

Centre Circular CS 91/38

3rd September 1991

To: All Centre Secretaries and Local Representatives

Shared Caseloads/Workloads

Introduction

The purpose of this Centre Circular is to inform and advise members regarding the fairly recent development within health visiting practice of the sharing of caseloads/workloads. It is an area of on-going development within health visiting and as such may be subject to revision response to changing circumstances and experiences.

As a development it has caused much discussion and at times dissension within health visiting circles. By circulating a questionnaire to all centre secretaries and Local Accredited Representatives, the Association obtained further information on the implementation of shared caseloads within health districts. A small number of questionnaires were returned with the majority commenting on issues around local working conditions rather than those pertaining to shared caseloads. It would appear that the sharing of caseloads is not widespread and in districts where they have been introduced thoughtfully and in collaboration with field staff few problems exist.

The Health Visitors' Association has always encouraged team working both between individual field staff and other nursing and professional disciplines. The sharing of knowledge, experience and mutual support that results is self-evident and seen as advantageous to both field staff, management and the client. Orr (1989) advocating a team approach to health visiting states:-

'Collective action not only makes the best use of skills but also offers a collegiate environment to support staff.'

The team approach to health visiting is becoming increasingly popular as practitioners and managers for new and better ways of working. The issue of actually sharing caseloads is a more recent development. With this development, a number of terms with a variety of meanings have emerged. These include 'team health visiting', 'corporate caseloads/workloads' and 'active and dormant cases'. Each of these terms implies a slightly different way of working, based on a variation of the individual caseload methods. The introduction of shared caseloads must not be confused with the separate issues of 'job sharing' and skill mix. An HVA Labour Relations Department guide to job sharing was published in September 1990, and an initial Centre Circular on skill mix is shortly to be produced.

The Central Issues

It is important to distinguish between collective and supportive methods of working in general and the more specific step of two methods of working in general and the more specific step of two or more health visitors amalgamating caseloads. There appears to be a number of different ways of working a caseload in terms of sharing in order to provide mutual support and ensure equality of workload. Definitions of the terms emerging with the sharing of caseloads are provided in the next section.

The sharing of caseloads should be not be seen as a way of maintaining a service in response to diminished resources. It is another way of delivering a service to meet as effectively as possible the needs of clients. The benefits of both clients and practitioners need careful consideration. It is essential that any new way of working be considered in terms of 'evidence of good practice' rather than the ultimate answer or a panacea for all ills. It is important to ensure that any new approach is always carefully appraised and guidance provided on where precisely both professional and legal responsibilities lie. Staff need preparation and support both prior to, during and after implementation. In addition, on-going evaluation is essential.

Management Responsibilities

Management has an important role in the implementation of shared caseloads/workloads. It is essential that all managers directly involved with practitioners at both locality and senior management level understand and support the philosophy of the initiative. Levels of responsibility and accountability discussed in a later section of the circular, need to be accepted and acknowledged by field staff and managers. Management need to accept responsibility for any resource implications identified.

Definitions

Traditionally the health visitors' work covered a geographical patch with their workload drawn from that specific area thus requiring them to relate to a number of general practitioners. In the 1960's and 1970's the idea of GP attachment, a team approach may be applied. Then, although each has her allocated workload, the team works closely together within the community setting. Advice offered on breast feeding, teething etc. is fully discussed so that a shared understanding within the team is achieved. All team members work together as a group in a collective and mutually supportive way.

With the introduction of shared caseloads a number of definitions of different ways of working a caseload in terms of sharing have been identified.

Geographically Divided Caseloads

Here a number of health visitors share a geographical patch which is divided between them in a fair and convenient manner. Individual health visitors accept their clients from their allocated patch. Equality of activity is not ensured.

Corporate Caseloads/Workloads

The term Corporate caseloads refers to the amalgamation of all caseloads within a given geographical area or for a number of GP attachments with individual cases being allocated according to needs. Equality of professional activity is attempted. Generally clients with specific recognised needs i.e. child abuse, post-natal depression etc. are allocated to a named health visitor for the duration of that need or 'episode of care'. Other cases are not visited by a specific health visitor but accepted by different health visitors as required. Again, agreement needs to be established on the advice given to the families on specific issues like immunisation, and child and adult continence.

The term Corporate Workloads refers to a similar way of working but includes the allocation of the total workload within a given area rather than the specific allocation of cases. It is important to note here the Association's agreed definitions of Workload and Caseload, which are provided later in the text.

Active/dormant/closed cases

In some areas health visitors are defining their workload in terms of active cases which, are those currently receiving and considered to require on-going in-put and closed or dormant cases which are those not receiving current in-put. Traditionally, health visitors have kept all their clients active, in theory at least, and always considered all the contents of their filing cabinets to be their on-going caseloads. Within some health authorities, dependency scales have been developed thus enabling health visitors to assess whether cases are of high, medium or low intervention need to plan contact accordingly. These new ways of looking at health visitors' work requires further debate.

Team Health Visiting

Here the workload within a geographical patch or large GP attachment is divided in a very different way. Individual health visitors take responsibility specifically for first parent visiting, developmental assessments, health promotion work, or-going family visiting, visiting older people etc. with the area's caseload and workload being allocated accordingly. This way of working requires excellent communication and understanding between all team members and regular discussions and sharing is essential.

Job Sharing

The Health Visitors' Association's guidance on Job Sharing (1990) defines the term as:

'an arrangement whereby two people share one full-time job between them. Each does a proportion of the work and receives a share of the pay, holidays and other benefits accordingly.'

In reality most sharers split the hours equally, although some choose to share on a proportional basis. It is important that any arrangements made, allow for continuity of

care and the establishment of clear lines of communication. The HVA guidance recommends that health visitors divide the caseload/workload between them with each having responsibility for part of it rather than both taking responsibility for the shared caseload/workload.

Responsibility and Accountability

The introduction of Shared Caseloads has caused further discussion around the issues of responsibility and accountability. The words 'accountable' and 'accountability' each occur only once in the UKCC Code of Professional Conduct for the Nurse, Midwife and Health Visitor (1984) but are seen as the central focus for the Code. They can be found in the second sentence of the stem paragraph to the Code which states:-

'Each registered nurse, midwife and health visitor is accountable for his or her practice, and in the exercise of professional accountability shall:'

The fourteen clauses contained within the Code then follow.

The UKCC Code of Professional Conduct is addressed to each practitioner individually and implies individual accountability, rather than a shared professional accountability. Although more than one person can be called to account for a professional failure in respect of the same matter, this will only happen where each in some identifiable way has failed to honour their personal professional accountability (Pyne 1990). Thus, even when working a shared caseload, individual accountability for a health visitor's actions remain. The whole health visiting team cannot be held responsible for a failure on the part of one of its members. As an employee, each individual is responsible to her employer to provide the type and level of care expected from her employment status.

Other Clauses within the Code of Conduct address the omission and commission of care, confidentiality and the acknowledgement of limitations of competence. Clauses 2, 4, 5, 9, 11 and 12 being particularly relevant. Any registered nurse, midwife and health visitor must act at all times in accordance with the UKCC Code of Professional Conduct.

Establishing Shared Caseloads

Prior to establishing shared caseloads, it is necessary to health profile the communities and practices involved in the sharing in order to establish levels of expected workload and to identify the health needs of the communities covered. Experience of health profiling has identified that different areas require different methods of working, and that the model applied must be to establish, according to the specific needs of that community identified by the health profiling process.

The HVA document, 'The Process of Health Profiling' (May 1990) suggests that the definition of the term 'health profile' in the context of health promotion has two major components which are seen as interdependent and of equal importance. These, it identifies as the systematic collection of data to identify the health needs of a defined population and the analysis of that data to assess, prioritise and implement strategies in health promotion. It further defines the terms 'caseload' and 'workload', the

definitions for which have been further refined in the light of discussion emanating from the health profile document (Centre Circular CS 90 52, dated 14th December 1990). Thus, caseload is defined as-

'the whole population for whom the health visitor has designated responsibility and therefore cannot be defined merely in terms of the clients for whom the health visitor holds actual records'.

Whilst workload is defined as -

' all the health visiting strategies used by practitioners to meet the health needs identified within the caseload...These strategies or activities may include child health clinics, group work, community health initiatives, participating in research projects and teaching students. The workload cannot therefore be considered in terms of a set of specific activities but must reflect the identified needs of the caseload.'

It is essential to understand and establish mutual definitions of caseload and workload before implementation of shared caseloads. Thus consultation with all staff involved at both management and practitioner level is required to ensure a joint philosophy and a joint understanding of the reasons behind introducing caseload sharing is held. Careful, sensitive planning is essential to ensure continuity and adequate support for vulnerable clients and their families.

It is imperative that all sharing the caseload learn to work together as a team. Time out is needed for practitioners and managers to agree criteria for practice i.e. priority cases, breast feeding policy, behavioural advice etc. Such agreements need to be clearly written and displayed and readily available and understood by all staff. Issues concerning ways of working for example, partnership with clients and the sharing of records need to be addressed, as do practical issues like accommodation for staff; provision for filing cabinets; the establishment of a joint birthbook and /or case listing, day diary and client reference system; as street index and the development of an information base of neighbourhood and community resources. All committed sessions requiring weekly/regular in-put from health visitors e.g. clinic sessions, health promotion activities, parent-craft need to be identified and fairly allocated. Agreements need to be reached by all professionals involved on priorities and targets for health visiting practice and protocol need to be established on how cases will be allocated; how exchange will take place; how supervision and support will be provided; the responsibility of each individual health visitor to forward a plan for clients visited and importantly, how often the group sharing the caseload needs to meet. Adequate communication between all health visitors and their managers is essential.

All staff involved needs to be committed to the introduction of shared caseloads and the model of service delivery agreed. Evidence from Hillingdon Health Authority where health visitors have been working corporate caseloads for over three years suggest that the system will only work with adequate negotiation. Communication with clinic staff, GPs, social workers and other community staff to notify them of planned changes is essential prior to implementation.

Educational and Training Needs

These different ways of working, although now provided as examples of interesting practice within initial health visitor education and training, have identified a number of educational and training needs for staff members not previously met within health visitor education. These include group work skills, interpersonal skills, problem solving skills, research skills, research skills, attitude change, resource management, consumer perspectives and in particular, the understanding of group life, decision making and power sharing. Attitude change is an issue of particular significance and involves examining issues like traditional methods of working, how the health visiting service is delivered and managed in practice. Experimental learning in the area of team building and group life has been found to be an essential training element for many groups when introducing shared caseloads/workloads. For anyone involved in the sharing of caseloads, flexibility is essential and Clauses 3 and 4 of the UKCC Code of Conduct are particularly relevant. It is essential that each practitioner acknowledge any limitations of competence and takes every opportunity to maintain and improve their professional knowledge.

Conclusion

Shared caseloads can be advantageous to all, providing they are thoughtfully and carefully introduced with the agreement of all involved. They can improve teamwork and the exchange of information between individual health visitors, as well as the service and choice offered to clients. They may also provide greater equity in the service and choice offered to clients and greater support for individual practitioners. The use of health visiting skills can be maximised and individual health visitors can be enabled to develop specific areas of expertise. Many participating health visitors report increased job satisfaction and welcome the informal peer review that occurs. However, the implementation of shared caseloads has resource implications.

Disadvantages identified include, difficulties in ensuring continuity of health visitor input, anxieties about ensuring adequate client care and uncertainty about workload and caseload for those health visitors involved. Shared caseloads can also be misused to provide minimal staffing cover. It is imperative that all involved, work within the principles of health visiting (CETHV 1977) using a process approach. They must constantly evaluate their work, clearly forward planning to aid the visiting by colleagues, establishing within families individualised packages of care which empower rather than leading to reliance on a specific professional. Continuous careful evaluation of individual workloads is also required and adjustments made accordingly to ensure equality of work amongst colleagues.

Where the proposals for working shared caseloads have come from fieldworkers and adequate consultation has occurred, it has been found to be an extremely rewarding and positive way of working for all. When introduced by management in response to staff shortages or resource shortages, then problems have arisen. Shared caseloads are not the ultimate way of working, but just another way of offering client care.

The issue of caseloads/workloads will continue to require discussion within our present changing National Health Service particularly, as skill mix is further introduced within health visiting practice and Project 2000 nurses trained to work

both in the community and hospital setting begin to be employed by Health Authorities and Trusts.

The Association supports health visitors attempting to manage change in their professional practice and would welcome comment and further discussion on this issue.

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