Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Public Trust Board Meeting: Wednesday 09 March 2022

TB2022.027

Title:	**OUH Maternity Plan for the achievement of Midwifery Continuity of Carer as the default model.**
Status:	**For Information**
History:	The Trust is required to develop a plan for the delivery of a Continuity of Carer model in line with the framework and monitoring evaluation tool published by the Royal College of Midwives (2018) for the Local Maternity and Neonatal system (LMNS). This model arises from the findings and recommendations of the Morecambe Bay enquiry (2015), the vision for Better Births set out by the Maternity Transformation program (2016) and the Ockenden report (2020). The original national guidance set a minimum trajectory of 50% to be achieved by 2021 of women being booked for maternity care to be booked onto a continuity of career pathway. The pathway should prioritise those from the most deprived and vulnerable groups and geographical areas. The original trajectory was amended to 35% due to the covid pandemic. In October 2021 delivering the maternity continuity of carer model at full-scale was published. This guidance supports Trusts to develop and deliver continuity of carer as the default model for the provision of maternity services.
Board Lead:	**Chief Nursing Officer**
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Confidential:	No
Key Purpose:	Strategy and Policy

Executive Summary

The attached report sets out a plan for OUH to achieve 56% Continuity of Care (3672 women) based on 6500 births per annum (excluding out of area women) by the end of the finical year 23/24.

The plan sets out the phased approached to achieving 56% at OUH and identifies the significant resources implications, recruitment, estate, training and consultation requirements.

Additional £13,000,000 funding has been made available national to be allocated between the LMNS's but it is recognised that the allocations will not meet the full cost of local plans. The NHSE/I sets an original deadline of 31/01/22 for receipt of approved plans but this was cancelled to offer local services more flexibility. The local LMNS are seeking to consider this plan in March 2022 following Trust Board approval.

Recommendations

The Trust Board is asked to:

Note the attached plan that will deliver 56% Continuity of Care model by the end of 2023/24 financial year. This will be subject to Trust business planning and Trust Management Executive (TME) approval subject to the resources made available through the local maternity and neonatal system (LMNS). This would be subject to approval by the Investment Committee if it is over £1million.

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1.4. Framework of activities that will ensure readiness to implement and sustain Maternity Continuity of Carer (MCoC)

1.5. Time frame and monitoring process

2. Background

Midwifery Continuity of Carer has been proven to deliver safer and personalised maternity care. Building on the recommendations of Better Births (2016) and the NHS Long Term Plan, the ambition is for continuity of carer to be the default model of maternity care. In 2021 updated requirements were published by the RCM (2021) setting out an achievement date of March 2023, where safe staffing allows and building blocks are in place for the Maternity Incentive Scheme (Year 4). Full continuity should be prioritised for those where it has been shown they are at higher risk of poorer outcome.

Midwifery Continuity of Carer as the 'Default Model of Care'

The model states women should be offered continuity in a case loading model and wherever possible receive the benefits associated with this pattern of care. However, it is accepted in the recommendation that not all birthing families will be suitable for continuity of carer, either because they choose to receive care outside of their local provider or in a small number of cases, they will require specialist services for maternal / fetal medical reasons.

Moving into a MCoC team represents a fundamental change in the way that midwives work: moving away from a shift-based rostered system to one where the midwife follows the woman to ensure right care, right place, right time. It is important to factor in protected time off for midwives working in this model.

MCoC teams are made up of no more than eight midwives (headcount). Experience from other Trusts report MCoC teams smaller than 6.8 WTE struggle to fill the out-of-

hours element. With full capacity, depending on the number of homebirths/MLU births, midwives work just one out-of-hours session per week.

The current position for continuity of carer at the OUH is addressed in Appendix 1 along with the current population demographics for the Oxfordshire County.

3. Continuity of Carer Plan

3.1. The first phase of the plan Oxford University Hospitals Trust (OUH) aims to increase and provide MCoC to 56% out of 6500 (birthing figures 2020/21) number of birthing people. The recommendation is that 3 teams would be simultaneously rolled out in 5 waves until reaching a total of 15 continuity teams (see Table paragraph 6). The teams will be geographically based with the first wave been launched in the areas where there are the highest indices of deprivation/ risk.

3.2. The phasing of the implementation has considered the national drive to prioritise continuity of care for women from ethnic minorities or vulnerable background in consideration of the published evidence regarding poorer clinical outcomes. Subsequently, the target of 35% Continuity of Carer for birthing families from an ethnic minority background is included in the planning assumptions of achieving 56%. This will include only those who book at the Trust before 28 weeks gestation and who choose to receive continuity across antenatal, intrapartum, and postnatal care. Those that receive care from other maternity services and are unlikely to change their position due to tertiary referral/ geography.

3.3. Future consideration will be given for maternal medicine teams as we have a high proportion of high-risk women cared for by this specialty tertiary referral hospital.

3.4. The service will require a team of core midwives who staff the hospital and care for women not receiving continuity of care.

3.5. The MCoC model has considered where existing Children's Centres, Hubs are located to provide bases from which the teams can operate from there are limited estate options available.

4. Safe Staffing

4.1. Evidence suggests that significant investment is required to support continuity of carer at full scale.

4.2. A workforce review took place of the current maternity establishment in December 2021 with the Lead Midwifery Clinical Advisor for the South East as part of the scoping required to implement MCoC in OUH.

4.3. A full Birth rate Plus (BR+) workforce analysis is in process on completion this will be utilised to refresh the calculations utilised in 4.2. An investment case of need will need to be formulated and submitted through the appropriate Trust process for consideration.

4.4. Current staffing establishment at the OUH does not consider the staffing requirements recommended for MCoC models, figures taken from BR+ (2019) and current funded establishment

4.5. Before implementation of a phased roll out of MCoC based on the modelling OUH would be required to recruit an additional 13.6 WTE midwives for Wave 1 this will support 735 birthing families (11%) within the continuity of carer philosophy (see Table paragraph 6).

5. Communication and Engagement Plan

5.1. Limited staff engagement has taken place, however further engagement activities will be required in order to take MCoC forward at the OUH.

5.2. In developing and implementing plans, the Trust and LMNS will engage with maternity staff, Maternity Voices Partnerships and clinician. Plans for rollout will be co-produced with the diverse communities that will be receiving MCoC.

5.3. A communication plan will be established supported by HR, Unions, and National Teams.

5.4. Recruitment plans will be produced aligned to the implementation options.

6. Skill Mix Planning / Midwifery Staffing

Teams	No Teams	Staffing WTE	CoC No. Women	% CoC Achieved	Additional WTE Establishment required	Planned Implementation
Lotus 1:30 (under establishment)	1	4	198.0	1%	0.0	Current
Lotus 1:30	1	6.8	204	1%	Allocated	May 2022
Wave 1 – 3 teams inc Lotus	3	20.4	735	11%	13.6	2022/23 Q1
Wave 2	6	40.8	1469	23%	20.4	2023/24 Q1
Wave 3	9	61.2	2203	34%	0.0	2023/24 Q2
Wave 4	12	81.6	2938	45%	0.0	2023/24 Q3
Wave 5	15	102.0	3672	56%	0.0	2023/24 Q4

** Based on 6500 women birthing per year (excludes out of area women)*

6.1. The NHSE/I toolkit has been used to plan the phased role out. The plan identifies the aim of establishing 6 teams of 6.8 WTE midwives to achieve the 56% continuity of carer by the end of the 2023/24 financial year. The table shows the proposed phasing although the timings may change due to finance, recruitment and other possible resource issue. This will be audited and reviewed with each proposed implementation wave as time scales may change.

6.2. The Birthrate plus outcome will be used to support a skill mix review across the maternity service to inform the planning of ongoing team continuity of carer solutions

6.3. To implement Continuity of Carer will require close operational supervision to ensure that all clinical areas are appropriately staffed. From wave 3 onwards, staffing will be redeployed with the pivot point of moving from the existing community midwifery model being reached when the ratio 1:70 birthing women becomes a1:36 ratio.

6.4. There is a requirement that no midwife should be financially disadvantaged for working in this way, discussions and plans will be agreed with the Trust HR and Trade Union representatives as part of the implementation plan.

7. Training

7.1. A training needs analysis for the service will be undertaken with any additional training requirements for MCoC to be identified and delivered within the service education plan.

8. Review Process

8.1. Continuity of care will be monitored locally, and the service will ensure accurate and complete reporting on provision of CoC using the Maternity Services Data Set (MSDS).

8.2. MCoC teams will report on outcomes and other quality matrix which will form part of the integrated governance process.

8.3. The evaluation will be reviewed and will be reviewed and include the service impact for example a reduction in attendance in maternity triage the reduction of postnatal readmissions and increased use of interpreting services. Use of the PDSA cycle will support the process and refinement of the model continuously improving both experience and outcome. Any changes will be implemented prior to any roll out of the next phase of continuity.

8.4. National monitoring of Midwifery Continuity of Carer will focus on measuring level of provision and evaluating outcomes for women and staff.

8.5. This initial plan will provide 56% continuity of care for women choosing to have their baby at the OUH Trust. The phasing of the implementation has considered the national drive to prioritise continuity of care for women from ethnic minority or vulnerable background supported by current evidence. Prior to expanding continuity of care above 56%, a full evaluation will be undertaken in collaboration with the LMNS.

9. Conclusion

9.1. A staged approach will be adopted supporting staff engagement in service change as this model fundamentally changes practice. Continuity of care is evidenced as a model which supports improved outcomes for all birthing families and positive and personal experience of care. This aligns to the Trust vision and values of excellence, delivery, learning and improvement.

10. Recommendations

10.1. The Trust Board is asked to;

- Accept the contents of this report.
- Support maternity service in delivery of transformed model of care.
- Implement the nation guidance of a return of plan to board on a quarterly basis.
- Note the attached plan that will deliver 56% Continuity of Care model by the end of 2023/24 financial year. This will be subject to Trust business planning and Trust Management Executive (TME) approval subject to the resources made available through the local maternity and neonatal system (LMNS). This would be subject to approval by the Investment Committee if it is over £1million.

Appendix 1

11.1 Current Position of MCoC

Current Position – figures from financial year 2020/21: Total bookings 8739

- 233 birthing families booked who have AN and PN care only from the OUH but who chose to go out of area to give birth. This includes women who currently receive care from the midwifery community team linked to local GP surgeries but live close to county borders and choose to give birth at their local hospital such as The Great Western Hospital, Swindon. This includes many women booked at RAF Brize Norton and Dalton Barracks, Abingdon. Other women may choose to birth at other units after having experienced birth trauma within the OUH and wish to receive care in a different setting. This may change by offering MCoC and may affect the total number of women who can receive MCoC by default, therefore at every phase of the roll out we will evaluate using the PDSA cycle to check on the expected number of women in the core and in MCoC teams.
- In 2020/21 662 women booked for intrapartum care only (indicating out of area). Provision for tertiary referral reasons is likely to remain steady but women moving because they perceive somewhere else as “nicer” may change with more women staying in their own locality due to being offered MCoC. Tertiary referrals are not expected to change.
- 7202 people birthed at the OUH Trust in 2020/21

The current Lotus Team in 2020/21, with 7.4 WTE midwives carried a caseload of 198 women with acknowledged complex social/economic vulnerability and achieved 91% MCoC. This is the only team at the OUH that is currently providing all three midwifery elements of care therefore, the Trust are currently achieving only 1% MCoC across the service.

11.2 Identification of Current Population Birthing People

37.2% of women booking are from Black, Asian or Mixed ethnicity (Equity Analysis BOB LMNS 2021). Out of these 37.2% women are Black, Asian, or Mixed ethnicity and live in clearly defined geographical areas. At the time of the Census 2011 survey, Blackbird Leys had a proportion of ethnic minority residents like that for the city of Oxford as a whole – higher than the country and country overall proportions (35% compared with 36% in Oxford, 16% in Oxfordshire and 20% in England) (JSNA 2021).

Lower Super Output Areas (LSOAs) are used as the geography for publishing the national Indices of Deprivation (IMD). Oxfordshire has 1 out of 407 LSOAs ranked within the 10% most deprived areas nationally, part of Northfield Brook ward, in Oxford. A further 16 areas were ranked in the 20% most deprived areas nationally, 9 in Oxford City, 6 in Banbury and 1 in Abingdon (JSNA 2020).

The most deprived areas are:

- 1st decile: Blackbird Leys (Oxford) and Holywell
- 2nd decile: Northfield Brook (Oxford) and Banbury Ruscote (Cherwell)
- 3rd decile: Barton and Sandhills, Littlemore and RoseHill and Iffley

Banbury is part of Cherwell district council. There are 6 MSOAs covering Banbury parish. In Banbury, there is a total of 31 LSOAs. Banbury includes some of the more deprived areas of Oxfordshire (alongside Oxford). The town has 6 areas that were ranked within the 20% most deprived areas nationally. The areas that moved into the 20% more deprived group in 2019 (areas which become relatively more deprived) are part of Banbury Ruscote ward and part of Banbury Cross & Neithrop ward.

The proportion of women booking for maternity care in the most deprived decile (1st decile) up to July 2021 was 1% for Oxford (which includes Blackbird Leys and Holywell). 5% of booked women were from the 2nd and 3rd deciles (2nd Banbury Ruscote and Northfield Brook) and 3rd decile (Barton and Sandhills, Littlemore and Rosehill and Iffley). 23% of women booking were living in the 10th decile (least deprived) (Maternity dashboard 2021).

The most deprived areas of income deprivation in children in Oxford were in parts of Blackbird Leys, Littlemore, and Rose Hill & Iffley, all in the 10% most deprived areas nationally. In Banbury, part of Ruscote ward is within the 10% most deprived (Oxford JSNA 2021).

Other population groups: The proportion of Gypsy, Romany Traveller, GRT in Oxford is 9.5 per 10,000 with 34.2 per 10,000 living in Banbury Roscote ward.

The last Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. A new BR+ assessment is currently being undertaken, with the report due to be published in April 2022. For the purposes of the CoC planning spreadsheet staffing levels and birth statistics report 2018/19 figures but will be recalculated when the new BR+ report is available.

Appendix 2

12.1 Proposed MCoC Planning Detail

Maternity services and LMS (or LMNS) are asked to prepare a plan to reach a position where midwifery Continuity of Carer is the default position model of care available to all birthing people by March 2023 where safe staffing allows and building blocks are in place for the Maternity Incentive Scheme (Year 4).

The plan for the implementation of MCoC teams is to prioritise those that are more likely to experience poorer outcomes, focusing on birthing families from ethnic minority backgrounds and also those from the most deprived areas as mapped out in our Perinatal Equity and Equality Analysis, and Maternity Booking Assessment data from 2020/21.

Community Area	Total bookings 2020/21	% women from ethnic minorities	% women with complex social needs.
Blenheim & Isis	1568	27.3%	23.4%
Banbury	919	12.1%	26.1%
Abingdon & Wantage	999	29.0%	29.0%
All bookings	8952	13.3%	20.6%

Notes: Figures taken from booking assessments created in 2020/21 not in the Dashboard summary.
Ethnicity recorded as “not known/not stated” on 16.2% of bookings
Community area not identified on 22% of all bookings.

Complex social needs include health and safety scoring 3&4, domestic violence, safeguarding, cannot understand English, learning disabilities, recent migrant or asylum seeker.

In the first wave of the implantation plan, two additional continuity teams will be established by to allow; a team in the north (Banbury), one in Oxford City, and one in the South based at Wallingford.

The model will commence with 6.8 WTE midwives per team, with a band 7 supporting a maximum of 4 teams. The band 7 requirement will by identified as part od the overarching skill mix review to be completed.

MCoC caseload numbers per 1.0 WTE will be approximately 1:36 with mixed health and social risk, within the team geographical area. The MCoC midwife will make

contact directly with the birthing person to offer option of MCoC and arrange a booking appointment.

The existing Lotus MCoC team be absorbed to provide the midwifery establishments in wave one for the launch of 3 teams. This will ensure that there is a geographically based model supporting vulnerable birthing families from across the whole of Oxfordshire. This is recognised as a more sustainable work pattern to prevent burnout of midwives.

The current Lotus Case loading Team – Standard Operating Procedure v1.1 valid from 25/01/21 will be updated to reflect the new geographical case loading teams.

Linked Obstetrician

Each team has a linked named obstetrician who is an integral member of the team in providing a clear well-defined route for obstetric or other specialist referral.

Equipment and Estates

Each Team will require their own clinical equipment, laptops, and mobile telephones.

Each team will need estate to be identified from which they will work.

Training

A completion of training needs analysis for the service will be undertaken.

Communication and Engagement

- Confirm the suggested locations for the teams based on the public health data
- Group discussions led by the current MCoC team in order to learn and identify development and training requirements of the staff
- Seek expressions of interest to join the teams and head up an external recruitment drive to support MCoC
- Explore MCoC in partnership with the wider maternity service
- Establish and agree care pathways
- Celebrate the successes of the project throughout

12.2 Staffing Planning

Current recruitment plan to reduce midwifery vacancy in progress;

- OUH have the first cohort of 45 midwives qualifying in 2022
- Increased student midwifery capacity will continue from 2022
- Increased short course midwifery capacity has been supported by OUH as an addition source of midwifery workforce
- International recruitment of Nurses is in place to support care in none midwifery roles

Challenges:

- Band 5/6 midwives working part-time under 0.61wte and flexible working contracts impacting on the ability to deliver requirement of the national definition of midwifery continuity teams
- Maternity staff needing to continue with current pattern of long days/nights as part of work-life balance
- The unpopularity of on-call integral to the provision of the model
- The maintenance of the protected 1:36 case loading ratios when there are periods of sickness absence within the teams