Sheffield Teaching Hospitals
NHS Foundation Trust

Executive Summary

Report to the Board of Directors

Being Held on 29 March 2022

Subject	Update on Continuity of Carer in Maternity Services Action Plan – March 2022
Supporting TEG Member	Chris Morley, Chief Nurse
Authors	Marie Reid, Midwifery Director Fiona Kew, Clinical Director Sue Gregory, Operations Director
Status[1]	A

PURPOSE OF THE REPORT

Whilst the plans are currently paused for Midwifery Continuity of Carer (MCoC), it is important to understand the steps required to reintroduce MCoC and the purpose of this report is to inform the Board of Directors of the actions required to reach full implementation.

KEY POINTS

The report;

- Highlights that Local Maternity and Neonatal Systems (LMNS) needs to agree a local plan that includes putting in place the 'building blocks' for sustainable models of Continuity of Carer by March 2022. It is expected that there is Board of Director approval of individual trust plans to support the LMNS plan.
- Provides an overview of plans for the re-launch of the Maternity Continuity of Carer programme following the pausing of the service in July 2021 due to staffing pressures.
- This implementation plan describes the steps required to meet the national ambition of a default position of MCoC for all maternity care.
- Provides a road map for the roll out of the delivery of Continuity of Carer which prioritises women from ethnic minority backgrounds and women from the most deprived areas as per the national guidance.
- This plan is supported by the on-going recruitment and retention work for registered midwives, progression through the plan will require an ongoing assessment of the midwifery workforce with the provision of a stable Labour Ward and inpatient service a prerequisite before moving the plan forward. For that reason, dates are not provided for the actual roll out but an indication is given of the time required to rollout, once the sustainable provision of safe Labour Ward and ward services is secured.
- This way of working requires a whole service change and involves the whole multidisciplinary network including obstetricians to support this change.
- Regular updates on progress with the implementation of the MCoC action plan will be provided to the Board of Directors.

IMPLICATIONS[2]

		TICK AS APPROPRIATE
1	Deliver the Best Clinical Outcomes	✓
2	Provide Patient Centred Services	✓
3	Employ Caring and Cared for Staff	✓
4	Spend Public Money Wisely	✓

5	Deliver Excellent Research, Education & Innovation	
6	Create a Sustainable Organisation	

RECOMMENDATIONS

The Board of Directors are asked to approve the MCoC action plan and note that regular updates on progress with both the action plan and the implementation of MCOC will be provided to the Board of Directors.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
TEG	09/02/22	Y
Board of Directors	29/03/22	

1 Status: A = Approval
A* = Approval & Requiring Board Approval
D = Debate
N = Note

2 Against the six aims of the STHFT Corporate Strategy 'Making a Difference – The next Chapter 2022-27'

Background:

Midwifery Continuity of Carer 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 Continuity of Carer to be the default model of care for maternity services, and available to all pregnant women in England where **safe staffing** allows, this should be achieved by March 2023 – with rollout prioritised to those most likely to experience poorer outcomes first.

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

All women should be offered the opportunity to receive the benefits of Continuity of Carer across antenatal, intrapartum, and postnatal care. However, not all women will be able to receive continuity of carer, 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.

Providing Continuity of Carer by default therefore means:

1. Offering all women Midwifery Continuity of Carer as early as possible antenatally; and
2. Putting in place clinical capacity to provide Continuity of Carer to all those receiving antenatal, intrapartum and postnatal care at the provider.

Maternity services and Local Maternity and Neonatal Service (LMNS) have been asked to prepare a plan to reach a position where midwifery Continuity of Carer (MCoC) is the default position model of care available to all women.

Requirement:

As a first step, it is expected that Local Maternity and Neonatal Systems (LMNS) agree a local plan that includes putting in place the 'building blocks' for sustainable models of Continuity of Carer by March 2022. Continuity of Carer will be the default model of care offered to all women. This plan is to include:

- The number of women that can be expected to receive Continuity of Carer, when offered as the default model of care.
- When this will be achieved, with a redeployment plan into MCoC teams to meet this level of provision, that is phased alongside the fulfilment of safe staffing levels.

- How Continuity of Carer teams are established in compliance with national principles and standards, to ensure high levels of relational continuity.
- How rollout will be prioritised to those most likely to experience poor outcomes, including the development of enhanced models of Continuity of Carer.
- How care will be monitored locally, and providers ensure accurate and complete reporting on provision of Continuity of Carer using the Maternity Services Data Set.
- Building blocks that demonstrate readiness for implementation and sustainability assessment – ensuring all the key building blocks are in place.

Current position:

Sheffield Teaching Hospitals (STH) current position is that MCoC is paused. This occurred in July 2021 due to acute staffing issues. Prior to pausing MCoC, STH had three teams of eight (headcount) midwives booking approximately 15% of pregnant women onto the MCoC pathway. This model of care had been in place for six months prior to pausing.

Booking Statistics - 2020-2021 financial year

Ante-natal Clinic (ANC) bookings	6511
Number of women birthed who also received their Ante-natal (AN) / Post-natal (PN) from the Trust	6170
A/N, P/N care only	531 (approx.)
Intrapartum Care only	695
MCoC eligible	5750 (approx.)
Ethnic Minority	1299 (20%)
Lowest decile of deprivation	2071 (32%)
Ethnic minority and lowest decile of deprivation	571 (8.7%)

Sheffield is a large city that borders four other NHS trusts and five maternity hospitals. Due to the woman's postcode location, the Jessop Wing being located in the centre of Sheffield and women's right to choose, they may opt to birth at a different location but have A/N and P/N care with Sheffield Community Midwives.

Currently approximately 695 women birth at the Jessop Wing who wouldn't be eligible for MCoC because they live out of area (OOA) or are referred to Jessop Wing for birth due to their individualised risk assessment and care plan. These reasons include accessing Maternal Medicine specialists, Fetal Medicine service or the Tertiary level Neonatal Unit.

The number of women eligible for MCoC is approx. 5750 who live within Sheffield and can be offered antenatal, intrapartum and postnatal MCoC. These numbers will flex up and down depending on the birth rate so this will need on-going monitoring.

MCoC guidance advocates prioritising women of Black, Asian and mixed ethnicity and also women who live in the lowest decile of deprivation for the first waves of the roll out. These women and babies are highlighted to have the poorest health outcomes. Women from ethnic minority backgrounds are scattered throughout the city however there are also communities located within specific postcodes. Prior to pausing MCoC, the previous MCoC teams were concentrated in these areas, (S1, S2, S3, S4, S5, S7, S9). These three teams were reporting 18% booked onto MCoC pathway and at 29 weeks gestation, 52.7% were from minority ethnic and/or lowest decile of deprivation postcode. This approach will be replicated at re-launch as it was successfully targeting women and babies likely to experience the poorest outcomes.

The Plan:

Sheffield Teaching Hospitals NHS Foundation Trust aims to provide MCoC to 5750 out of 6500 (approximate) women. The roll out will consist of stepped/staged approach in six waves over a two-year period. This will need constant evaluation via Plan, Do, Study, Act (PDSA) cycles ensuring that overall safety is monitored. It will be reviewed considering both staff engagement and recruitment. This ultimately will build to twenty mixed risk geography based teams. Each team will consist of eight headcount midwives (7WTE) to ensure a 24hr service is covered. Each woman will be allocated a named midwife who will be responsible for planning and providing clinical care across the antenatal, intrapartum and postnatal periods. If the named midwife is unavailable, a team midwife will be allocated to perform the care. Midwives will be required to complete 3-4 bookings per month to have a caseload of 1:36 per annum.

MCoC teams will be prioritised for roll out in the highest areas of Black, Asian and Mixed Ethnicity populations and the postcodes of the lowest deciles. As highlighted above, this approach had previously been adapted and was successful at targeting women and babies likely to experience the poorest outcomes.

Whilst achieving optimal staffing, an action plan which includes all the recommended evidence is being submitted but with a delay in achieving the national target of a default model of care for

women by March 2023. STH action plan looks at commencing MCoC roll out once we have achieved a full establishment of midwives to provide a 90/10 traditional workforce model. Once achieved, we will move forward with our plans to have 50% of pregnant women booked onto a MCoC pathway with 10 teams (70WTE – 80 headcount midwives). These teams will be targeting the geographical areas of deprivation and ethnic minority due to the poor outcomes. The enhanced continuity of carer model targets these areas to support health equality and improve outcomes to the most vulnerable.

Safe staffing:

Sheffield Teaching Hospitals NHS Foundation Trust have completed a review regarding the required current funded establishment to support a roll out to a full MCoC model using a combination of Birth rate plus which considered activity and acuity and the NHS workforce planning toolkit which maps out a plan for the phased roll out of MCoC. The NHS workforce continuity tool (9 WTE higher than BR+) calculates the staffing required within the traditional teams and hospital services, whilst rolling out MCoC and demonstrates a requirement for a staffing establishment of 283.3WTE.

The service is currently recruiting 'Integrated Midwifery posts at Band 5 and Band 6 with an expectation that these midwives will move into MCoC teams once their orientation period has been completed and the next MCoC phase team is being established and implemented. This is stated within job descriptions and adverts to manage expectations from recruitment.

International midwifery recruitment is in progress with the intention of recruiting fifteen midwives by the spring-summer 2022 to STH. This is a new method of midwifery recruitment within STH so structures to support the integration into midwifery and preceptorship in the UK will need to be in place prior to being able to release these midwives into MCoC teams.

A new full Birth Rate plus assessment is being commissioned to ensure that the workforce calculations are in line with the current requirements of maternity services using a validated methodology.

Re-starting Continuity of Carer roll-out will be considered appropriate once:

1. Staffing is equivalent to 234WTE midwives with the absence rates being within the allocated headroom. This will leave a reliance on temporary staffing of up to 10WTE which is achievable and realistic.
2. The staffing model is clearly described and there is identified funding to support this model.

Planning spreadsheet demonstrating who will receive care where and ratios to evidence safety

The planned roll out of the teams is described in the action plan at appendix A and an example of a workforce plan showing how the staffing in different areas would vary is in Appendix B. The teams are being rolled out as recommended by the NHS England MCoC guidance, (NHS England 2021).

After attending regional and local networking sessions, it has been concluded that a model utilising specialist MCoC teams focusing only on highly vulnerable women or women with specific maternal medicine needs is logistically difficult and therefore the plan is to use mixed caseload geographically based MCoC teams, similar to the previous model operating in Sheffield.

There will be an evaluation undertaken at each phase of the roll out to ensure process and systems work efficiently to provide safe effective outcomes and excellent patient experience. A series of metrics will be kept under review to monitor the impact of MCoC including attendance rates at the Labour Ward Assessment Unit, readmissions to the postnatal ward and clinical outcomes for example, gestation and mode of birth.

Communication and engagement plan

Staff engagement regarding the move to MCoC programme of care has been on-going since the first team in Sheffield was created. This engagement has occurred via face-to-face team meetings, virtual open team meetings, and individual meetings. There is staff side representation as part of the on-going engagement work, and they also have representation at the LMNS monthly assurance meetings. Further engagement will continue involving the Quality and Experience Lead Midwife.

When the teams were paused, and the midwives were moved back to traditional community teams or in hospital care they were informed that this was a temporary change and there would be an expectation of moving back to MCoC teams upon re-launch. Since then, other midwives have come forward expressing an interest in moving to MCoC teams.

The Maternity Voices Partnership (MVP) is fully supportive of moving to a MCoC programme although recognises that optimal staffing needs to be ensured first.

Skill mix planning

From the previous implementation of MCoC in Sheffield, the following lessons have been learnt.

Each team should compromise 3-4 traditional community midwives, 3-4 in hospital midwives and a Band 5 preceptor midwife. This is meeting the national guidance of eight headcount midwives (7WTE). This team will be overseen by a Band 7 MCoC team leader who will have responsibility of 2-3 teams, although this will continually be evaluated.

The team leader will be responsible to ensure adequate time and support for the Band 5 preceptor midwife. This will mean monthly support meetings, visibility during clinical days and protected time on Labour Ward to consolidate midwifery clinical skills. Their caseload numbers and complexity should also reflect this support. MCoC teams will need the flexibility to flex numbers up and down depending on factors such as experience of team members, short term or long-term absence and vacancies.

Maternity Support Workers (MSW) also provide an additional support network and are key to the success of teams. This group of staff hasn't previously been utilised in MCoC and their role is pivotal to providing wrap around care freeing up midwives to be available for intrapartum care. MSWs are trained to provide health education, basic clinical skills, infant feeding support and plans. These staff currently work exclusively in hospital so their introduction into MCoC teams will need to be carefully implemented.

Training

This is a key building block, and a training needs analysis has been developed and will be utilised as midwives move into MCoC teams.

Each Midwife will have a four-week supernumerary period to orientate to the MCoC way of working. Midwives will be being redeployed from different areas of midwifery work so each midwife will require an individualised training needs assessment to target support to their individual need. After the four weeks, the individual midwife, team leader, education team and matron will need to assess whether the midwife is competent to be allocated a caseload and create a bespoke package to support any additional training needs identified.

Linked Obstetrician

Having a linked obstetrician for each MCoC team provides the opportunity to forge and improve multidisciplinary team discussions. It also provides obstetric input where required. Agreement has been made with the Clinical Obstetric Lead that each team will have a specific consultant linked to their team. This will occur on a rotation basis as the next MCoC team is implemented.

Further clinical oversight will be provided for women requiring obstetric led antenatal care by the woman being booked into the named team consultant clinic. If women require a specialist maternal or fetal medicine consultant, then the specialist team will be the named consultant and provide the clinical care plan, but the team consultant will also support the MCoC midwives with any additional needs.

Standard Operating Policy (SOP)

A SOP describing roles and responsibilities has been developed. This is awaiting review and approval via the Governance Guideline group however will need a further review three months

after the first team is rolled out to confirm that it is effective. The current SOP is based on the previous learning from the MCoC teams.

Midwifery Pay

Nationally, it has been specified that no midwife should be financially disadvantaged for working in this way. Further work will be undertaken with Human Resources to determine how this national aspiration can be achieved at STH.

Estate and equipment

The first four teams will be based in family centre hubs with some overlap with GP practices depending on size and locality of caseload. This is already embedded into routine community midwifery. As more teams roll out, there will need to be negotiations to secure space within family centres. Additional locations will need to be secured to keep services accessible within the community.

The initial procurement of additional equipment required for the role has been undertaken. Further equipment will be required as the number of teams is expanded.

Review Process

1. Monthly review at maternity governance meeting.
2. Quarterly review at board for assurance and escalation.
3. Submission to LMNS for assurance.

References

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- 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 2016, Issue 4. Art. No.: CD004667

Appendices

A) Roll out Action Plan
B) Example Workforce Plan

A) Roll out action plan	Continuity of Carer Action Plan to work towards Continuity of Carer being the default model of care offered to all women by March 2023 prioritising those most likely to experience poor outcomes which include Minority Ethnic and the most vulnerable populations

Reason for action plan (e.g. risk assessment, incident, audit):	To implement Midwifery Continuity of Carer (MCoC) in line with national guidance
Reference number (e.g. Datix ref, AIMS ref):	-
Action plan approved by (job title or group/committee):	
Date action plan approved:	
Individual responsible for monitoring the action plan (name and job title):	Midwifery Director / Head of Midwifery / Continuity /Transformation lead

The introduction of Continuity of Carer can only commence when the hospital service has robust, sustainable staffing, in recognition of this dates have not been allocated to actions that cannot commence until that is achieved. Instead, actions have either been denoted as go live, starting at the point of agreed stable hospital staffing or the interval after go live when the action would commence. These will be converted to actual dates at the point of go live.

Problem or concern		Improvement aim	Actions agreed		Lead for each action (name and job title)	Resource needed	Target completion date	Date completed	Evidence that the action has been completed
1	Ensuring that there is funding available to support the workforce required to implement Continuity of Carer.	Establish funding required to support workforce establishment required to implement a Continuity model. Recruit to 90/10 baseline	1.1	To produce a business case outlining the funding required to meet the establishment required to support Continuity of Carer.	Midwifery Director/ Operations Team/Finance Director	Finance	March 2022		
			1.2	Present the business case to the Trust Business Planning Team	Operations Director				

		establishment of 261.80 wte. (234 wte clinical midwives)	1.3	Continue with rolling midwifery recruitment programme	Midwifery Director		Go Live Continuity date		
2	Reduced staffing levels	Ensuring the safety of clinical care whilst midwives are released to create new continuity teams and undertake training.	2.1	Commission new full Birthrate Plus assessment	Head of Midwifery	Funding allocation	July 2022		Birthrate plus report
			2.2	Recruitment of midwives (equivalent to 234WTE midwives with the absence rates being within the allocated headroom required to recommence CoC).	Midwifery Director	Recruitment team support	Ongoing		Increased WTE workforce
			2.3 2.3 b	Recruitment of clinical support workers Include the increase of support staff needed within the BPT paper	Head of Midwifery	Recruitment team support	Once agreed via BPT		Increased WTE workforce
			2.4	Train Maternity support workers to work alongside continuity of carer teams	Pre and Post registration Lead Midwife	Sheffield College resource	March 2024		
3	Midwives need support and training to be confident working in community and Labour Ward.	Appropriately skilled workforce who have been supported to refresh skills. Team working and improved relations between	3.1	Training sessions for community midwives to work on labour ward to take place and be promptly followed by a supported shift and on-going shifts.	Education Lead Midwife		September 2022		

		community and hospital teams	3.2	Community induction plan for rotational midwives joining continuity.	Education Lead Midwife		1/2 months following Go Live date		
			3.3	Develop individualised TNAs for each continuity midwife.	Education Lead Midwife		1/2 months following Go Live date		
			3.4	Allocate Band 7 team leaders from both community and labour ward to each team to provide guidance and support.	Community Matron Labour Ward Matron		1/2 months following Go Live date		
			3.5	Provide each team with an allocated PMA to raise staff awareness and visibility of PMA support.	PMA Lead		1/2 months following Go Live date		
4	Inequalities in health outcomes for women from Black, Asian and Ethnic minorities and the 10% most deprived communities	Women from Black, Asian, and Ethnic minorities and the 10% most deprived communities to be prioritised for placement on a pathway for Continuity of Carer at community booking.	4.1	Prioritise allocation of CoC teams in the areas where these communities are most prevalent (Postcodes S1, S3, S9 and S5)	Community Matron		1/2 months following Go Live date		
			4.2	Explore options for providing midwives with training regarding equity and challenging unconscious bias.	Education Lead Midwife		1/2 months following Go Live date		
5	Women to have meaningful contact with all the team of CoC midwives	Women should be cared for by a midwife she knows before, during and after the birth,	5.1	Create video of CoC midwives to enable recognition of the whole team.	Community Matron		6 months following Go Live date		

		ensuring a safe and personalised maternity journey and offering a more positive and personal experience.	5.2	Allocate regular Meet the Midwife sessions for ANC education and enable virtual videos/teams training.	Community Matron		6 months following Go Live date		
			5.3	Gain formal and informal feedback from the women about their care provision	Community Matron Quality and Experience Lead Midwife		Informal data from Go Live and formal data 6 months from Go Live date.		
6	National research suggests that 35% of midwives are reluctant to work in a MCoC model.	Engagement and consultation with staff has been shown to change perceptions and understanding.	6.1	Hold monthly staff engagement sessions including questionnaires, talks, presentations	Community Matron/Head of Midwifery/Labour Ward Matron		July 2022		
7	Data collection – MSDS data will be used in March 2022 to formally assess whether most women of Black, Asian and Minority 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.	Ensure systems and processes in place to record and submit the requisite data items to MSDS on a monthly basis.	7.1	Analyse data to identify gaps, inconsistencies or inaccuracies in data submissions.	Systems manager		6 months following Go Live date		
			7.2	Develop systems and work with MCoC teams as appropriate to embed changes in everyday practice, so that the provision of MCoC can be evidenced through routine care records.	Systems manager /Community Matron / Head of Midwifery / Labour Ward Matron)				

8	Obstetricians to be engaged with continuity of carer. Service development being led by midwifery staff.	Each team of midwives to have a linked obstetrician who is available to the midwifery team by an agreed process and who attends team meetings on a regular basis.	8.1	Conversations with consultant lead regarding obstetricians being embedded within the service change and available to meet with teams.	Labour Ward Matron / Community Matron		Go live date		

Appendix B – Example Continuity Workforce Plan

Uplift= 24.3%	Birth rate plus	Actual		C of C	All women		deliveries:			
Percentage and local calc	Midwife to woman ratio:1:	funded midwifery: 274	attrition rate:	15%	1052					
168/37.5=4.48+24.3 %=5.5	total b3-b8=288.25 specialist/manager=29 clinical midwives= 232.25 PN MSW:27	actual staffing =223	deployment (=BR+)	C of C pathway	All care given: 5569 AN/PN only:531 attrition:1052	% of women delivered	in area: 5569 OOA:695		time scale	recruitment plan
care location	Total b5-8 midwives:261.25		15 on IP shift	0.00%	7015	0.00%	6264			31
C of C team		0	0	0					current	
LW	82.5	73	8 (9)					1 to 76		
LWAU			2 (4)							
AOCU			3 (2)							
ADU	0	4	2 Mon-Fri							
FMU	0	3.6	1 Mon - Fri							
ANC	19.5	7.9								
AN ward	19.25		(BR+ 12 in total)							
48 bed 2 PN ward	44	63	actual 11.45							
ELCS	3		1.5 Mon- Fri							
community	64	45	1 to 109 (BR+)		msw					
specialists		10								
managers 7	29	8.8								
managers 8a & up		8								
TOTAL	261.25	223.3	v=46.46							254.3

Wave 1	7WTE	2 teams	16 ip care	8.38%		8.05%				6
C of C team		14		588		504				
LW		77	14				5760	1 to 74		
LWAU										
AOCU										
ADU		4	2 Mon - Fri							
FMU		3.6	2 Mon - Fri							
ANC		7.9								
AN ward		58	4 3 2							
PN ward			6 6 4							
ELCS		3	1.5 Mon -Fri							
community		58	1 to 109		6427					
specialists										
managers 7		29								
managers 8a & up										
TOTAL		254.5								260.5

Wave 2		4 teams	17 ip	17%		16.09%				1
C of C team		28		1176		1008				
LW		75	13				5256	1 to 70		
LWAU										
AOCU										
ADU		4	2 Mon - Fri							
FMU		3.6	2 Mon - Fri							
ANC		7.9								
AN ward		58	4 3 2							
PN ward			6 6 4							
ELCS		2	1.5 Mon -Fri							
community		53	1 to 109		5839					
specialists				75						
managers 7										
managers 8a & up		29								
TOTAL		**260.5**								**261.5**

Wave 3		8 teams	18.9 av	33.53%		32.18%				0
C of C team		56		2352		2016				
LW		60	10.9				4248	1 to 70		
LWAU										
AOCU										
ADU		2.4	2 Mon - Fri							
FMU		2.4	2 Mon - Fri							
ANC		8.2								
AN ward		58	4 3 2							
PN ward			6 6 4							
ELCS		2.9	1.5 Mon -Fri							
community		42.7	1 to 109		4663					
specialists										
managers 7		29								
managers 8a & up										
TOTAL		**261.6**								**261.6**

Wave 4		12 teams		50.29%		48.28%				0
C of C team		84		3528		3024				
LW		37	6.7				3240	1 to 67		
LWAU		5.5								
AOCU		5.5								
ADU		2.4	2 Mon - Fri							
FMU		2.4	2 Mon - Fri							
ANC		8.2								
AN ward		16.5	3							
PN ward		44	8							
ELCS		1.5	1 x 12hr							
community		31	1 to 109		3487					
specialists										
managers 7		29								
managers 8a & up										
TOTAL		267								267

wave 5		16 teams		67.06%		64.37%				0
C of C team		112		4704		4032				
LW		22	4 4 4				2232	1 to 45		
LWAU		16.5	3 3 3							
AOCU		11	2 2 2							
ADU		2.4	2 Mon - Fri							
FMU		2.4	2 Mon - Fri							
ANC		8								
AN ward		13.9	3 3 2							
PN ward		27.8	6 6 4							
ELCS		1	1 x 6hr							
community		21			2311					
specialists										
managers 7		29								
managers 8a & up										
TOTAL		267								267

wave 6		**22**		**92.20%**		**88.51%**				0
C of C team		154		6468		5544				
LW		16.5	3 3 3				720			
LWAU		5.4	1							
AOCU		5.4	1							
ADU		2.4	2 Mon - Fri							
FMU		2.4	2 Mon - Fri							
ANC		5								
AN ward		13.9	4 3 2							
PN ward		27.8	6 6 4							
ELCS		1	1 x 6hr							
community		4	1 to 109		547					
specialists										
managers 7		29								
managers 8a & up										
TOTAL		**266.8**								**266.8**