University Hospitals of Leicester NHS
NHS Trust

Meeting title:	UHL Trust Board **Public Trust Board paper G1**					
Date of the meeting:	7th July 2022					
Title:	UHL Maternity Continuity of Carer Report, Action plan and Building blocks					
Report presented by:	Julie Hogg, Chief Nurse					
Report written by:	Elaine Broughton Head of Nursing and Midwifery					
Action – this paper is for:	Decision/Approval		Assurance	x	Update	
Where this report has been discussed previously	This report has been presented at LMNS (Local Maternity and Neonatal System)					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
This report is to provide Trust Board with an update on the roll out of Continuity of Carer across the maternity service. Submissions are expected the NHSE/I to describe the UHL plan for roll out taking into account recommendations from the Ockenden report and local midwifery staffing levels. The mitigated risk is in place to not commence this model of care until midwifery staffing levels have improved

Impact assessment
N/A

Acronyms used:
CoC-Continuity of Carer
LMNS-Local Maternity and Neonatal System

Purpose of the Report

This paper is to inform Trust Board on our progress with implementing the midwifery Continuity of Carer model as recommended in the Better Births report (2016). It is a national requirement for the board of directors to have oversight of this plan.

Recommendation

The paper is to provide assurance to the Trust Board members, that UHL Maternity services are fully supportive of the model of care and are committed to doing so when midwifery staffing levels have reached the recommended Birth rate plus requirements. In anticipation of this board are asked to approve our implementation plan and the building blocks to prepare for roll out of this way of working.

Summary

The documents required for the national team are templates required from all Trusts, UHL have not described the detail of each team and the caseloads, the intention is to complete these as the staffing levels start to increase, we have good knowledge of where there are social deprivation areas and where the population is predominantly minority ethnic.

The maternity team together with the LMNS have worked tirelessly at looking at different pathways and solutions to supporting this since the publication of Better Births and will continue to do so.

Main report

The Better Births report (2016) was published following a national maternity review as part of the NHS five year forward review. Seven key recommendations were made and recommendation two highlighted the need for continuity of carer to ensure safer care based on a relationship of mutual trust and respect in line with a woman's decisions. Every woman should have a midwife, who is part of a small team of six to eight whole time equivalent (WTE) midwives, based in the community who knows the women and family, and can provide continuity throughout the pregnancy, birth and postnatal period. In addition, there should be community hubs which enable women and families to access care close to home, in the community from their midwife and from a range of other services, particularly for antenatal and postnatal care.

The benefits and improved outcomes for this model of care has been well researched and documented, but it is also recognized that it will not be successful unless there are sufficient staff to support it.

All Trusts have been asked to provide the National Maternity team with a report of the implementation plan, an action plan on how this will be achieved and complete a spreadsheet that provides the building blocks to prepare for roll out of this way of working.

Prior to the pandemic, UHL had completed all the preparation, including focus groups to inform staff, a survey on midwives views about working in this way, and discussed a management of change process for staff and commenced roll out of continuity of carer with an inner city team caring for women with a minority background, the home birth team also adjusted their way of working to ensure the 240 women who deliver at home each year were receiving continuity and St Marys community team also adjusted to work in this way. Three further community teams were prepared. The senior midwifery team and community midwives were becoming very concerned regarding staffing levels and further roll out was suspended.

In 2021 UHL began engagement with the national lead for continuity and prepared a spreadsheet following a birth rate plus review of staffing, to describe how the Trust could continue to implement COC. As staffing became more challenged, it was felt internally that this was not safe to continue with an overall vacancy of 14% and particularly in the community the vacancy rate was 20%, it would cause inequity of care for some groups of women and leave the acute units unsafe.

The final Ockenden report published in March 2022 supported the Trust's stance. Therefore the papers attached, describe the UHL journey towards COC as we continue to look at every option available to achieve the necessary staffing levels. The trajectories are realistic and not over ambitious and senior midwives will continue to work with staff and prepare for launching the first team again in June 2023 and continue on the journey until we have 90% implementation, providing our vacancy rates reach 5% or below.

Conclusion

The paper is to provide assurance to the Trust Board members, that UHL Maternity services are fully supportive of the model of care and are committed to doing so when midwifery staffing levels have reached the recommended Birth rate plus requirements. In anticipation of this board are asked to approve our implementation plan and the building blocks to prepare for roll out of this way of working.

Supporting documentation

UHL Implementation plan

COC Action Plan June 2022

University Hospitals of Leicester

Midwifery Continuity of Carer Implementation Plan June 2022

Summary of report

Background

The Better Births report (2016) was published following a national maternity review as part of the NHS five year forward review. Seven key recommendations were made and recommendation two highlighted the need for continuity of carer to ensure safer care based on a relationship of mutual trust and respect in line with a woman's decisions. Every woman should have a midwife, who is part of a small team of six to eight whole time equivalent (WTE) midwives, based in the community who knows the women and family, and can provide continuity throughout the pregnancy, birth and postnatal period. In addition, there should be community hubs which enable women and families to access care close to home, in the community from their midwife and from a range of other services, particularly for antenatal and postnatal care.

In September 2019, University Hospitals of Leicester (UHL) maternity service commenced the roll out of continuity of carer, as highlighted in the Better Births report 2016, with the implementation of the Lotus Midwifery Team. The Lotus team provided care throughout all stages of a woman's pregnancy, birth and postnatal period from January 2020 to January 2021, with a break in intrapartum care from June to November 2020 due to staffing pressures within the team. In January 2021 the Lotus team stopped providing birth care (thus stopping CoC teams at UHL) due to staffing pressures in the wider community midwifery team.

UHL does provide a small percentage of CoC for women living in the Melton Mowbray area who choose to birth at the St Mary's Birth Centre, or women who are cared for intrapartum by their named homebirth midwife. However, these are not MCoC teams as do not meet the required standard and cannot be include in the MCoC statistics.

The senior midwifery team are fully engaged in rolling out continuity of carer, recognising the enormous benefits for the mother and baby and the aims of the maternity transformation programme and ten year plan. The process to implement continuity of carer requires a complete transformation of the maternity service. There will be a new model of care for the women, a transformation of how community works as well as a significant workforce reconfiguration. Rolling out this model of care is a huge challenge for UHL, due to the current staffing and workforce pressures. Ultimately the benefits to the women and babies underpin our need to be as proactive as possible without compromising safety elsewhere in the service. This report provides an overview of how UHL intends to roll out continuity of carer teams across UHL including the necessary building blocks required for successful implementation.

Current position

- Total bookings – 13427 (12313 in area; 61 out of area).
- Total bookings with non-UHL provider – 1114.
- Number of deliveries – 10462 cross Trust; 5851 LRI, 4215 LGH, 132 SMBC, 250 HB, 14 BBA's. Women who choose to birth outside of the Leicester, Leicestershire and Rutland (LLR) often do so due to the distance from their home to the acute maternity site. Women living on the borders of LLR may choose bordering maternity units in Northampton, Kettering, Peterborough, Nottingham, Nuneaton, or Coventry as it is closer to their home. The offer of MCoC is unlikely to change this significantly as the distance to the acute site is the deciding factor. This will be reviewed at each stage of the roll out of MCoC to ensure the core and MCoC teams have the appropriate number of midwives allocated. It is not anticipated that the tertiary referrals will significantly change, as there are three tertiary referral units across the region and the numbers of referrals will not be affected by MCoC.
- 1114 women having only antenatal and postnatal care.

- 61 women come to UHL for birth and received AN/PN community midwifery care elsewhere. This number potentially may change as the women's local area start to offer MCoC, although any tertiary referrals are not expected to change significantly.
- 13427 women eligible for MCoC based on total bookings.
- Recent data from UHL maternity system identifies that the women are from 60.77% White, 28.42% Asian, 4.87% Black, 2.69% Mixed and 3.63% Other, ethnic backgrounds.
- Local GP System One data identifies that the practices with the greatest number of women from non-white ethnicities are predominantly located within Leicester City.
- Local GP System One data identifies that the populations who live in the bottom deciles of deprivation are also predominantly located within Leicester City (Bottom 27 surgeries all located within Leicester City with deprivation scores ranging 48.80 down to 29.57).
- Currently it is not possible to pull reports from the UHL maternity system relating to the number of women birthing who live in areas of social deprivation. Work is on-going with the Business Intelligence Specialist to aim to capture this data moving forward.
- The proposed initial locations for MCoC teams are all located within Leicester City, taking into consideration the above data regarding ethnic background and local social deprivation scores.
- At present proposed MCoC team location is based on the GP System One data. Long term it is preferred that local maternity data for ethnicities and social deprivation can be reported on by the maternity system using postcodes and booking/delivery information.
- The last Birthrate Plus (BR+) report was presented to the Head of Midwifery in April 2021 for the period of activity 2020/21. BR+ identified a variance at that time of -50.24 wte staff (-42.08 band 5-8 midwife and -8.16 band 3 wte maternity support worker). Safe staffing and recruitment are discussed in more detail further on in this report.

The plan

UHL aims to provide MCoC to 9468 out of 10520 number of women. The reminder of the women receive care from other maternity services and are unlikely to change their position due to the distance of the acute maternity unit from their home.

MCoC teams will be prioritised for roll out in the highest areas of Black, Asian and Mixed ethnicity populations and the postcodes of the lowest deciles to ensure that we target women who are most likely to experience adverse outcomes first. As described in the previous section, these areas have been identified using GP System One data.

Summary of proposed locations for initial MCoC teams

The table below shows the proposed locations for the initial MCoC teams. The teams will not be implemented based on the GP surgery; however, the surgeries are listed to illustrate where in the city the teams will be located. The table identifies the GP practices and areas across Leicester, Leicestershire and Rutland (LLR) where there are communities with the highest black and ethnic minority service users and the highest social deprivation scores. These are all located within the Leicester city area and will form the areas of focus for the first CoC teams to be introduced.

Practice	Post code	Ethnicity mix	Social deprivation score	Current caseload numbers
Spinney Hill M/C	LE5 5FD	Asian 92.9%, Black 0.6%, Mixed 0.6%, Other 1.5%, White 1.5% Unknown 2.9%	27.7317	196
Dr Patel, High Fields Medical Centre Spinney Hill Road	LE5 3GH	Asian 85.3%, Black 3.4%, Mixed 1.3%, Other 3.4%, White 3.7%, Unknown 2.9%	29.3466	96
Heron GP Practice, Spinney Hill Road	LE5 0FQ	Asian 47.1%, Black 23.3%, Mixed 5.2%, Other 6.3%, White 13.3%, Unknown 4.6%	36.1396	101
Prince Phillip House, St Matthews	LE1 2NZ			114
Leicester City Assist Practice (Charles Berry House)	LE1 4SX	Asian 26.7%, Black 23.8%, Mixed 18.2%, Other 21.2%, White 7.2%, Unknown 2.9%	30.877	9
The Practice Beaumont Leys & Baxter's Close	LE4 0UZ LE4 0QR	Asian 11.8%, Black 19.2%, Mixed 5.9%, Other 6.0%, White 54.5%, Unknown 2.6%	48.2761	220 combined
Beaumont Lodge Medical Practice	LE4 1EF	Asian 15.5%, Black 13.6%, Mixed 4.3%, Other 4.3%, White 58.4%, Unknown 3.9%	36.3736	60

In order for the MCoC to have a sustainable model and caseload numbers, it is proposed that the MCoC teams are not implemented with the GP practice as a base. Instead, the postcodes the GP practice covers will be identified and the English indices of deprivation 2019 used to identify which postcodes are in the most deprived areas, allowing specific postcodes to be identified for the initial areas of focus. Long term UHL will aim to report on this data from its maternity system. Women booking for care in the identified postcodes will be allocated to a MCoC team. Once the team reaches capacity in its caseload numbers, the women will be allocated to the next MCoC team in that area. Each team will need a named link obstetrician allocating and the Head of Service for obstetrics is aware of this.

The action plan for implementing MCoC at UHL can be found in appendix one. It includes a management of change process with a planned start date of September 2023. This is a requirement as the need to have CoC teams as the default model of care involves the significant reconfiguration of services and redeployment of staff, affecting their area of work and pattern of working. By deferring the management of change process until September 2023, this allows time for not only workforce recruitment but also time for maternity staff to recover from the effects of the Covid-19 pandemic. There is a risk that staff leavers will increase once the management of change process starts. The team will try to mitigate this as far as possible by ensuring there is regular staff engagement prior to the management of change process. It is also planned that the models for the continuity of carer teams will be co-produced with the maternity staff so the teams implemented are modelled in a way that is acceptable to the staff.

By June 2023 it is hoped the Lotus Midwifery team will function once again as a full CoC team, providing intrapartum care as well as antenatal/postnatal care. Meeting this action on time is dependent on the ability to ring-fence the team and not redeploy the midwives into the wider

community team to support community midwifery services outside of the Lotus team caseload. The Lotus midwifery team already has a named link obstetrician and this will remain the same consultant.

Safe staffing

The last BR+ identified a variance at that time of -50.24 wte staff (-42.08 band 5-8 midwife and -8.16 band 3 wte maternity support worker). UHL is currently ensuring that all maternity support workers who meet the requirements of a band 3 post are being promoted from their current band 2 to a band 3 post.

There is currently a budgeted vacancy rate of 60 wte across the service and this includes the increase in establishment following the additional Ockenden funding received. When the Birthrate Plus recommendations are taken into consideration the vacancy rate is 72 wte. There are particular pressures in the community midwifery workforce where there is a 30% vacancy rate at present. The rollout of MCoC teams will not be commenced until the vacancy rate across the service falls to 5% providing safe staffing to support the implementation plans.

A business case has been written to take to the Trust board regarding uplift in salary for MCoC teams instead of the traditional on call payment system. This has not yet been actioned due to the current delays in implementation at UHL.

UHL had already stopped any existing CoC teams prior to the release of the final Ockenden report (March 2022) due to the significant staffing concerns. Following the publication of the final Ockenden report, the Trust has assessed the current staffing position and agreed that minimum staffing requirements cannot currently be met for re-starting rollout of MCoC teams and it remains paused.

A combined risk assessment has been submitted and accepted by the Women's Governance Board, identifying both the risk to safety if the rollout of MCoC was continued, and also the risk to those women who would most benefit from MCoC by not receiving CoC (Black and ethnic minorities and those in the most socially deprived areas).

Workforce recruitment

There is a quarterly rolling recruitment plan, which includes the recruitment from local universities De Montfort University and University of Leicester, with regular periodic adverts for band 5 and 6 midwives. UHL have been successful in appointing a second recruitment, retention and pastoral care midwife to support the current post-holder in supporting both newly qualified midwives and experienced staff needing support. UHL are part of an international recruitment programme with funding to recruit 14 wte midwives from abroad and support their transition into practicing in the UK and working at UHL. A band 7 education midwife post has recently been appointed to ensure these international midwives have the appropriate level of support as they adapt to working in the U.K. A midwifery recruitment open day is planned for 11th June 2022, with representation from the multidisciplinary team on the day. It is hoped the recruitment gap will be filled by 2024 provided there are not significant numbers of midwives who retire or leave the Trust.

All newly appointed midwives to UHL have the expectation of working in continuity of carer teams expressed in their contract of employment. The updated university curriculum, in line with the new NMC standards for midwifery education, has continuity of carer as a continuous theme throughout the programme. The universities are dependent on UHL implementing CoC to support their students throughout their training.

UHL recognises the positive benefits to women and their families of having a workforce that reflects the diverse backgrounds of the communities they serve. Leicester City has a very diverse mix of communities and it is hoped the midwives working in the CoC carer teams in the city will be able to reflect the communities where they are based. However, in the first instance the teams will need to be staffed with midwives willing to work in a CoC team until the full staff consultation process has been completed and the transformation process is fully implemented.

Planning spreadsheet

The rollout of teams is planned over 6 phases and based on best evidence our MCoC teams will comprise mostly mixed risk geographically based teams, totalling 38 teams to reach the default model of care. It is intended to keep the system as simple as possible and allowing flexibility; with each midwife booking approximately 3-4 women per month and birthing 3 women per month. Each team will have a maximum of 8 midwives and with full time midwives holding a caseload of 1:36. Part time hours will be accommodated by the caseload number being pro rata dependant on the midwives working hours. At each stage of the rollout an evaluation will take place to ensure all areas of the service are staffed safely and there are no unintended consequences, amending the plan as necessary.

The NHSE/I toolkit has been used to plan the rollout (appendix two). The plan is divided into the two acute sites (Leicester Royal Infirmary -LRI and Leicester General Hospital – LGH) with a 60:40 split in the delivery numbers respectively. The staff and births for the freestanding St Mary's Birth Centre have been included in the LRI side and the homebirths have been divided with the 60:40 split.

The implementation will commence with the re-launch of the Lotus midwifery team as a full CoC team in June 2023, dependent on community staffing needs. There has been an expression of interest from some midwives regarding working between the hospital and community areas. Where these midwives can be released from their current areas of work it is anticipated they will gain community experience, supporting the community staffing and updating their community midwifery skills at the same time. These midwives will then be ready to join CoC teams when implemented.

Communication and engagement

Before the Covid-19 pandemic started, there were nine virtual staff engagement sessions with staff which were attended by 52 maternity staff. The matrons were discussing MCoC as part of their staff meetings and virtual Facebook live sessions.

As UHL moves closer to implementation, virtual staff engagement sessions will re-commence to be led by the Consultant Midwife. The Consultant Midwife has already held one meeting with the Human Resources Business partner to discuss the management of change process and work will commence in June 2022 to draft the management of change paper. Once a first draft is available the plan is to involve the Trust staff side/unions at an early stage to ensure they are fully involved in the process. As part of the consultation process, a staff 'listening into action' engagement event will be held prior to the formal consultation process starting.

Skill mix planning and Training

The maternity practice development team have created a Midwifery Continuity Team competency assessment document, which includes an assessment of development needs, record of completed mandatory training and Leicester Competency Assessment Tool (LCAT) for all competencies covering both community and acute site care settings (see appendix three for assessment of needs). This is an in-depth, 74 page book which covers all aspects of training and competency assessment for both acute areas and community settings. Staff will already have completed LCATs for the areas in which they currently work and will only be

required to complete further training and LCATs for the areas where development is needed. The sign-off process will be supported by the matrons, team leaders and maternity education team.

UHL already has a robust preceptorship package which will include rotation to the community setting towards the end of the first year in practice as a newly qualified midwife. The inclusion of community as part of the preceptorship has been positively received by our senior student midwives and recent feedback from qualifying students has informed us this influences which Trust they decide to join upon completion of their training.

The Trust is supporting the transition of band 2 maternity care assistants (MCA) to band 3 maternity support workers (MSW) and it is planned that MCoC teams in the areas of highest social deprivation will have an allocated MSW to support with care of the families.

The consultant midwife and matrons will work with the band 7 delivery suite coordinators to ensure they are prepared and ready for implementation of MCoC teams. The delivery suite coordinators already have experience of working alongside MCoC teams as the Lotus midwifery team was working well until it stopped providing intrapartum care.

Linked obstetrician

The Lotus midwifery team already has a named linked obstetrician and the team have formed a good working relationship with the consultant. When full scale MCoC is implemented the Heads of Service will need to allocate linked obstetricians for the teams. UHL currently has significant staffing vacancy within the obstetric team and the linked obstetrician will be challenging to allocate at present.

Standard operating procedure

A guideline was written for the Lotus Midwifery Team that was approved by the Maternity Governance Committee in January 2020. The guideline outlines the focus of the team (it is located in an area of Leicester City with a high Asian population and high levels of social deprivation) and the inclusion/exclusion criteria for the team.

This guideline has been adapted into a standard MCoC standard operating procedure (SOP) for use across all MCoC teams.

Midwifery pay

A business case will need to be presented to the Trust board to decide how the midwifery staff will be paid, with the following options:

1. Traditional on call payment system.
2. Shift pattern model with night pay.
3. Salary uplift.

The Lotus midwifery team were paid using a traditional on call payment system. The business case has been written but was not submitted due to the suspension of MCoC roll out locally during the Covid-19 pandemic.

Estate and equipment

The Lotus midwifery team was based in the local GP surgery and the women's' homes and the initial MCoC teams at present will need to be based from the GP surgery as well. Long term funding will be needed for community hubs and this forms part of the local transformation plans for the UHL community services and support from the board/local commissioners will be needed to identify suitable locations. Teams will initially be located within Leicester City in areas with high social deprivation and the highest number of black and ethnic minority communities.

Review process

MCoC is a standard agenda item on the UHL maternity governance committee and women's governance board, as well as the LLR LMNS meeting. These meetings are attended by the multidisciplinary team, with attendance from midwifery, obstetric and commissioning workforce teams. MCoC is captured electronically via the EuroKing system; with mandatory questions for MCoC asked throughout the women's care journey from antenatal contact, labour and birth and postnatal contacts. This is reported to the maternity services data set.

At each wave of the rollout, the implementation of MCoC will be closely reviewed and monitored by the maternity governance committee. Workforce data will be reviewed to understand the potential impact on maternity staff leavers and absence rates. The midwifery vacancy rate will be reviewed monthly via the Women's services quality dashboard along with the patient safety and birth outcomes to ensure that with each stage of implementation the service remains safe with no unexpected adverse outcomes on staffing or patient care.

Appendix One

Action plan for implementation of continuity of care within UHL Maternity services

DATE COMMENCED:	DATE OF LATEST REVIEW:	DATE OF NEXT REVIEW:	MONITORING COMMITTEE:
February 2022	10/06/22		W&C CMG Quality & Safety Board LMNS EQB Maternity Safety meeting
EXECUTIVE LEAD:		**OPERATIONAL LEAD:**	
Julie Hogg (Chief Nurse)		Elaine Broughton and Kerry Williams	

No	Action Required	Risks to delivery	Lead	Timescale	Progress/Comment	RAG
1.	Meet with midwifery matrons to review current CoC models and plans for future		EB/KW	Re-commence May 2023	This is an ongoing process and will be at least monthly	4
2.	Arrange meeting with national CoC lead TM to discuss requirement of core staff in areas		HF	December 2021	Completed	5
3.	Prepare HoM letter for staff		EB	May 2022	Completed	5
4.	Prepare management of change paper		EB/HF	June 2022		4
5.	Re-start Lotus midwifery team as CoC		HF/EW	June 2023		4
6.	Complete business case for CoC to include uplift to cover on calls.		ND	February 2021	29/12/21 business case written; will need updating when ready to submit	4

Both numerical and colour keys are to be used in the RAG rating. If target dates are changed this must be shown using strikethrough so that the original date is still visible.

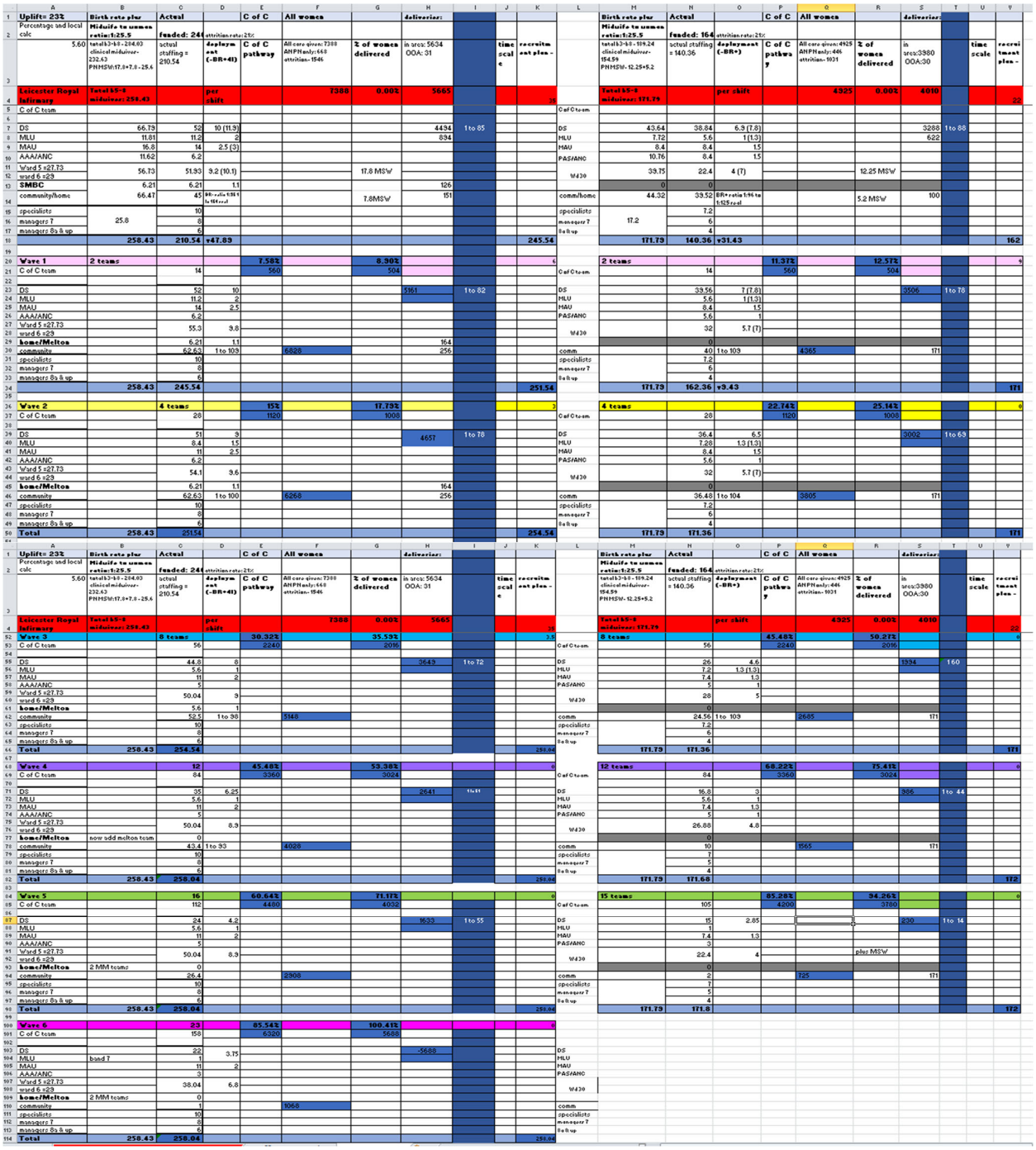
RAG Status Key:	5	Complete	4	On Track	3	Some Delay – expected to be completed as planned	2	Significant Delay – unlikely to be completed as planned	1	Not yet commenced

1

7.	Arrange virtual staff engagement sessions and assign 2 people to facilitate. Throughout September & different times.		HF/KW	May 2023		4
7.	Follow management of change process – 90 days		EB/HF	Start September 2023 until November 2023		1
8.	Commence plan for roll out of waves		ALL	January 2024	Delay in roll out as change management process needed and staffing/vacancy concerns	3
9.	Change contracts to ensure CoC as standard on band 6 contract		EB/Human resources	January 2021	Completed	5
10.	Inform PMA's about plans to support midwives		EB	January 2021	Completed	5
11.	Workforce review from Birthrate™ plus to calculate existing workforce plan and review for CoC model		EB	December 2020	Completed	5
12.	Following management of change process send out staff competency assessments to ensure staff upskilled appropriately		Matrons	December 2023		1

Appendix Two

Leicester MCoC Implementation Plan



Appendix Three

Assessment of development needs

Assessment of development needs

Name	
Email	
Current place of work and role	Caseload team joining (if known)

General Clinical Skills	Not competent	Competent, not used skill for some time	Competent and confident
Venepuncture & cannulation			
IV drug administration			
Perineal Suturing			
Epidural care			

Areas of experience	No experience	Some experience or knowledge	Recent experience or good knowledge
AN care/Community			
Inpatients ward			
IOL			
Triage			
Home birth			
Birth centre			
Water birth			
Labour ward			
Multiple pregnancy and birth			
Theatre/recovery			
Postnatal care/community			
Safeguarding/mental health			
Parent Education			
Newborn resuscitation			
Interpretation of test results			
CTG interpretation/IIA			
Enhanced maternity care			
E-meds			
Nervecentre			
Comments:			