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Delivering Midwifery Continuity of Carer at full scale

Guidance on planning, implementation
and monitoring 2021/22

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Summary

Midwifery Continuity of Carer (MCoC) has been proven to deliver safer and more personalised maternity care. Building on the recommendations of Better Births and the commitments of the NHS Long Term Plan, **the ambition for the NHS in England is for MCoC to be the default model of care for maternity services, and available to all pregnant women in England – with rollout prioritised to those most likely to experience poorer outcomes.** Where safe staffing allows and building blocks¹ are in place, this should be achieved by March 2023.

Developing a plan

As a first step, local maternity systems (LMS) must by 31 January 2022 agree a local plan that describes how you will achieve MCoC as the default model of care offered to all women. This will include putting in place the ‘building blocks’ for sustainable models of MCoC by March 2022.

Plans must cover, on a trust-by-trust basis:

- number of women expected to receive MCoC, when offered as the default model of care (see **Section 2.3**)
- when this level of provision will be achieved by; and a redeployment plan into MCoC teams to staff it, phased alongside the fulfilment of recommended staffing levels (see **Section 3**)
- how MCoC teams are established in compliance with national principles and standards, to ensure high levels of relational continuity (see **Section 4**)
- how rollout will be prioritised for those most likely to experience poor outcomes, including with the development of enhanced models of MCoC (see **Section 5**)
- how care will be monitored locally, and providers ensure accurate and complete reporting on provision of MCoC using the Maternity Services Data Set (see **Section 6**).

¹ Building blocks are set out in Appendix A.

In developing local plans, maternity services and LMS will assess their readiness for further implementation – these are the building blocks that need to be in place (see Appendix A).

This document provides guidance on how to develop this plan and what it should contain, so that all women, babies and families can benefit from these much needed improvements in care, experience and outcomes.

It takes into account longstanding challenges for local implementation, and the concerns stakeholders raised at a national roundtable meeting in July and with the Health and Social Care Committee.

It also sets out recommended practice, how delivery against these plans will be assured nationally, and how MCoC provision will be measured at provider and LMS level.

What is Midwifery Continuity of Carer?

MCoC is provided by midwives organised into teams of eight or fewer (headcount). Each midwife aims to provide antenatal, intrapartum and postnatal midwifery care to approximately 36 women per year (pro rata), with support from the wider team for out-of-hours care. Within this:

- MCoC is **not** antenatal or postnatal care only or 1:1 care in labour. The evidence for its benefits is clearly based on models employing continuity across antenatal, intrapartum and postnatal care
- each team has a linked obstetrician
- all staff in the maternity service contribute to achieving MCoC and must feel involved in its provision. MCoC is everybody's business.

For more information on the key principles of a MCoC team, please see **Section 4**.

1. Introduction

Midwifery Continuity of Carer (MCoC) delivers safer and more personalised maternity care. Building on the recommendations of Better Births and the commitments of the NHS Long Term Plan, **the ambition for the NHS in England is for MCoC to be the default model of care for maternity services, and available to all pregnant women in England** – with rollout prioritised to those most likely to experience poorer outcomes. Where safe staffing allows and building blocks² are in place, this should be achieved by March 2023.

Maternity services and local maternity systems (LMS) have made significant progress in recent years in establishing midwifery MCoC teams across the country. While a number of maternity services and LMS have shown commendable progress launching teams through the COVID-19 pandemic, in other areas unavoidable staffing pressures due to coronavirus have hampered implementation. Progress has also been limited in some areas by longstanding challenges with midwifery staffing, and the local issues and challenges associated with bringing about wholesale change in midwifery staffing models.

1.1 What are maternity services being asked to deliver?

As set out in the [NHS Operational Planning Guidance for 2021/22](#), LMS should **put in place the building blocks by March 2022, so that MCoC is the default model of care offered to all women**. This involves, by March 2022:

- continuing with MCoC teams already in place and to roll out new teams as planned, where appropriate
- undertaking a Birth-rate Plus assessment or equivalent to understand the current standard-model midwifery workforce required and following this through with recruitment
- co-designing a plan with local midwives, obstetricians and service users for implementation of MCoC teams in compliance with national principles and standards, and phased alongside the fulfilment of required staffing levels. This

² Building blocks are set out in Appendix A.

plan should also take into account the need to support maternity staff to recover from the challenges of the pandemic

- prioritising those women most likely to experience poorer outcomes, including by ensuring most women from Black, Asian and Mixed ethnicity backgrounds and also those from the most deprived areas are placed on a MCoC pathway by March 2022
- developing the ability to measure progress electronically and report it to the Maternity Services Data Set (MSDS)
- developing an enhanced model of MCoC that provides extra support for women from the most deprived areas, for implementation from April 2023.

As a first step, LMS must develop and agree a local implementation plan by 31 January 2022. This document provides guidance on how to develop this plan and what it should contain, so that all women, babies and families can benefit from these much needed improvements in care, experience and outcomes.

1.2 How the implementation strategy has changed to address challenges and concerns

While the Health and Social Care Committee provided clear support in its [July report](#) for the importance of MCoC, and the strength of its evidence base, it highlighted longstanding challenges in local implementation, and the need for sufficient resources and support for LMS to deliver it. In individual submissions to the committee, several stakeholders highlighted the need to ensure that the transition to MCoC does not put undue pressure on midwives or compromise safe staffing levels across any part of the wider maternity service.

To respond to these challenges, a national roundtable event was held in July to review evidence and progress to date, and to listen to the concerns of a broad range of stakeholders. Three broad themes emerged:

- provision of safe and personalised care
- engaging midwives and obstetricians
- resources.

Appendix B summarises the operational issues raised and solutions to these.

Table 1: Key changes to the national implementation strategy to address concerns

Concern	Response
Not all maternity providers are able to meet the same level of implementation of MCoC due to service user choice	Maternity services and LMS plans should state how many women can receive MCoC when offered it as the default model of care, based on the number of women who remain at providers for antenatal, intrapartum and postnatal care (see Section 2.3).
Universal deadlines for full implementation do not account for local workforce challenges	LMS plans should set out timescales for implementation, phased alongside the fulfilment of required staffing levels. While many trusts will be able to achieve this by March 2023, this may not be possible for every trust. Alternative timescales will therefore be accepted on a case-by-case basis, where they clearly link to a credible recruitment plan. This will be assessed through regional assurance (see Section 3).
MCoC must be implemented at a pace that is safe for women and midwives across the service	In developing local plans, maternity services and LMS will assess their readiness for further implementation. Regional assurance of plans will in turn consider readiness to proceed and the sustainability of proposals, and whether transitional arrangements uphold the safety of care for all women across the service (see Section 2.6). The NHS England and NHS Improvement workforce tool will support this process.
Maternity services and LMS need sufficient resources – including midwives – to deliver MCoC	Funding of £96 million has been announced as part of the national response to the initial Ockenden Report: part of this is funding an extra 1,200 midwives and 100 obstetricians nationally from 2021/22. £6.8 million transformation funding has been allocated to LMS for implementation of MCoC and equity strategies in 2021/22. Further transformation funding will be provided in 2022/23. £1.4 million is being invested in 2021/22 in nine LMS to pilot models of enhanced MCoC in their most deprived neighbourhoods. Pending evaluation, this funding will be rolled out nationally, with additional sustained funding in baselines to support enhanced MCoC teams from 2023/24.

1.3 Why provide Midwifery Continuity of Carer?

Based on the best evidence available, MCoC delivers safer and more personalised care:

- The 2016³ Cochrane review concluded that MCoC models save babies' lives, prevent preterm birth, reduce interventions and improve women's experiences and clinical outcomes.
- The 2018⁴ and 2020⁵ Cochrane reviews concluded that MCoC prevents stillbirth and preterm birth.
- Working in this way facilitates good personalised care and supports planning and continuous risk assessment.
- Relational care improves women's experience and perceptions of quality of care.⁶

The workforce literature suggests teamworking benefits healthcare professionals too.^{7,8}

Appendix C gives more information on the evidence base for MCoC, and background on policy and implementation in England.

³ Sandall J, Soltani H, Gates S, Shennan A, Devane D (2016) [Midwife-led continuity models versus other models of care for childbearing women](#). *Cochrane Database of Systematic Reviews* 4. Art. No.: CD004667.

⁴ Medley N, Vogel JP, Care A, Alfirevic Z (2018) [Interventions during pregnancy to prevent preterm birth: an overview of Cochrane systematic reviews](#). *Cochrane Database of Systematic Reviews* 11. Art. No.: CD009599.

⁵ Ota E, da Silva Lopes K, Middleton P, Flenady V, Wariki WMV, Rahman MO, Tobe-Gai R, Mori R (2020) [Antenatal interventions for preventing stillbirth, fetal loss and perinatal death: an overview of Cochrane systematic reviews](#), *Cochrane Database of Systematic Reviews* 12. Art. No.: CD009599.

⁶ Perriman N, Davis DL, Ferguson S (2018) [What women value in the midwifery continuity of care model: A systematic review with meta-synthesis](#). *Midwifery* 62: 220-229.

⁷ West MA, Lyubovnikova J (2013) [Illusions of team working in health care](#). *J Health Organ Manag* 27(1): 134-142.

⁸ Fenwick J, et al, (2018) [The emotional and professional wellbeing of Australian midwives: A comparison between those providing continuity of midwifery care and those not providing continuity](#). *Women and Birth* vol 31, issue 1 Feb 2018 pages 38-43

2. Developing a plan

As a first step, local maternity systems (LMS) must by 31 January 2022 agree a local plan that describes how you will achieve MCoC as the default model of care offered to all women. This will include putting in place the ‘building blocks’ for sustainable models of MCoC by March 2022.

Plans must cover, on a trust-by-trust basis:

- the number of women expected to receive MCoC, when offered it as the default model of care (see **Section 2.3**)
- when this level of provision will be achieved by, with a redeployment plan into MCoC teams to staff it, phased alongside the fulfilment of recommended staffing levels (see **Section 3**)
- how MCoC teams are established in compliance with national principles and standards, to ensure high levels of relational continuity (see **Section 4**)
- how rollout will be prioritised for those most likely to experience poor outcomes, including with the development of enhanced models of MCoC (see **Section 5**)
- how care will be monitored locally and providers ensure accurate and complete reporting on provision of MCoC using the Maternity Services Data Set (see **Section 6**).

A sample board paper can be found [here](#).

In developing local plans, maternity services and LMS will assess their readiness for further implementation (see **Appendix A**). Regional assurance of plans will in turn focus on readiness to proceed and the sustainability of proposals, and whether transitional arrangements uphold the safety of care for all women across the service (see **Section 2.6**).

2.1 Timescales for planning

To ensure senior engagement and buy-in, **local implementation plans should be agreed at respective provider boards by 31 January**. These should link to local plans that take account of LMS equity and equality analyses, required for submission on 30 November by [the Equity and Equality Guidance for LMS](#).

Provider senior leadership teams must understand and value the process and approach to achieving full-scale MCoC and be able to support it. The board safety champion should ensure the board reviews delivery against this plan on a quarterly basis.

Action 9 of [Year 4 of the CNST Maternity Incentive Scheme](#) requires board-level safety champions by March 2022 to have reviewed their MCoC action plan in the light of COVID-19, and be assured that a revised action plan describes how the maternity service will work towards MCoC being the default model of care offered to all women, prioritising those most likely to experience poor outcomes.

2.2 What does it mean to offer Midwifery Continuity of Carer as the 'default model of care'?

In line with Better Births and the NHS Long Term Plan, all women should be offered the opportunity to benefit from MCoC across antenatal, intrapartum and postnatal care. However, not all women will be in a position to receive MCoC, through choosing to receive some of their care at another maternity service. In a small number of cases, women will be offered a transfer of care to a specialist service for maternal/fetal medicine reasons. They are known as out-of-area women.

Providing MCoC by default therefore means both:

1. offering all women MCoC as early as possible antenatally
2. putting in place clinical capacity to provide MCoC to all those receiving antenatal, intrapartum and postnatal care at the same provider.

2.3 Determining the required level of provision

Providers should begin by determining how many women they provide antenatal, intrapartum and postnatal care to annually. This is the number of women to whom MCoC needs to be provided for it to be the default model of care.

The benefits of MCoC should be explained to women when they are deciding where to receive their care. Providers should therefore have contingency plans in place for an increase in women remaining with them for antenatal, intrapartum and postnatal care.

2.4 Communications and engagement

Engagement is vital and an early and ongoing step. In developing and implementing plans, the trust and LMS should engage with maternity staff, Maternity Voices Partnerships and wider clinicians, including obstetricians, neonatologists, GPs and health visitors.

Models of care and plans for rollout should be co-produced with the diverse communities that will be receiving MCoC. This relates to details such as where teams will be placed, not the operationalisation of MCoC, which is about midwifery deployment into teams. This is particularly important for enhanced models of MCoC, to ensure extra support is directed to areas of greatest need. Women should also receive information on what MCoC is, what they can expect and what it will mean for them.

Maternity leadership should involve key stakeholders, such as frontline midwives, human resources, informatics and shop-floor union representatives, early in planning changes to delivery. This should not be left to the Better Births midwife alone – the whole senior team should be talking about best practice with their staff, including MCoC.

Inform all staff about the plan and timescales for rollout, so they understand what they are being asked to do and how it might affect them. This will also help staff recognise that everybody has a role in supporting MCoC. Studies have shown that engagement events help to assuage concerns in the workforce.⁹ Midwives may also appreciate hearing from colleagues already working in teams providing MCoC.

2.5 Funding for implementation

In response to the initial [Ockenden Report](#), 1,200 more midwives and 100 more obstetricians are being funded from the extra £96 million for maternity services from 2021/22.

LMS have also been allocated £6.8 million of funding in 2021/22 to support the implementation of MCoC and the upcoming equity strategy for maternity and neonatal services. Funding allocation is calculated on a ‘fair shares’ basis but each LMS is

⁹ Harris JM, Watts K, Page L, Sandall J (2020) [Reflections on an educational intervention to encourage midwives to work in a continuity of care model – exploration and potential solutions](#). *Midwifery* 88: 1027–33.

receiving a minimum of £90,000 to reflect the basic costs of the work all LMS are likely to incur. Transformation funding will continue into 2022/23.

Plans should therefore set out how and when this funding will be used in 2021/22 to support implementation.

2.6 Submission and assurance of plans

Following board sign off, plans should be shared with regional maternity boards, again by 31 January, for assurance. Regional assurance of plans will focus on the readiness to proceed with implementation and the sustainability of proposals, and whether transitional arrangements uphold the safety of care for all women across the service.

Appendix A sets out the key lines of enquiry for readiness to proceed, to be reviewed by regions.

Regional boards may provide feedback and request revisions at locally agreed timescales in Q3; but will be asked to submit summaries of assurance – and of LMS' planned levels of provision – as part of Q3 regional assurance.

2.7 Assurance of delivery

From Q3 2021/22, LMS will report on progress relating to implementation of their plans on an ongoing basis, as part of quarterly regional assurance. LMS will also be assessed nationally on whether implementation is on track, against regular trust-level measurements of level of provision.

Provision of MCoC will be measured nationally using provider surveys, monthly publications of MSDS data and the CQC Maternity Survey.

The placement of Black, Asian and Mixed ethnicity women and those from deprived neighbourhoods will be measured.

Table 2: Assurance of Midwifery Continuity of Carer deliverables

What	When	KLoE	How will this be assured?
Submission and agreement of plans	January 2022 (submission) Q4 (assurance)	Has the plan been signed off by the trust board and subsequently the regional maternity board?	Q3 regional LMS assurance
Delivery against plans: building blocks	Quarterly from Q4 2021	Is the LMS on track against stated deliverables and milestones?	Quarterly regional assurance (RAG rating)
Delivery against plans: provision	Quarterly from Q4 2021	Is the current level of provision on track against the planned phased implementation?	Quarterly regional assurance (latest data on level of provision)
Workforce capacity surveys	October 2021 and March 2022 and ongoing until providers are reporting provision on MSDS	What is the current establishment and caseload of MCoC teams?	Survey of maternity providers across England
Placing most Black, Asian and Mixed ethnicity women and women from deprived neighbourhoods onto MCoC pathways	March 2022	Rate eligible women reaching 29 weeks gestation in March are placed on MCoC pathways (>51%)	Analysis of rates of placements using MSDS data

See **Appendix D** for more information on how provision of MCoC will be measured.

3. Phasing delivery

Plans must cover how the rollout of additional MCoC teams will be phased alongside the fulfilment of required staffing levels.

Once providers have determined the level of provision required to offer MCoC by default (see **Section 2.3**), they can begin to plan the configuration of midwifery teams across the service.

Dependent on rates of out-of-area women, tertiary referral and geography, for many maternity services about 45–65% of midwives are likely to be deployed to MCoC teams, with about 35–55% remaining in the core.

A [national modelling tool](#) is available to help you determine the required number and whole-time equivalency (WTE) of MCoC teams, along with core staffing. Instructions for use are given in **Appendix E**.

3.1 When must full implementation be achieved?

[NHS Operational Planning Guidance for 2021/22](#) requires that MCoC is established as the default model of midwifery care and offered to all women by March 2023.

While many will be able to achieve this by March 2023, alternative timescales will be accepted on a case-by-case basis, where it is clear that full staffing cannot be achieved by March 2023 and there is a credible linked recruitment plan. These revised timescales will be assessed and agreed through regional assurance.

3.2 Ensuring safe staffing

In recent years, implementation has been limited for some maternity services by existing challenges with midwifery establishment, and the local issues and challenges associated with bringing about wholesale change in midwifery staffing models.

There is no evidence that MCoC requires extra midwifery time on an ongoing basis when deployed at scale, but all services need to be fully established for safe care. Women are more likely to experience MCoC in a well-established service.

All services must therefore have undertaken a recent Birthrate+ (BR+) or equivalent assessment to determine the number of midwives currently needed across the service.¹⁰ This is usually undertaken every three years, in addition to standard staffing assessments.

As part of the national response to the initial Ockenden Report, an additional 1,200 midwives and 100 obstetricians are being funded from the extra £96 million for maternity services from 2021/22. Providers and LMS are working with regional

¹⁰ We recommend that this whole-service assessment is based on a 'traditional' midwifery configuration.

maternity leadership to determine what additional staffing is required, and what share of the funding they will receive for this.

In meeting the required MCoC provision, deployment will in some areas need to be phased alongside a recruitment plan for any additional midwives to meet identified gaps. Where this is the case, MCoC implementation should be prioritised for those women most likely to experience poorer outcomes (see **Section 5**).

This phasing should be set out clearly, **with a clear trajectory for capacity of MCoC teams for each quarter until March 2023, or until MCoC is being provided as the default model of care.**

National recommendations

- Services plan their midwifery staffing redeployment using a phased approach, so **no** double running is required. An Excel spreadsheet within the national [Continuity of Carer Workforce modelling tool](#) will help with this (see **Appendix E**). Each team picks up its full complement immediately (where each WTE midwife has three women due in month and rolling forwards).
- Where trusts have yet to roll out CoC teams, roll out the first two or three teams and then check the standard operating policy (SOP) covers all it was intended to, and if not resolve any operational issues. Further rollout can then proceed at pace: a new team or teams at 2–3-month intervals and upping this number as implementation progresses.
- Although each team will have its own features, it is recommended that each team is of similar size and make up (ie mixed-risk geographical teams) as these are easier to operationalise and for control of the workflow. The required number of MCoC midwives and teams can be determined by dividing the total number of women receiving all maternity care at the trust by 36 (the recommended annual caseload for each midwife). In the example, $4,300 \text{ deliveries (women)}/36 = 119.4$ WTE midwives, meaning about 17 teams will be needed.
- Maternity providers need to understand their attrition rates. For example, if this is 15%, to control flow each continuity midwife books three or four women a month

(or 42 a year) and has a plan to birth three a month. However, if the attrition rate is 10%, then each midwife can book 40 women a year.

- No midwife should lose pay as a result of working in a MCoC team. It is a trust's responsibility to agree pay and conditions in this context (see the AfC Handbook). An exemplar can be found at <https://continuityofcarer-tools.nhs.uk/tools> to support each trust's planning around this with their finance and HR/OD departments.

4. Configuring teams

Plans must show how established MCoC teams will comply with national principles and standards and ensure high levels of relational continuity.

This [video](#) gives an overview of 'what good looks like'.

4.1 Key principles of a Midwifery Continuity of Carer team

All three phases of care

Each woman has a named midwife who is responsible for co-ordinating her care. Each midwife aims to provide antenatal, intrapartum and postnatal care to each of the women on her caseload but is supported by the team for protected days off, periods of sickness, training and annual leave. This allows a trusting relationship to be built between the midwife and woman. Midwives ensure that each woman has a personalised care and support plan (PCSP) that is updated at each visit along with the risk assessment.

Linked obstetricians

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 (see **Section 4.2**).

Model of working

Moving into a MCoC team represents a fundamental shift in the way that midwives will work: away from a shift-based rostered system to one where the midwife follows the

women to ensure right care, right place, right time. It is important to factor in protected time off for each team member in line with their WTE contract.

Team size

MCoC teams are made up of no more than eight midwives (headcount). With full capacity, this could mean, depending on team size, organisation and number of home births, midwives work just one out-of-hours session per week, which should be no more onerous than a night shift and can be planned well in advance. Out-of-hours sessions are part of the contracted hours, not in addition to them. It is worth noting that trusts report MCoC teams smaller than 6.8 WTE struggle to fill the out-of-hours element, as each midwife would have a greater burden of out of hours to cover.

In some trusts a high proportion of midwives work part time. Ideally team sizes should be no more than eight headcount, but it is appreciated that this may sometimes be difficult due to specific work situations. Therefore, providers are able to request variation on this, by exception with local and regional leads, subject to the following conditions:

- all reasonable efforts have been made to keep team size to eight headcount and there is a clear plan to return to this where possible
- there is a commitment to evaluating service user experience and outcomes of these teams.

Caseload

Each midwife cares for 36 completed cases per year – and books slightly more women to account for attrition. Part-time midwives have a pro-rata caseload: a 0.8 WTE midwife will care for 30 women and a 0.6 WTE midwife 24. Team size is therefore expressed in terms of WTE.

On-call working

No midwife is expected to work over their contracted hours. When working flexibly they can keep a tally of hours worked to ensure that they do not work additional hours. This should be monitored on a four-weekly basis to ensure no-one works more than their contracted hours. This is not 'on-call' working in the traditional sense, ie where midwives work hours additional to their set hours. In MCoC, team members take turns to do out-of-hours work. This can be planned weeks or months in advance, although midwives can also be flexible with each other as need arises.

Recruitment of women

To offer MCoC to all women, services must control workflows so that all women referred into the system are swiftly and easily allocated to the appropriate MCoC team for booking. This will minimise the risk of women being missed or required to change teams, and is particularly important as continuity is being scaled up. Flow is most easily controlled by implementing mixed-risk geographically-based teams, particularly if continuity is to be provided with the BR+ or equivalent recommended number of midwives. For planning purposes, it is helpful to have evenly sized teams and of a size where each WTE midwife can book three or four women a month and expect to be at a birth three times a month. Part-time midwives will book fewer women pro rata and attend fewer births.

Evidence suggests that geographical teams are more sustainable than vulnerable women's teams.¹¹ Homebirth teams and low risk teams can be associated with higher rates of attrition; if women change their minds or develop clinical problems, changing teams means a loss of continuity. Continuity team midwives are allocated to specific women and are expected to follow each one to where she is cared for, to ensure that all women have a known/team midwife at all times. This avoids the traditional problem of dealing with peaks and troughs in activity: as midwives follow their women, it is women and not buildings that are staffed.

Team support

Midwives support each other. They can do this best with a **flexible, autonomous approach** and when working in geographically-based teams. The team has a strong team ethos that welcomes 'fresh eyes', case review and improvement initiatives.

Professional midwifery advocates (PMAs)

This is a new and fundamental leadership and advocacy role designed to deploy [the A-EQUIP model](#). The role supports staff through a continuous improvement process that aims to build personal and professional resilience. Trusts can consider using these midwifery leaders to support all elements of maternity transformation, including by providing education and training for midwives new to the role, working on quality improvement and providing restorative clinical supervision as necessary.

¹¹ Rayment-Jones H, Murrells T, Sandall J (2015) [An investigation of the relationship between the caseload model of midwifery for socially disadvantaged women and childbirth outcomes using routine data - A retrospective, observational study](#). *Midwifery* 31(4): 409-417.

Team leaders

While it is generally for trusts to decide what is appropriate, in line with flexible, autonomous teams, a Band 7 team leader could oversee a number of teams made up of Band 6 midwives.

Preceptee midwives

Recent evaluation¹² suggests that preceptee midwives feel more confident working in MCoC teams and achieve their competencies quicker than those working in the traditional model. Initial reports suggest one preceptee and at least one preceptor per team works well and maintains a healthy skill mix.

Medical complexity

The one exception to basing care around geographically-based teams is where women can be identified early as having obstetric or medical complications that require more specialist care. Services should consider introducing a limited number of ‘maternal medicine’ (including women with previous preterm birth) teams; these can ensure relational continuity within more medicalised pathways. These teams and their model of care should be developed in line with the agreed clinical guidelines for management, escalation and referral established by the local maternal medicine network.¹³ A system-level approach may be considered for smaller maternity services.

Whole-service involvement

The whole maternity service is part of MCoC, even those not working directly in a MCoC team: ‘we are continuity’ is an important concept.

4.2 Linked obstetricians

- Each team of midwives must have a linked obstetrician, an individual who is an integral member of the team, who is available to the midwifery team by an agreed process and who attends team meetings on a regular basis (eg monthly). Obstetricians may be linked to more than one team.
- The midwives and the linked obstetrician agree their method of communication and working.

¹² Wilson C, Ingram D, Lyons J, Groves S (2020) [Being a newly qualified midwife in continuity of carer: what is it really like?](#) *The Practising Midwife* 23(11): 29–31.

¹³ Fernandez Turienzo C, Bick D, Briley AL et al (2020) [Midwifery continuity of care versus standard maternity care for women at increased risk of preterm birth: A hybrid implementation–effectiveness, randomised controlled pilot trial in the UK.](#) *PLoS Medicine* 17.10: e1003350.

- The linked obstetrician is not necessarily the lead professional for the women being care for by the MCoC team, but they may take on this role particularly for women who develop risk factors during pregnancy. This should be clarified in local policies, SOPs, guidelines and procedures.
- Women with clear medical/obstetric risk factors that are set out in their referral letter (either by themselves or their GP) are referred from the outset to the maternity service obstetrician with a specific interest/specialisation in their condition. Midwives are aware of agreed local protocols for escalation and management of medical problems in pregnancy. Wherever possible midwives remain involved in a woman's care, including by attending appointments with them.
- As set out above under 'Medical complexity', services should consider deploying maternal medicine teams for the highest risk women. These women are usually identifiable from the booking referral letter or, for services where self-referral is in place, from initial information or the booking process.

4.3 Estate

- Trusts need to consider where MCoC teams will be based. It is helpful if they are community based, eg in a community hub, with easy access to other healthcare providers, including services such as primary care, health visiting, social services or mental health services.
- Maternal medicine teams may determine that an on-site base may provide the best and easiest access to additional facilities.

4.4 Equipment

- Teams need to be properly equipped. Although individual trusts will have their own standard items it is worth considering the following:
 - computer or tablet for data capture, including IT infrastructure
 - telephone
 - lone working device
 - standard midwifery equipment for each midwife
 - means of transport.

4.5 Training and support

- All maternity services must complete a training needs analysis. This should identify what clinical skills midwives in MCoC teams need to update to provide care for women throughout the pregnancy journey and across a range of settings, and also for providing care to women from diverse ethnic backgrounds and those living in the most deprived communities.
- Many midwives will need to make a fundamental shift, but in moving away from a rostered approach and working in a set department, they will be able to work more flexibly. They will be providing care to a set number of women at a time and place agreed between the woman and midwife, with out-of-hours care provided by the wider team as required. Consistent training and support are essential in ensuring that midwives are aware of the underlying evidence base and have the confidence and skillset to deliver continuity of care.
- Trusts will allocate work differently – some midwives already work in a rotational model and are used to working in all areas; others are not. This needs to be accounted for when considering what training or upskilling midwives may need. Time and resources should be planned to upskill midwives where required to work in unfamiliar environments and the different areas of midwifery care must be covered in implementation plans. Use of a buddy scheme and the PMA role could be beneficial.
- Training time should include time for team building to ensure healthy, high-functioning teams.

5. Prioritising equity

Plans should set out how rollout will be prioritised to those most likely to experience poorer outcomes.

LMS must ensure that most (>51%) women from Black, Asian and Mixed ethnicity backgrounds, and women from the most deprived areas are placed on a MCoC pathway by March 2022. This is with a view to meeting the [NHS Long Term Plan](#) commitment for 75% of women from these groups to be provided with MCoC by March 2024.

5.1 Targeting communities in need

This should be achieved by rolling out geographically-based teams available to all women, in places where the highest number of Black, Asian and deprived women live, and in the most deprived postcodes.

Implementation plans must therefore be based on an understanding of the local population, including analysis by ethnic groups and distribution of deprived areas.

[The equity and equality guidance for LMS](#) requires a local analysis of health outcomes, communities and community assets by 30 November 2021. Plans for prioritising rollout of geographically-based teams should be clearly linked to this analysis.

5.2 What is meant by Black and Asian women, and women from the most deprived areas?

For the purposes of targeting MCoC, Black and Asian women are women who are identified in the following categories in the Maternity Information System, [as set out in the NHS Data Model and Dictionary](#):

Mixed	
D	White and Black Caribbean
E	White and Black African
F	White and Asian
Asian or Asian British	
H	Indian
J	Pakistani
K	Bangladeshi
L	Any other Asian background
Black or Black British	
M	Caribbean
N	African
P	Any other Black background

Note: In the categorisations listed above, 'Asian' women does not include 'Chinese' or other East Asian women. For the full list of ethnicity categorisations beyond those in scope above, please see the [NHS Data Model and Dictionary](#).

The most deprived 10% of areas are those defined by the [2019 Index of Multiple Deprivation \(IMD\)](#). If there are no such areas in your footprint, then focus should be on the bottom 20%, and so on. Information on deprivation of postcodes can be found at <https://continuityofcarer-tools.nhs.uk/>.

5.3 Enhanced Midwifery Continuity of Carer

Further funding is being allocated to LMS to provide additional support for women living in the most deprived areas.

Nine pilot areas in 2021/22 and 2022/23

For 2021/22, £1.4 million has been allocated to nine LMS with the highest concentration of the most deprived lower support output areas (LSOAs) (there are 110 in total). These LMS have been notified of this funding and their plans should set out how this funding will be used to provide additional clinical support for women in their areas of highest deprivation.

Funding should be used to provide more holistic support that reduces midwives' workload and releases additional time for the midwives to care for women. This could include providing extra staff:

- maternity support workers (MSWs), eg those who speak community languages, or to provide breastfeeding support
- link workers
- administrative workers.

Consideration could be given to other creative approaches such as working with third-sector organisations in the geography to bring about a joined-up approach to care.

Any additional staffing should be evaluated against other teams, for the benefit of national learning. For more guidance on evaluation, see **Appendix D**.

Funding will continue for these areas into 2022/23, with funding levels to be confirmed in coming months.

Learning will be gathered from models deployed on an ongoing basis in 2022/23 and shared nationally for the benefit of all LMS by March 2023.

All LMS

In 2023/24, funding will increase to extend it to all LMS. This funding is subject to confirmation and annual business planning, but indicative values will be shared alongside national learning and guidance from pilot sites by March 2023.

6. Monitoring and reporting provision

Plans must set out how care will be monitored locally, and providers will ensure accurate and complete reporting on provision of MCoC using the Maternity Services Data Set (MSDS).

6.1 Monitoring care

MCoC teams should put in place regular monitoring to ensure quality of care, and this should feed into routine maternity services quality surveillance and governance. This should include:

- each service agreeing a SOP or guideline that clearly defines roles and responsibilities within each trust. An example SOP can be found in the [national MCoC toolkit](#)
- all midwives and the linked obstetrician attend team meetings on a regular basis (eg monthly)
- regular team audits are held on activity and outcomes, where cases, adverse events and compliments are discussed, embedding learning within the team. Information is shared with the wider maternity team as appropriate, including reporting to the maternity clinical governance board for review.

6.2 Recording and reporting the provision of Midwifery Continuity of Carer

As set out in the NHS Operational Planning Guidance for 2021/22, plans must describe how maternity services will ensure accurate and complete reporting on provision of MCoC using the MSDS by March 2022.

While MCoC workforce surveys are planned in October and March to assess the capacity of teams to provide MCoC to the general population, MSDS data will be used in March 2022 to formally assess whether most women of Black, Asian and Mixed ethnicity and most women from the most deprived areas have been placed on MCoC pathways, and from then on each month to assess the provision of MCoC for all women.

All maternity services must urgently take three key steps to improve data quality:

1. Understand how MCoC will be measured and the key data requirements:

- the two planned MSDS measures for MCoC are defined in the **Technical annex: Definitions for Maternity Services Data Set measures**
- within the **Technical annex, Resource B** sets out the data items required for each measure, and why.

2. Ensure the capability of the Maternity Information System (MIS):

- services should work with their MIS suppliers to ensure their MIS can record and submit the requisite data items to MSDS on a monthly basis
- on 17 June, NHS England and NHS Improvement and NHSX announced [£52 million additional funding in 2021/22](#) to accelerate providers' work to upgrade or re-procure MIS to meet data and interoperability standards. Providers have been invited to complete digital maturity assessments to inform next steps for accessing this funding.

3. Embed good data practice into business as usual:

- heads of midwifery, digital midwives and data submitters should form a project group to identify what practice is required across the service on an ongoing basis to ensure consistent data quality and reporting
- since October 2020, service-level data on MCoC has been published monthly in [MSDS experimental statistics](#), including a basic measure of data quality

- more detailed assessments of data quality are provided in the regional maternity dashboard
- NHS Digital is also developing an instant feedback tool for providers to assess quality of MSDS data directly after submission, rather than waiting for published statistics
- heads of midwifery, digital midwives and data submitters should use this analysis to identify gaps, inconsistencies or inaccuracies in data submissions, and work with MIS suppliers and MCoC teams as appropriate to embed changes in everyday practice, so that the provision of MCoC can be evidenced through routine care records.

Appendix A: The building blocks: readiness to implement and sustain MCoC assessment framework

Building block	Detail/notes	RAG
	The plan needs to be developed and presented to the board. It then needs to be rolled out according to the trust's specific needs. Work already underway should continue unless there is an urgent reason not to.	
Safe staffing	<ul style="list-style-type: none"> • Agreed safe staffing level for traditional model, proceeding only when safe to do so – using the NHS England and NHS Improvement tool to support planning • How many midwives required • How many in post • Recruitment plan with timeframes 	
Planning spreadsheet	<p>Demonstrates safety from a staffing perspective:</p> <ul style="list-style-type: none"> • how many women can receive MCoC – reviewing in and out of area and cross-boundary movement • where women are cared for at any given time, now and in MCoC models (see NHS England and NHS Improvement toolkit https://continuityofcarer-tools.nhs.uk/tools for an example of this) • midwifery deployment plan for MCoC, including timescales and recruitment plan for a phased scale up to default position 	
Communication and engagement	<ul style="list-style-type: none"> • Provides evidence of staff engagement and logs responses/counter responses • Gives opportunity to share vision 	
Skill mix	<ul style="list-style-type: none"> • Review of skill mix, within whole service. This includes: <ul style="list-style-type: none"> – number of Band 5 midwives placed in MCoC team. Likewise, number of Band 5 midwives working in the core – in both settings ensure there is appropriate support for these newly qualified members of staff, via the preceptor framework – Band 5 midwives (usually one per team) report being very well supported while undertaking preceptor programme • Appropriate and planned use of MSW, particularly in teams working in areas of greatest need. 	

Building block	Detail/notes	RAG
	<ul style="list-style-type: none"> Ensure preparedness of Band 7 delivery suite co-ordinators to support programme of change 	
Training	Each midwife who will work in the team has a personal training needs analysis (TNA); existing TNAs can be used and the toolkit also gives examples.	
Team building	Time allocated for team building and softer midwifery development as midwives move to a new way of working.	
Linked obstetrician	Has there been obstetric involvement and are linked obstetricians identified? Is the referral to obstetrician process clearly set out in the SOP as well as other clinical guidance?	
Standard operating policy (SOP)	Each trust needs a SOP (an example can be found in the toolkit) that outlines roles and responsibilities to support delivery of MCoC. As with other guidance documents, it should pass through the maternity service governance processes.	
Pay	No midwife should be financially disadvantaged for working in this way. Each trust needs to review and manage this; the toolkit provides helpful information.	
Estate and equipment	Place for midwives to see women. Equipment with which to provide care. Any problems should be escalated at trust board quarterly review and to the ICS.	
Evaluation	Is there a system for local, regional, and national evaluation and reporting to take place smoothly?	
Review process	Date for initial plan to be reviewed by the trust board. Quarterly review dates set. Dates set for LMS and regional and national review.	

Appendix B: Maternity services' concerns in planning the implementation of and sustaining MCoC, and solutions (summary of roundtable discussion)

Theme	Issue/concern	Solution
Safe and personalised care	MCoC rolled out at expense of safe staffing in the unit	The NHS England and NHS Improvement toolkit https://continuityofcarer-tools.nhs.uk/tools ensures and assures that the right midwives are in the right place at the right time (must be calculated locally)
	(Related to above) MCoC leads to unintended consequences	Current practice and workflows need to be understood – use of toolkit as recommended mitigates this, allowing all midwives to see where women need care and who will care for them
	Rollout of MCoC requires a service to double run (requiring more midwives)	With appropriate use of the toolkit no double running is required – and there will be the appropriate number as core. Always have right people in right place
	MCoC will lead to unsafe and inconsistent staffing	Building blocks must be in place – maternity services must understand traditional staffing needs and then in their plan include a recruitment strategy that works in tandem with MCoC rollout As set out in the guidance, an individualised TNA for each midwife is recommended as each service and midwife is different. This will ensure they are fully prepared to work in this way – for some this will include very little due to their current work patterns; for others this may include supernumerary status in an area they are not familiar with.

Theme	Issue/concern	Solution
		<p>Team building for new teams is also recommended to ensure team dysfunction due to working in a new way (eg falling out or being unable to manage autonomy) does not happen.</p>
		<p>Appropriate skill mix is one of the building blocks that needs to be considered – one Band 5 per MCoC team is reported to work well, with Band 5 midwives reporting that with this arrangement they feel more confident and can complete their preceptorship requirements more easily.</p>
		<p>It is expected that sickness rates will decline – this has been reported by services that have successfully rolled out several teams over a period of time.</p>
	<p>Concern that the ask is for a big bang approach – which won't work</p>	<p>The guidance recommends a phased approach. The guidance and toolkit propose an iterative approach. A few teams are rolled out and processes and procedures are then tested; if working as expected, further teams are rolled out until the default position for the trust is achieved. Each service is unique, and so must conduct a whole-service review and then develop MCoC in an iterative way that applies to that service, so that over a period of time all women can receive MCoC.</p>
	<p>MCoC will create a two-tier system – some women who are not disadvantaged will not receive the benefits of this care</p>	<p>As MCoC is rolled out all women will receive MCoC by default, but this will first be provided to those at greatest need, once first building blocks are in place. This is about prioritisation, not a two-tier system.</p> <p>One trust commented “our MCoC (at 35%) is so effective we need it to be available to our other women as soon as possible”.</p>
<p>Check model is actually required</p>	<p>Women report they want this model of care (MVP survey) – many trusts report better women have a better experience when MCoC has been provided.</p> <p>Women will benefit from the evidence-based improved clinical outcomes, compared to standard care. Therefore, just like implementing other evidence-based improvements, such as aspirin or magnesium sulphate, nationally, MCoC should be tailored to individual need but in keeping with the guidance.</p>	

Theme	Issue/concern	Solution
Engaging staff (midwives and obstetricians)	Loss of resilience due to pandemic/do not want to change	By sharing the vision and supporting the model, leaders have made a difference: explaining the benefits, talking through perceived costs. A good example is where one HoM undertook over 120 1:1 meetings, midwives are now asking to speed up the rollout as this is seen as a solution to the wider problem
	Midwives are tired and burned out	Working in a MCoC model, midwives will have a manageable workload and one that is planned ahead. They will be able to give their best and feel psychologically safe at work and regain lost resilience.
	MCoC leads to poor team working and lack of MDT working	Working as recommended mitigates this with better working between teams and MDT and having a linked obstetrician.
	Midwives are afraid that MCoC will have an adverse effect on work–life balance	Provide insight from those who are doing it, provide opportunities for discussion and engagement wherever possible.
	Obstetricians not actively engaged	Three obstetricians now support the MCoC ERG and have joined trust visits and supported MCoC forums. Further work around this is planned.
	Research suggests that ¹⁴ 35% of midwives do not want to work in a MCoC model	Engagement and consultation with staff has been shown to change perceptions and understanding.
		MCoC myth busting and appropriate implementation, to help staff understand that 24% of midwives had experience of working in a MCoC model in this paper. The ask is not as represented in the 2018 paper: case loading 24/7 on-call availability to women.
	About 40–45% of midwives are required for core, depending on each trust’s configuration; therefore, not all midwives will have to work in teams.	

¹⁴ Taylor, Beck, et al (2019) [Midwives’ perspectives of continuity based working in the UK: a cross-sectional survey](#). *Midwifery* 75: 127-137.

Theme	Issue/concern	Solution
		Ongoing monitoring and evaluation of results demonstrate this is best practice for women and good for midwives too. Individual team surveys have already demonstrated improvements in work-life balance for midwives.
		Invest in 1:1 career conversations to identify the barriers and put in place individualised support for those team members supporting management of caring responsibilities.
	Student engagement	Ensure midwives have good training and education programmes, from when they start as students and then through their career. Tools are being developed to support this.
Resources	Data collection	£52 million investment in digital fund.
	Estate	Work system-wide with ICS to reduce costs and gain substantial public health and society gains.
		Work more collaboratively across the health economy.
Miscellaneous	Not allowed vulnerable women teams	NHS England and NHS Improvement do not dictate models of care but advise based on evidence and what is reported to work. Research demonstrates that socially complex women generally do not want to be placed in 'vulnerable women's teams' as they find it stigmatising and outcomes are not better. There is also risk of midwife burnout which is reduced by spreading the workload. This is why we recommend mixed-risk geographical teams. Furthermore, maternity services are expected to keep some/all of their specialist midwives, depending on trust configuration.
	Interface of MCoC with other patient safety initiatives	If MCoC is implemented correctly, through providing a safety net, this should facilitate other initiatives.
	'Paralysis by analysis'	Take a phased approach to implementing the plan. The toolkit supports this approach.

Appendix C: Evidence for Maternity Continuity of Carer and progress to date

[Better Births](#), the report of the National Maternity Review, set out a vision for safe and personalised maternity services in England: one that puts the needs of the woman, her baby and family at the heart of care; with staff who are supported to deliver high quality – and continuously improving – care.

At the heart of this vision is the ambition that women should be cared for by a midwife she knows before, during and after the birth, ensuring a safe and personalised maternity journey and offering a more positive and personal experience.¹⁶ Women told the National Maternity Review team how important it was for them to know and form a relationship with the professionals caring for them. They preferred to be cared for by one midwife or a small team of midwives throughout their maternity journey. A key recommendation was for most women to receive Midwifery Continuity of Carer (MCoC), to ensure safe care based on a relationship of mutual trust and respect, and in line with the woman's choices and decisions.

The Maternity Transformation Programme was established to deliver the vision, establishing and supporting local maternity systems (LMS) to deliver change locally. In March 2017, LMS were asked to begin planning to meet the ambition that “most women receive continuity of the person caring for them during pregnancy, birth and postnatally by the end of 2020/21”.

Improved outcomes and experience

There is strong evidence that MCoC, and the relationship it allows to develop between caregiver and receiver, leads to better outcomes and experience for the woman and baby (Box 1).¹⁵

¹⁵ Sandall J, Soltani H, Gates S, Shennan A, Devane D (2016) [Midwife-led continuity models versus other models of care for childbearing women](#). *Cochrane Database of Systematic Reviews* 4. Art. No.: CD004667.

Box 1: Outcomes of MCoC compared to other models of care

- 24% less likely to experience preterm birth
- 16% less likely to experience a pregnancy loss overall
- 19% less likely to experience a pregnancy loss before 24 weeks
- 15% less likely to experience regional analgesia
- 16% less likely to have an episiotomy
- 10% less likely to experience instrumental vaginal birth
- 7 times more likely to be attended at birth by a known midwife

Women also reported a higher level of satisfaction with:

- information giving, advice and explanations
- making an informed decision about place of birth and the preparation for labour and birth
- decisions about intrapartum analgesia and feeling in control during labour and birth

Women report that MCoC is important for their health and wellbeing as they consider it increases trust, safety and quality of care.¹⁶ The team working model also makes the workforce more effective.¹⁷

Further, Cochrane reviews of interventions to prevent preterm birth and stillbirth (2018¹⁸ and 2020¹⁹) concluded that MCoC is among the most effective models. MCoC can make a significant contribution to our ambitions to halve stillbirth and neonatal death and to reduce preterm births from 8% to 6% by 2025. If we are guided by the evidence and we listen to women, there is a strong case for MCoC being a vital part of our transformation programme.

Recent MBRRACE reports show that women of Black, Asian, and Mixed ethnicity and those who live in the most deprived areas are at higher risk of dying or losing their baby.

¹⁶ Perriman N, Davis DL, Ferguson S (2018) [What women value in the midwifery continuity of care model: A systematic review with meta-synthesis](#). *Midwifery* 62: 220-229.

¹⁷ West MA, Lyubovnikova J (2013) [Illusions of team working in health care](#). *J Health Organ Manag* 27(1): 134-142.

¹⁸ Medley N, Vogel JP, Care A, Alfirovic Z (2018) [Interventions during pregnancy to prevent preterm birth: an overview of Cochrane systematic reviews](#). *Cochrane Database of Systematic Reviews* 11. Art. No.: CD012505.

¹⁹ Ota E, da Silva Lopes K, Middleton P, Flenady V, Wariki WMV, Rahman MO, Tobe-Gai R, Mori R (2020) [Antenatal interventions for preventing stillbirth, fetal loss and perinatal death: an overview of Cochrane systematic reviews](#). *Cochrane Database of Systematic Reviews* 12. Art. No.: CD009599.

The evidence demonstrates that MCoC improves outcomes for women with social risk factors, and those from specific ethnic groups.²⁰ It may also help avoid unconscious racial bias and circumstances that lead to harm for Black and Asian women.²¹

Progress to date

There has been significant progress in rolling out MCoC: in October 2020 about one in six pregnant women were being placed on a MCoC pathway. Some trusts and systems have continued to make commendable progress despite the COVID-19 pandemic, achieving around 35% MCoC. However, nationally progress has not followed the anticipated trajectory as the pandemic has reduced the capacity of frontline clinicians in trusts and systems to undertake transformation, as well as other barriers.

Infrastructure support

- MCoC has been policy since 2016 and commissioned since 2017.
- National, regional and local support has been provided, both financial and logistical.
- Safety and quality assurance methodology such as CNST safety actions have been used to support this good practice since 2018.
- Nursing and Midwifery Council standards of proficiency encompass MCoC, ensuring our education systems and future midwives are prepared to work in this model.

²⁰ Rayment-Jones H, Murrells T, Sandall J (2015) [An investigation of the relationship between the caseload model of midwifery for socially disadvantaged women and childbirth outcomes using routine data - A retrospective, observational study](#). *Midwifery* 31(4):409-417;
Rayment-Jones H, Harris J, Harden A, Khan Z, Sandall, J (2019) [How do women with social risk factors experience United Kingdom maternity care? A realist synthesis](#). *Birth* 46(3): 461-474;
Rayment-Jones H, Silverio SA, Harris J, Harden A, Sandall J (2020) [Project 20: Midwives' insight into continuity of care models for women with social risk factors: What works, for whom, in what circumstances, and how](#). *Midwifery* 84: 1026–54;
Rayment-Jones H, Dalrymple K, Harris J, Harden A, Parslow E, Georgi T, Sandall J (2021) [Project20: Does continuity of care and community-based antenatal care improve maternal and neonatal birth outcomes for women with social risk factors? A prospective, observational study](#). *PLoS One* 16(5): e0250947.

²¹ Kai J (2007) Professional uncertainty and disempowerment responding to ethnic diversity in health care: a qualitative study, *PLoS Medicine* 4(11): e323;
Homer CS, Leap N, Edwards N, Sandall J (2017) Midwifery continuity of carer in an area of high socio-economic disadvantage in London: A retrospective analysis of Albany Midwifery Practice outcomes using routine data (1997-2009), *Midwifery* 48:1-10;
Bridle L, Bassett S, Silverio SA (2021) “We couldn’t talk to her”: a qualitative exploration of the experiences of UK midwives when navigating women’s care without language. *International Journal of Human Rights in Healthcare*, Vol. ahead-of-print No. ahead-of-print.

- Since January 2019 Health Education England has provided a robust and comprehensive training system for all maternity services, available to all trusts.
- NHS England and NHS Improvement's major survey of midwifery staffing in January 2021 led to the provision of funding for 1,200 extra midwives. Trusts are advised they need to ensure appropriate staffing levels as they roll out their MCoC plan.

Appendix D: Monitoring and evaluation

National monitoring of Midwifery Continuity of Carer (MCoC) will focus on **measuring level of provision** and **evaluating outcomes** for women and staff.

Monitoring level of provision

Provision of MCoC will be measured at trust level in three ways:

	Measure	Method	When?	Frequency
1	Number and capacity of MCoC teams (interim)	Survey of maternity services	2021/22	October 2021 and March 2022
2	Provision of MCoC using individual care records	Maternity Services Data Set v2 (MSDS)	Ongoing	Monthly
3	Asking women whether they received continuity of carer	CQC maternity survey	Ongoing	Annually

These are explained in greater detail below.

1. Measuring the number and capacity of teams (interim measure)

As stated above, providers must set out plans for how they will ensure accurate and complete reporting on provision of MCoC using the MSDS v2 by March 2022.

As an interim measure for 2021/22 while data quality improves, the level of provision will be measured by surveying all maternity providers. The survey will estimate the capacity of each trust to provide MCoC, by looking at the number, size (whole time equivalency) and caseload of teams in a given month. Rate of placement will be estimated by comparing this capacity with the total number of women reaching 29 weeks gestation in the same month. The survey has been conducted twice already for 2020/21 and another two surveys are planned for 2021/22, looking at clinical capacity of teams in October 2021 and March 2022.

2. Measuring provision through the Maternity Services Data Set

Two metrics will be used to assure delivery of MCoC nationally, using monthly data from the MSDS v2:

- A routine, ongoing measure looking at the percentage of women placed on MCoC pathways (placement measure). NHS England and NHS Improvement will use this indicator to measure delivery of the LMS ask for most (>51%) Black and Asian women and women from the most deprived neighbourhoods to be placed on MCoC pathways by March 2022.
- A routine, ongoing measure looking at the percentage of women who have received MCoC (receipt measure). This will operate in shadow form, and not be used for the purposes of assurance, until there is sufficient data to demonstrate viability.

Within these, additional measures will look at the percentage of women being placed on and receiving continuity who are recorded as:

- Black and Asian (to include mixed ethnicity).
- living in the most deprived IMD decile of areas.

Technical specifications for each of these measures – including the data providers need to submit to MSDS v2 – can be found in the **Technical annex: Definitions for Maternity Services Data Set measures**. Any questions or feedback should be sent to england.maternitytransformation@nhs.net.

3. Asking women whether they received Midwifery Continuity of Carer

The [CQC Maternity services survey](#) contains validated questions on women's experience of MCoC and quality of care. We will analyse the responses to this to establish whether women report they have received MCoC and the relation with other experiences of care. We will also analyse this by ethnicity. Services should also analyse this data locally to establish whether local models are meeting women's expectations – ie whether the rate of women reporting seeing the same midwife antenatally, during the birth and postnatally corresponds to level of provision.

Evaluating outcomes

Clinical outcomes and staff outcomes should be used at a micro, meso and macro level to audit services, learning from outcomes as care is provided in this way.

Local services should therefore consider the following outcomes when establishing local evaluations. This will allow data to be compared with that from other trusts, LMS and countries implementing MCoC at scale and change over time.

An evaluation tool is being developed to support the system in collecting the following information, including the experience of women and staff. The CQC Maternity Survey report will provide information about women’s experience and satisfaction

Outcome measure
Stillbirth
Neonatal death
Pre-24-week loss (23 weeks and 6 days)
Gestational age at birth
Birth weight
Unassisted vaginal birth
Instrumental delivery
Elective C/S (cat 4)
Emergency C/S
Total length of stay (hours) for IP episode
Destination post birth? Home/PNW
Epidural
Episiotomy
3 and 4-degree tear
Booking by 10/40
Breastfeeding at birth
Breastfeeding at discharge to health visitor
Skin-to-skin for 1 hour
Apgar <7
Smoking at booking
Smoking at delivery

Outcome measure
Sickness midwives
Incidents
Complaints
Attrition rate/vacancy rate (all and specific)

How are Black and Asian women and women from the most deprived areas defined?

For the purposes of targeting MCoC, Black and Asian women are women who are identified in the following categories in the Maternity Information System, [as set out in the NHS Data Model and Dictionary](#):

Mixed	
D	White and Black Caribbean
E	White and Black African
F	White and Asian
Asian or Asian British	
H	Indian
J	Pakistani
K	Bangladeshi
L	Any other Asian background
Black or Black British	
M	Caribbean
N	African
P	Any other Black background

Note: 'Asian' does not include 'Chinese' or other east Asian women. For the full list of ethnicity categorisations beyond those in scope above, please see the [NHS Data Model and Dictionary](#).

The most deprived 10% of areas are those defined by the [2019 Index of Multiple Deprivation \(IMD\)](#). Maternity providers should identify women from these areas using postcode recorded at booking.

How much continuity should we aim to provide each woman with? Why does the measure for receipt only require MCoC for 70% of antenatal and postnatal appointments?

Ideally a woman is cared for by her lead midwife from booking onwards to maximise the dosage of the therapeutic relationship. This is best achieved by organising midwives into geographical or place-based teams.

In any case, models should be developed so that every woman can expect to receive most of their care from their **named lead midwife**, and that out-of-hours and unscheduled care that the lead midwife cannot attend is covered by arrangement between the named midwife and team.

Ideally a woman will be seen by her lead and team midwives at all appointments. There may be occasions a woman must be seen for clinical reasons by a midwife outside her team, such as attendance at a day assessment centre or a specialist appointment. MSDS v2 is at present unable to exclude such care contacts when considering whether a woman has received MCoC.

Services can be designed in a way that mitigates the need to be seen by a clinician outside the team – such as with all risk teams or lead midwives shadowing medical and obstetric appointments – but for practical purposes, national measurement of whether or not a woman has received MCoC allows for a limited number of care contacts to be delivered by midwives outside the team.

How much intrapartum care must a lead or team midwife provide for it to count in the ‘receipt’ measure for MCoC?

Ideally, a woman will receive all her intrapartum care from a midwife she knows, such as her lead midwife or a team midwife. However, where multiple midwives are recorded as having provided intrapartum care, eg in an extended labour, measurement will seek to identify whether one of the midwives present was the named lead or a team midwife.

Services have a responsibility to provide clear and accurate records of women’s care. The named or team midwife should have been sufficiently involved in intrapartum care to warrant being recorded as having provided care in the woman’s record.

Why do the MSDS measures focus on 29 weeks gestation?

LMS should develop models of care that place women on MCoC pathways as early as possible – ie at antenatal booking – to give every woman maximum opportunity to build a trusting relationship with her midwife and realise the benefits of this. The ‘all risk’ pathway, whereby a woman is assigned a midwife at booking who then stays with the woman throughout the pathway is a model for this. A number of systems have developed local solutions focusing on identified higher risk pregnancies, whereby women are placed on MCoC pathways after the booking appointment.

National measures will therefore look at placements up to the 28-week antenatal appointment, as the first universal appointment following routine antenatal scans. The national Continuity of Carer Reference Group has agreed that placements on pathways after the 28-week antenatal appointment will not be considered MCoC for the purposes of national measurement. As there is a level of practical flexibility around when this appointment takes place, records will be interrogated for determining placement at 29 weeks (28 + 7 days).

Appendix E: Instructions for NHS England and NHS Improvement toolkit

Showing 7 of 7 items

The screenshot displays a grid of seven resource cards. The first row contains 'Sickness Absence rates' (dataset), 'Continuity of Carer Workforce Modelling Tool' (calculator), and 'Birth Rate Plus' (resource). The second row contains 'Complaints' (dataset), 'Epidural Rate: Cost Calculator' (calculator), and 'English indices of deprivation - GOV.UK (www.gov.uk)' (resource). The third row contains 'digital maternity programme' (dataset) and 'Reducing Pre-Term Birth: cost' (calculator). A callout box on the right points to the 'Use Calculator' button of the 'Continuity of Carer Workforce Modelling Tool' with the text 'Click here to enter main tools area'.

Sickness Absence rates
Data published by NHS Digital
Provisional Stats Monthly
Official Stats published Quarterly
[Visit Resource](#)
dataset

Continuity of Carer Workforce Modelling Tool
Use this tool to help you plan your midwifery workforce to deliver Continuity of Carer. This is designed to help you plan midwifery deployment /redeployment as you move to using Continuity of Carer at scale
[Use Calculator](#)
calculator

Birth Rate Plus
Birthrate Plus®. Is a method the needs of women for mid throughout pregnancy, labor postnatal period in both hos community settings
[Visit Resource](#)

Complaints
This quarterly collection is a count of written complaints made by (or on behalf of) patients. Data are collected via the KO41a and are for complaints about NHS Hospital and Community Health Services (HCHS) in England
[Visit Resource](#)
dataset

Epidural Rate: Cost Calculator
Epidural Rate vs. Continuity of Carer Local Cost Calculator
[Use Calculator](#)
calculator

English indices of deprivation - GOV.UK (www.gov.uk)
 Statistics on re deprivation in England.
Published 26 September 201
From: Ministry of Housing, C Local Government
[Visit Resource](#)

digital maternity programme
Information about the NHS Digital digital

Reducing Pre-Term Birth: cost
[Visit Resource](#)

Click here to enter main tools area

A new page opens:

Continuity of Carer Workforce Modelling Tool

Use this tool to help you plan your midwifery workforce to deliver Continuity of Carer. This is designed to help you plan midwifery deployment / redeployment as you move to using Continuity of Carer at scale

The screenshot shows the user interface of the Continuity of Carer Workforce Modelling Tool. It is divided into several sections:

- Welcome to the Midwifery Workforce planning tool.** A light blue box with a "Try Calculator" button. A callout box points to this button with the text: "Click here to enter number of women and teams calculating area".
- Information / About** A section with a pink header box that says: "If this is your first time using this tool please spend a few moments to read this guidance first". Below this, it explains that Continuity of Carer (C of C) means that:
 - A woman's maternity care is provided by midwives organised into teams of eight or fewer (headcount). Each midwife will aim to provide all antenatal, intrapartum and postnatal care for up to 36 women per year, but at agreed times is supported by the team, such as for unsocial hours or out of hours care.
 - All staff in the Maternity Service contribute to achieving Continuity of Carer, including CoC team midwives, core midwives and others in the MDT working in the acute setting, such as obstetricians and sonographers.
 - Based on the best evidence available, Continuity of Carer supports the delivery of safer and more personalised care. The 2016 Cochrane review concluded that continuity of carer models save babies' lives, reduce interventions and improve clinical outcomes.
- Hints and tips for using the tool:** A section with a "Read more" button.
- Resources & Links** A section listing various resources with "Download File" or "Follow Link" buttons. Two callout boxes point to these buttons:
 - "Click here to access excel spread sheet to" points to the "Download File" button for "NHSEI excel tool kit workbook for C of C midwifery staffing plans".
 - "Click here for other resources as labelled" points to the "Download File" buttons for "Uplift pay calculations for midwives working a flexible model", "SOP with obstetrician Standard Operating Policy v1", and "Tool kit work book midwifery staffing workbook".

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This publication can be made available in a number of other formats on request.

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