homer et al., 2002; McCourt and Stevens, 2006; Williams et al., 2010) but there has been limited research on the implementation of this form of practice serving deprived multi-ethnic communities.

In the UK caseload midwifery has been in existence in the National Health Service for nearly 20 years, having been first introduced to implement the Department of Health recommendations that women should be offered continuity of care throughout pregnancy, childbirth and the postnatal period (Department of Health, 1993). Continuity of care in maternity has continued to be a recommendation made by the Department of Health at the same time emphasising the needs of vulnerable and disadvantaged women (Department of Health, 2004, 2007). Greater continuity has also been advocated in health care more widely as a contribution to safety and quality of care (Nutting et al., 2003). An English national survey of women's experience of maternity care

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(National Perinatal Epidemiology Unit, 2007) found that women from ethnic minorities and those living in the most deprived areas were less likely to have felt they were treated with respect and talked to in a way they could understand. One of the key areas of concern in the Healthcare Commission's review of maternity services (2008) was that there was not adequate continuity of care for women. Caseload midwifery has been introduced in a number of units in the UK and in other countries with integrated midwifery services with favourable results, including increased continuity, a reduction in intervention in labour and increased satisfaction for women (McCourt et al., 1998; North Staffordshire, 2000; Beake et al., 2001; Benjamin et al., 2001; Homer et al., 2001; Page et al., 2001; Sandall et al., 2001; Homer et al., 2002; McCourt et al., 2006). These findings echo those of wider studies of continuity in health care (Haggerty et al., 2003; Nutting et al., 2003) Despite positive findings, the introduction of caseload practice has not been widespread, although there is little research to suggest why this may be. Although a Cochrane Review of midwife led care indicates this form of midwife-led care is clinically cost-effective (Hatem et al., 2008) it is widely anecdotally perceived as an un-necessary and unsustainable luxury. As there is now more emphasis in UK policy on meeting the needs of vulnerable and disadvantaged women, some maternity units in the UK have chosen to focus on offering this form of care to the more disadvantaged women in their catchment area, sometimes in association with Sure Start schemes or Children's Centres (Finlay and Sandall, 2009).

There is considerable wider evidence of inequity of access to health care and for maternity care specifically, with indications that this is a matter of safety as well as quality. This evidence underpins the view that women's experience of care is deeply connected to both quality and safety, rather than simply being a nicety. Epidemiological evidence indicates interaction between indicators of social deprivation and minority ethnicity: put simply, women in minority groups are also more likely to be poor and specific groups such as recent migrants may lack social support (Barnard and Turner, 2011). Minority ethnicity, living in a socially deprived area and being born outside the UK are all associated with booking late for maternity care (Redshaw and Heikkila, 2010) and lack of attendance for care is associated with poorer clinical outcomes (Kurinczuk et al., 2009) highlighting the importance of developing models of care that increase access and responsiveness of care. The UK CMACE Report in 2011 highlighted late booking and poor attendance for antenatal care as associated with maternal deaths and recommended measures to increase take up. Similarly, it highlighted the higher rates of deaths and 'near misses' among minority ethnic women and those who are socially deprived, with such women also being more likely to be poor attenders for care (CMACE, 2011). This indicates a need to address barriers to care for some women. The report also indicated areas where care that is accessed is sub-optimal, and successive maternity safety enquiries have implicated difficulties in accessing care, poor responses from professionals, lack of co-ordinated care and poor communication between professionals as well as between the women and professionals (De Souza and Garcia, 2004). National surveys indicate that women living in more disadvantaged area and those from minority ethnic groups are offered fewer choices and are less satisfied with care (Redshaw et al., 2006) and that women who experienced continuity of care antenatally were more likely to feel they were given choices, information and kind, respectful care (Healthcare Commission, 2008). Despite this growing evidence, few studies so far have focused on the views and needs of minority ethnic women (McCourt and Pearce, 2000; Harper-Bulman and McCourt, 2002; McLeish, 2005; McAree et al., 2010) or on how maternity services may best be designed to meet their needs more effectively. McLeish's study, focused on asylum seekers' experiences, highlighted lack of access and information, isolation and unmet needs for social support, as well as explicit barriers such as hostility and racism, whereas studies of midwives' attitudes indicate that the way in which care is organised may encourage stereotyping of their clients (Green et al., 1990).

This study was designed to evaluate the outcomes of caseload midwifery practice in a socially deprived and ethnically diverse inner-city area. The caseload practices that formed the focus of this study were introduced into this inner-city hospital service approximately a year before the study commenced. There were two group practices of 4–6 midwives, each linked to one or more GP practices in a socially deprived neighbourhood, as a specific targeted policy. The midwives had, for the most part, previously worked in conventional community midwifery teams, serving these neighbourhoods, although a few relocated from hospital based practice within this maternity service. In either case, these midwives would not have previously practised midwife-led care for low-risk women, or with a defined caseload following women through from pregnancy to birth and postnatal care. This article describes one aspect of the study, the women's views of the care they received. Other aspects of the study including the midwives' experiences of working in a caseload group practice will be reported elsewhere. However, we refer to midwife experiences in our discussion of the key themes, as there was a high level of concordance between the women's perspectives and those of the midwives regarding the care relationship, suggesting relational continuity and reciprocity is an important aspect of this model of care and its sustainability (Hunter, 2006; McCourt and Stevens, 2009).

Methods

Individual, semi-structured interviews between three to six months postnatally were conducted at a time and venue of the woman's own choice, for the most part this was the woman's home. Interviews were chosen as the most appropriate way of gaining insight into the women's views and experiences in this context as it avoids the common problem of skews in questionnaire survey response rates towards white middle class women. It also enables more detailed exploration of what matters to the women.

Sample

Two samples of 12 women (caseload and standard care) were interviewed to ensure a sufficient sample for saturation of data was reached. These were drawn from a list of all women who gave birth within the local community area in a two-month period. Invitation letters were sent to all women on the list who had received caseload care and all those who agreed to participate were interviewed until no new themes emerged from analysis. A sample of 12 women from adjacent postcode areas receiving conventional maternity care was also interviewed to enable exploration and understanding of women's usual maternity experience within this setting. Women from the list who matched those interviewed in terms of parity and ethnicity as far as possible were contacted and invited to participate until a comparable sample was achieved. Women who had experienced a stillbirth or neonatal death were excluded as they might be distressed by contact with a researcher asking about their maternity experience. Although we planned to use bilingual interviewers or interpreters as needed, no women who did not speak English consented to participate.