

BETTER BIRTHS

Improving outcomes of maternity services in England

A Five Year Forward View for maternity care



A LETTER TO THE WOMEN OF ENGLAND AND THEIR FAMILIES

The birth of a child should be a wonderful, life-changing time for a mother and her whole family. It is a time of new beginnings, of fresh hopes and new dreams, of change and opportunity. It is a time when the experiences we have can shape our lives and those of our babies and families forever. These moments are so precious, and so important. It is the privilege of the NHS and healthcare professionals to care for women, babies and their families at these formative times.

For me, it has been an honour to lead this national review of maternity services. Over the last year I have had the opportunity to meet with many women and their families. You took the time to share with me your experiences and reflections on the care you and your loved ones have received – both good and bad. You did that willingly and honestly. I have heard many inspiring stories and wonderful ideas, but also heart-breaking experiences and moments when the care provided has fallen short. The insight you have given to me into what matters to you, what could be better and where things are already great, has been tremendously helpful and at times deeply moving. For that I thank you.

I am particularly grateful to mothers and fathers who shared accounts of the tragedies they experienced – I am in no doubt that our task is to make all care as safe as the best.

I have also met many of the healthcare professionals working on the front line providing maternity care. Their passion and dedication has been striking. Their opinions, ideas and experience have been invaluable.

I was privileged to witness the birth of twins by caesarean section – the bravery of the mother, the calm skill and professionalism of the team and the first moments of life of two beautiful babies will stay with me. I heard women and their partners telling me of life affirming births in their own homes - the place where they felt most confident, in charge - and how their midwife became a close professional friend. Similarly, births in midwifery units with skilled midwives providing care which was compassionate and kind. I met with fathers, who gave me an insight into how they feel and what matters to them - so often forgotten but a vital part of the picture. I saw communities enthusiastically supporting their local services and healthcare professionals, in rural and urban areas, passionate in their pursuit of high quality services that meet their needs.

20 years ago I produced a report as a government minister, *Changing Childbirth*, which sought to describe a modern maternity service, as we moved into a new century. Great strides have been made in transforming maternity services in those last two decades. Despite the increasing numbers and complexity of births, the quality and outcomes of maternity services have improved significantly over the last decade. The stillbirth and neonatal mortality rate in England has fallen by over 20% in the last ten years.

I have also seen that change has not always happened or has not achieved what was initially hoped for. And I have seen that new challenges have arisen.

More women have children at an older age. More women have complex health needs that may affect their pregnancy, their well-being and that of their baby.

We heard that many women are not being offered real choice in the services they can access, and are too often being told what to do, rather than being given information to make their own decisions. Hospital services are at capacity with some running at 100% occupancy too much of the time. Yet some community-based services are struggling to survive, while some women are unable to choose the service they want because it sits on the wrong side of an administrative boundary.

We found almost total unanimity from mothers that they want their midwife to be with them from the start, through pregnancy, birth and then after birth. Time and again mothers said that they hardly ever saw the same professional twice, they found themselves repeating the same story because their notes had not been read. That is unacceptable, inefficient and must change.

There is too much variation in quality across maternity services. Health professionals are working under pressure and too often do not work well together, especially across the professional divides. They spend far too much time collecting data and filling in forms, yet the data we have is often of poor quality, or paper-based when it should be electronic, and in some aspects of care, there is no data at all.

Things go wrong too often. We spend £560 million each year on compensating families for negligence during maternity care. And when things do go wrong, the fear of litigation can prevent staff from being open about their mistakes and learning from them. No family should wait for years as the rights and wrongs of their tragedy are fought over by lawyers.

All these factors contribute to the UK having poorer outcomes on some measures than our peers in Europe, which is unacceptable. We can and must do better. This report seeks to describe how we might do so.

There has been much debate as this review has unfolded about two fundamental principles - the importance of women being able to make choices about their care, and the safety of the mother and baby being paramount. There has been a good deal of discussion about whether these two components are compatible. Of course it is true that birth is not without risk, but every woman wants – and has a right to – the safest possible birth for herself and her baby. Every woman should also be cared for by services which fit around and respect her, and her baby's needs and circumstances. Safe care is personalised care.

Women have made it abundantly clear to us that they want to be in control of their care, in partnership with their healthcare professionals. With this control comes a responsibility which mothers must accept and professionals must support - that personal health and fitness are integral to safe and fulfilling childbearing.

What this review has not sought to do is to inspect and pass judgement on individual services, nor have we seen our role as to monitor the delivery of all recommendations from the investigation into the serious failings in maternity care at Morecambe Bay. Rather, we have sought to learn from these, and to build on them in setting out a vision for a modern maternity service that delivers safer, more personalised care for all women and every baby, improves outcomes and reduces inequalities.

It is an ambitious vision and no one action alone will deliver the change we all need to see. Among those providing maternity care, it will require greater teamwork, more and better dialogue, and a willingness to break down professional boundaries; all in the best interests of women, babies and their families. It will require an openness and inclusiveness, so that all services can work together – the independent, voluntary and charitable sectors are a key part of this and we must support, include and recognise the contribution they make.

It is a vision that reflects what I have heard from you, the women of England and your families.

It also reflects a consensus that we have sought to build among the health professionals providing maternity care. I believe they have the appetite for this change. Their commitment, determination and passion to make things better for the women, babies and families have been crystal clear. With the right

support from national organisations and the inspiration of local leaders, they will be able to make these changes happen.

I urge you to play your part in creating the maternity services you want for your family and your community. Voice your opinions, just as you have during this review, and challenge those providing the services to meet your expectations.

For me this report is the start of a journey of change. I look forward to the task ahead. Together, we will ensure that our maternity services are amongst the very best in the world.



A handwritten signature in black ink that reads "Julia Cumberlege". The signature is written in a cursive, flowing style.

*Baroness Julia Cumberlege,
Independent Chair, National Maternity Review*

ACKNOWLEDGEMENTS

I would like to thank my fellow review team members for their time, commitment and energy in working with me to conduct this review. Your expertise, advice and challenge has been invaluable, and the vision that we have developed for the future of maternity services in this country reflects the breadth and depth of the perspectives that you have brought to our important task.

National Maternity Review Team Members:

- Professor Sir Cyril Chantler, Vice Chair
- Alison Baum, Best Beginnings
- Dr Jocelyn Cornwell, The Point of Care Foundation
- Dr Catherine Calderwood, Chief Medical Officer for Scotland
- Rowan Davies, Mumsnet
- Elizabeth Duff, National Childbirth Trust
- Sir Sam Everington, GP and Tower Hamlets Clinical Commissioning Group
- Dr Alan Fenton, Newcastle NHS Foundation Trust
- Annie Francis, Neighbourhood Midwives
- Professor Dame Donna Kinnair, Royal College of Nursing
- Dr Bill Kirkup, Chair of the Morecambe Bay Investigation
- Sarah Noble, Birmingham Women's NHS Foundation Trust
- Melany Pickup, Warrington and Halton Hospitals NHS Foundation Trust
- Dr David Richmond, Royal College of Obstetricians and Gynaecologists
- James Titcombe OBE, Morecambe Bay parent and Care Quality Commission adviser on safety, (until September 2015)
- Janet Scott, Sands, the Stillbirth and Neonatal Death Charity, (after September 2015)
- Professor James Walker, University of Leeds
- Professor Cathy Warwick, Royal College of Midwives

I would also like to acknowledge the unfailing support we have had from the team from NHS England and also from Simon Whale and his staff at Luther Pendragon.

OUR VISION

Every woman, every pregnancy, every baby and every family is different. Therefore, quality services (by which we mean safe, clinically effective and providing a good experience) must be personalised.

Our vision for maternity services across England is for them to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances.

And for all staff to be supported to deliver care which is women centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries.

Our report sets out what this vision means for the planning, design and safe delivery of services; how women, babies and families will be able to get the type of care they want; and how staff will be supported to deliver such care.

A table of recommendations for action, who should take responsibility and what timescale they should work towards is at Annex A.

1. Personalised care, centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information.

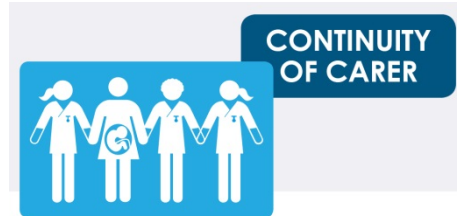
PERSONALISED CARE



- i. Every woman should develop a personalised care plan, with her midwife and other health professionals, which sets out her decisions about her care, reflects her wider health needs and is kept up to date as her pregnancy progresses.
- ii. Unbiased information should be made available to all women to help them make their decisions and develop their care plan. This should be through their own digital maternity tool, which enables them to access their own health records and information that is appropriate to them, including the latest evidence and what services are available locally.
- iii. They should be able to choose the provider of their antenatal, intrapartum and postnatal care and be in control of exercising those choices through their own NHS Personal Maternity Care Budget.

- iv. Women should be able to make decisions about the support they need during birth and where they would prefer to give birth, whether this is at home, in a midwifery unit or in an obstetric unit, after full discussion of the benefits and risks associated with each option.

2. Continuity of carer, to ensure safe care based on a relationship of mutual trust and respect in line with the woman’s decisions.



- i. Every woman should have a midwife, who is part of a small team of 4 to 6 midwives, based in the community who knows the women and family, and can provide continuity throughout the pregnancy, birth and postnatally.
- ii. Each team of midwives should have an identified obstetrician who can get to know and understand their service and can advise on issues as appropriate.
- iii. The woman’s midwife should liaise closely with obstetric, neonatal and other services ensuring that she gets the care she needs and that it is joined up with the care she is receiving in the community.

3. Safer care, with professionals working together across boundaries to ensure rapid referral, and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation, honesty and learning when things go wrong.



- i. Provider boards should have a board level champion for maternity services. They should routinely monitor information about quality, including safety, and take necessary action.
- ii. Boards should promote a culture of learning and continuous improvement to maximise quality and outcomes from their services.
- iii. There should be rapid referral protocols in place between professionals and across organisations to ensure that the woman and her baby can access more specialist care when they need it.
- iv. Teams should routinely collect data on the quality and outcomes of their services, measure their own performance and compare against others’ so that they can improve.

- v. There should be a national standardised investigation process when things go wrong, to get to the bottom of what went wrong and why and how future services can be improved as a consequence.
- vi. There is already an expectation of openness and honesty between professionals and the family, which should be supported by a system of rapid resolution and redress, encouraging learning and ensuring that families quickly receive the help they need.

4. Better postnatal and perinatal mental health care, to address the historic underfunding and provision in these two vital areas, which can have a significant impact on the life chances and wellbeing of the woman, baby and family.



- i. There should be significant investment in perinatal mental health services¹ in the community and in specialist care, as recommended by NHS England's independent Mental Health Taskforce.
- ii. Postnatal care must be resourced appropriately. Women should have access to their midwife (and where appropriate obstetrician) as they require after having had their baby. Those requiring longer care should have appropriate provision and follow up in designated clinics.
- iii. Maternity services should ensure smooth transition between midwife, obstetric and neonatal care, and ongoing care in the community from their GP and health visitor.

5. Multi-professional working, breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies.



- i. Those who work together should train together. Multi-professional learning should be a core part of all pre-registration training for midwives and obstetricians, so that they understand and respect each other's skills and perspectives.
- ii. Multi-professional training should be a standard part of continuous professional development, both in routine situations and in emergencies.

¹ Perinatal mental health services care for women during pregnancy and in the first year after birth

- iii. To support sharing of data and information between professionals and organisations, use of an electronic maternity record should be rolled out nationally. Providers should ensure the woman shares and can input the information that is important to her.
- iv. Data collection should be refocused on the most useful information so as to minimise the burden on women and their professionals. A nationally agreed set of indicators should be developed to help local maternity systems track, benchmark and improve the quality of maternity services.
- v. Multi-professional peer review of services should be available to support and spread learning. Providers should actively seek out this support to help them improve, and they should release their staff to be part of these reviews.

6. Working across boundaries to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed.



- i. Community hubs should be established, where maternity services, particularly ante- and postnatally, are provided alongside other family-orientated health and social services provided by statutory and voluntary agencies. Community hubs should work closely with their obstetric and neonatal unit(s).
- ii. Providers and commissioners should work together in local maternity systems covering populations of 500,000 to 1.5 million, with all providers working to common agreed standards and protocols.
- iii. Professionals, providers and commissioners should come together on a larger geographical area through Clinical Networks,² coterminous for both maternity and neonatal services. They should share information, best practice and learning, provide support and advise about the commissioning of specialist services to support local maternity systems.
- iv. Commissioners need to take clear responsibility for improving outcomes and reducing health inequalities, by commissioning against clear outcome measures, empowering providers to make service improvements and monitoring progress regularly.

² formerly Strategic Clinical Networks

7. A payment system that fairly and adequately compensates providers for delivering high quality care to all women efficiently, while supporting commissioners to commission for personalisation, safety and choice.



- v. The payment system for maternity services should be reformed so that it is fair, incentivises efficiency and pays providers appropriately for the services they provide.
- vi. In particular, it should take into account:
 - o The different cost structures services have, i.e., a large proportion of the costs of obstetric units are fixed because they need to be available 24 hours a day, seven days a week regardless of the volume of services they provide.
 - o The need to ensure that the money follows the woman and her baby as far as possible, so as to ensure women's choices drive the flow of money, whilst supporting organisations to work together.
 - o The need to incentivise the delivery of high quality of care for all women, regardless of where they live or their health needs.
 - o The challenges of providing sustainable services in certain remote and rural areas.

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CHAPTER 1: INTRODUCTION

- 1.1. Pregnancy, the birth and the early weeks of a child's life are a crucial period for the future of the family and of the child.³ For babies, this period has a major influence on their physical, social, emotional and language development.^{4, 5} For mothers and the wider family, pregnancy may be the first time they have sustained contact with health services and so presents the ideal opportunity to influence their life style and to maximize their life chances. It is therefore vital that families in England are supported by high quality maternity services which cater for their needs and support them to begin their new lives together.
- 1.2. Maternity services in England are always in the spot light given their importance to the people of this country; and especially in recent years due to high profile failings in care, not least at Morecambe Bay NHS Trust in Cumbria. This review was commissioned in March 2015 by Simon Stevens, Chief Executive of NHS England on behalf of the national organisations who authored the Five Year Forward View⁶ to consider how our maternity services need to change to meet the needs of the population, and to ensure that learning from the Morecambe Bay Investigation could be embedded throughout the NHS.
- 1.3. Baroness Julia Cumberlege was appointed as independent chair of the review and she has been supported by Professor Sir Cyril Chantler as vice-chair and a review team, bringing together the perspectives of midwives, doctors, women's representatives, charities and other experts. The review team was supported by a secretariat from NHS England.

Terms of reference and scope

- 1.4. The National Maternity Review was asked in its terms of reference to:
 - i. review the UK and international evidence and make recommendations on safe and efficient models of maternity services, including midwife-led units;

³ Fair Society Healthy Lives (The Marmot Review), Professor Marmot, 2010.

⁴ The Marmot Review, p60

⁵ Conception to age 2 – the age of opportunity, Wave Trust 2013, p3

⁶ NHS England, Care Quality Commission, Health Education England, NHS Improvement, National Institute for Health and Care Excellence, and Public Health England

- ii. ensure that the NHS supports and enables women to make safe and appropriate choices of maternity care for them and their babies;
- iii. support NHS staff including midwives to provide responsive care;
- iv. pay particular attention to the challenges of achieving the above objectives in more geographically isolated areas, as highlighted in the Morecambe Bay Investigation report.

The NHS Five Year Forward View also said that the review should:

- v. ensure that tariff-based NHS funding supports the choices women make, rather than constraining them; and
- vi. as a result, make it easier for groups of midwives to set up their own NHS-funded midwifery services.

- 1.5. The review team met as a group eight times over the course of 2015. At the outset, the team agreed a scope for the review: encompassing maternity care from conception through to six weeks after birth.
- 1.6. The review team also agreed a set of shared goals for the future of maternity services, which has guided their thinking throughout and in developing this report, as well as a set of workstreams through which they would take forward the review. Figure 1 below describes the shared goals and the workstreams.
- 1.7. This approach enabled the involvement of a far wider group of experts than would otherwise have been practical. Their involvement has added depth, breadth and challenge to the review team's work. Across all workstreams, the themes of improving mental health and public health, and reducing inequalities were considered.

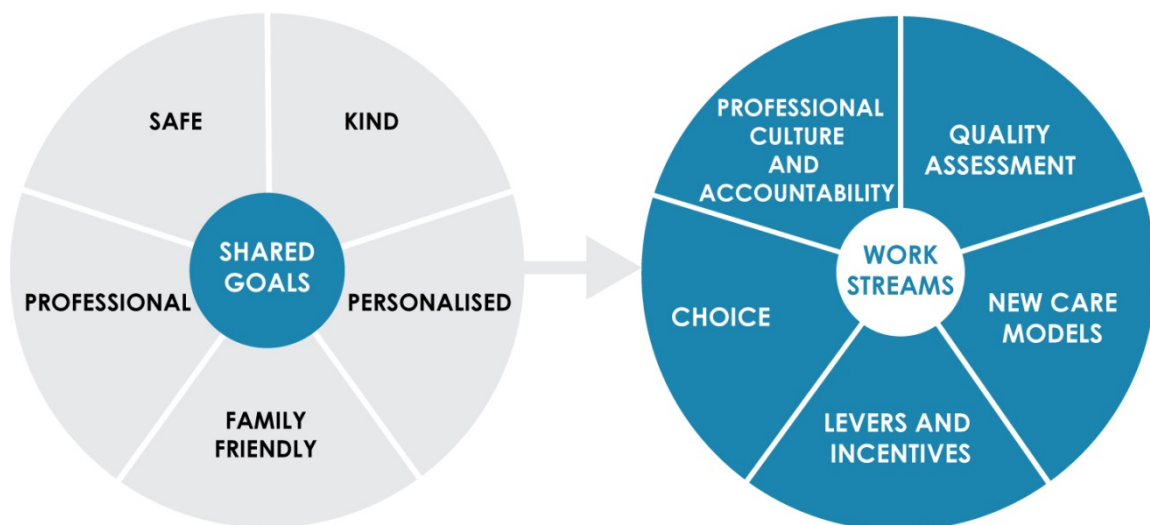


Figure 1: Shared goals and workstreams

Engagement

1.9. The review team carried out an extensive programme of engagement with the public, users of services, staff, and other stakeholders over the twelve months of this review. This activity was to ensure that the review’s findings and conclusions took into account the opinions, expertise and perspectives of as wide a range of people as possible. It covered all regions, and specifically sought to gather views across rural, urban, and suburban areas.

1.10. The programme of engagement included:

15 regional drop-in events open to the public, women and their families, commissioners, charities, clinicians and other stakeholders to give their views on current maternity services – highlighted in blue on figure 2

38 visits to different services to talk to women, their clinicians and those who commission services on their behalf – highlighted in orange on figure 2

An online consultation, which ran from 9 September to 15 November and received **5192** responses

Two national BirthTank events with **300** key stakeholders to listen to and test emerging findings

156 submissions to the maternity review email inbox

3 focused discussions with groups of women and families from seldom heard groups who use maternity services

4 dedicated listening events for women and families who have experienced loss or complications affecting the health of the mother or baby, as well a survey for those who were unable to attend the events, which received **1200** responses

46 Individual meetings with key stakeholders and experts to gather their insight and expertise

3 international visits to Sweden, Denmark and the Netherlands to learn about countries with different cultures of maternity care and identify good models of practice which can be developed for use in England.

1.11. A full list of engagement events and visits is presented at Annex B. A large number of people and organisations have taken time to engage with the review and have influenced this report. The review team would like to thank everyone who took the trouble to speak or write to them. Their insight has informed this review, and is referenced throughout.

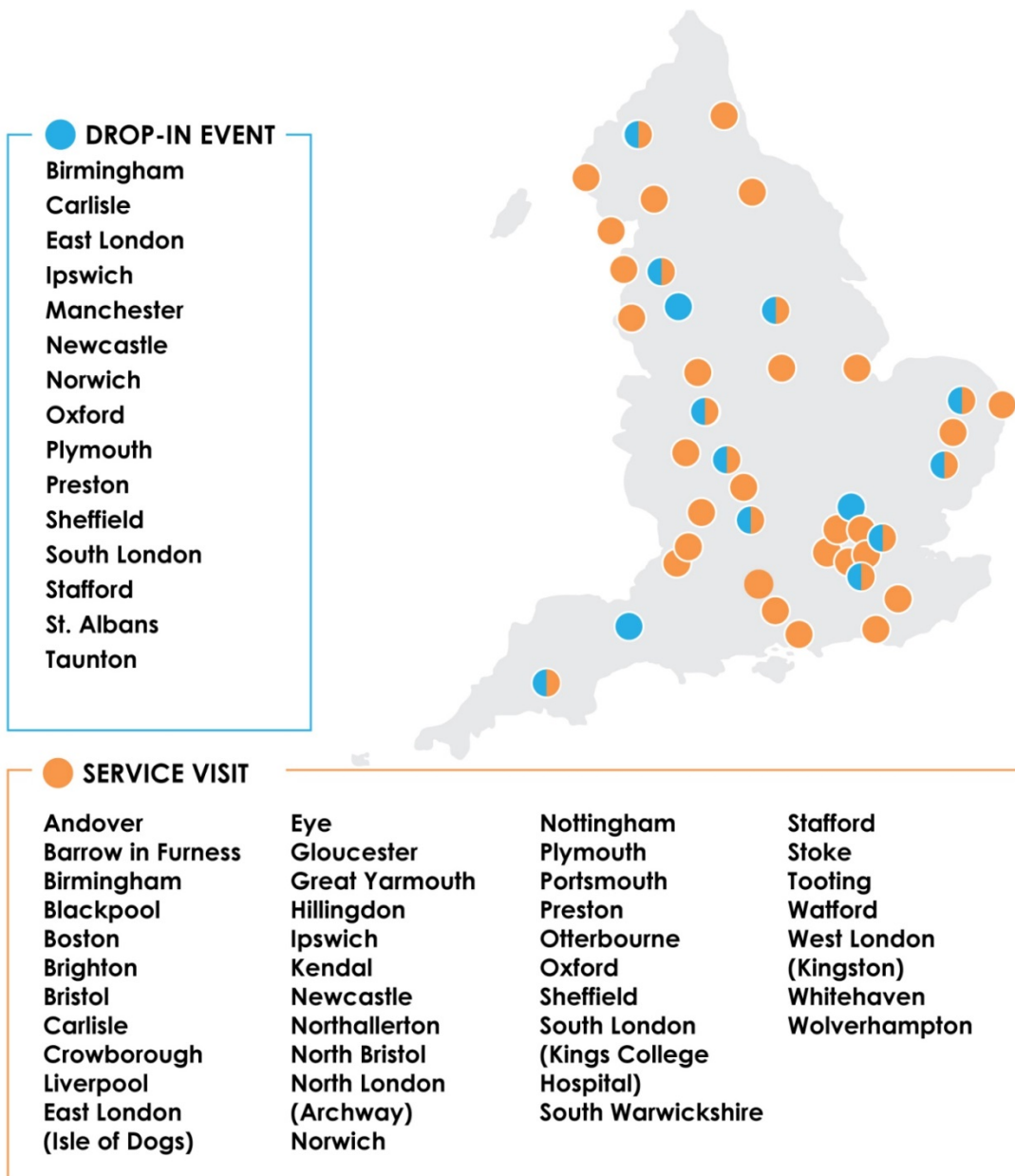


Figure 2: map of engagement events and visits

CHAPTER 2: THE CASE FOR CHANGE

- 2.1. The total number of births in England has fluctuated since declining to a low in 1977. In 2014 there were 664,543 births in England, compared to 566,735 in 2001.⁷ By 2020 the number of births will have increased by 3% to 691,038, although by 2030 it will have begun to fall and is projected to be 686,142.
- 2.2. Women are giving birth later: there has been a steady increase in the average age of first time mothers from 27.2 years in 1982 to 30.2 years in 2014. The proportion of women who have conditions such as diabetes in pregnancy has increased. In line with these trends, a higher proportion of births involve more complex care, which requires risks to be managed and more interventions.⁸
- 2.3. There are 136 NHS trusts⁹ in England providing maternity services in a range of settings, plus 15 mother and baby units provided by mental health trusts. There are four broad types of setting for care in labour and birth: at home, freestanding midwifery units (FMU), alongside midwifery units (AMU) and hospital obstetric units (OU). In 2012, 87% of births took place in NHS obstetric units. Although 96% of trusts offered home births, 2.4% of births were at home (see figure 3).¹⁰
- 2.4. Data from the Royal College of Obstetricians and Gynaecologists (RCOG) shows that there are approximately 1,970 consultants and 1,630 trainees working in the Obstetrics and Gynaecology specialty in England. Data from the Health and Social Care Information Centre (HSCIC) shows that in 2014 there were a total of 21,517 full time equivalent midwives working in maternity services based on a head count of 26,139.¹¹

⁷ Office for National Statistics, Birth Characteristics in England and Wales 2014

⁸ Comptroller and Auditor General, Maternity Services in England, Session 2013-14 HC 794, National Audit Office, November 2013

⁹ Based on 2015 Friends and Family Test submissions

¹⁰ Comptroller and Auditor General, Maternity Services in England, Session 2013-14 HC 794, National Audit Office, November 2013, p.29

¹¹ HSCIC Workforce Annual Census

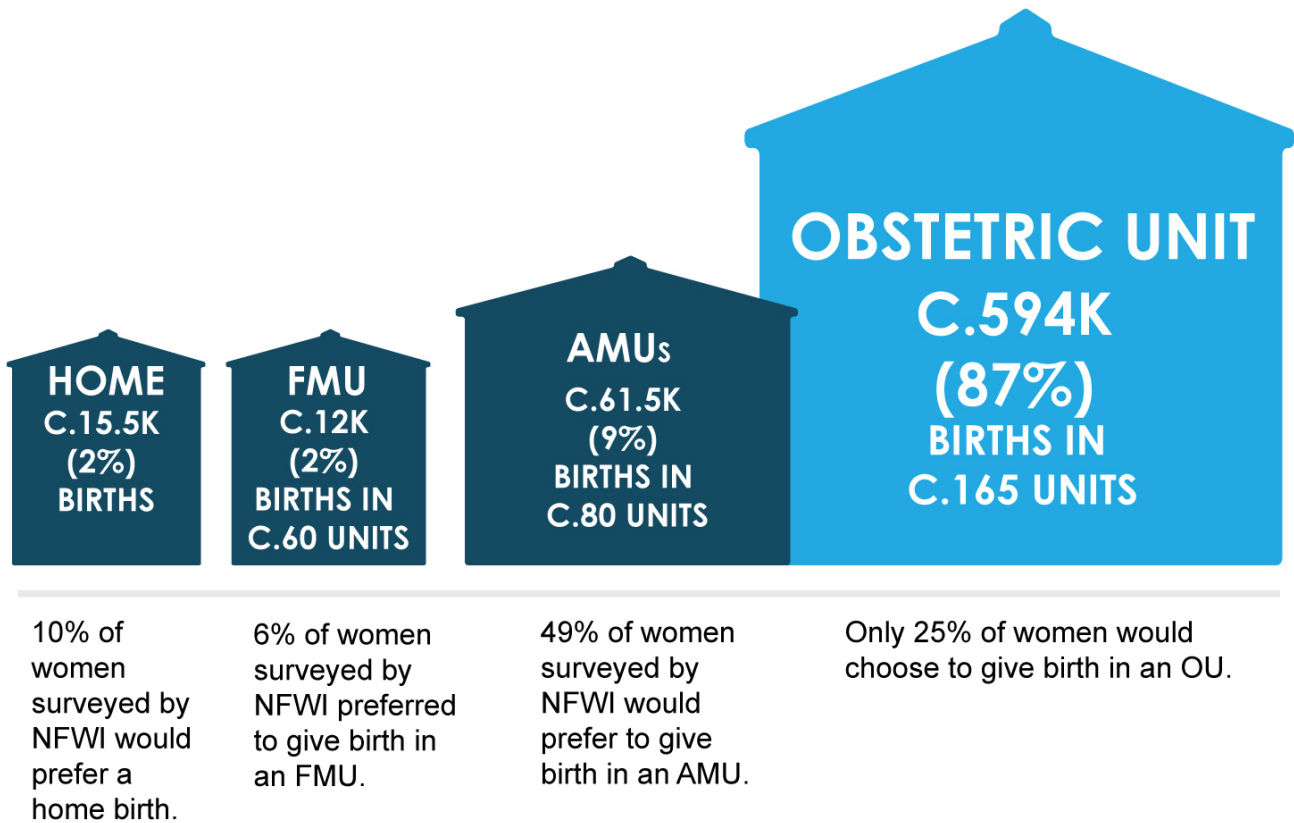


Figure 3: Number of births by unit type, 2012 (also referenced in the NHS Five Year Forward View). Women's preferences from survey of 5500 women by NFWI in 2013 (sample was self-selecting, other surveys are available). Data compiled from a variety of sources including ONS and NAO and provided by BirthChoiceUK. Numbers of births, units and percentages are approximate.

2.5. Chapter 1 mentioned the 156 responses received to the Maternity Review inbox by email, many of which provided sources of evidence and data to inform the review. Much of this evidence is referenced throughout the report. In addition, there have been three key sources of evidence which the review team have relied upon in drawing their conclusions and developing recommendations. A summary of what the review has learnt from these three sources is set out in this chapter:

- a. Dr Bill Kirkup was asked to lead a group to assess the current quality of care provided by maternity services in England;
- b. an independent evidence review was commissioned from the National Perinatal Epidemiology Unit (NPEU) at Oxford University; and
- c. the final report of the investigation into failings in care at Morecambe Bay NHS Trust.

Quality assessment

- 2.6. **Despite the increases in the number of births and the increasing complexity of cases, the quality and outcomes of maternity services have improved significantly over the last decade. The stillbirth and neonatal mortality rate in England fell by over 20% in the ten years from 2003 to 2013.¹² Maternal mortality in the UK has reduced from 14 deaths per 100,000 maternities in 2003/05 to 9 deaths per 100,000 maternities in 2011/13.¹³ The conception rate for women aged under 18 in England, a key indicator of the life chances of our future generations, reduced by almost half, between 1998 and 2013.¹⁴**
- 2.7. However, the Review team was acutely aware that these positive headline indicators, belied variation across the country in terms of the outcomes for women and babies and the quality of the services they receive. Therefore, Dr Bill Kirkup was asked to lead a group to assess the current quality of care provided by maternity services in England and understand that variation. This section sets out the overall findings.
- 2.8. A steering group was established to guide this work. The group considered a broad range of available data, from routine returns, regulatory inspections and national audits. In addition, the group carried out visits to a selection of units to hear from front-line staff their views on what impacts on the quality of care and the reporting and learning culture in their experience.
- 2.9. The assessment considered quality across the breadth of the pathway that is in scope of this review (care during pregnancy; care during labour and birth; and care following birth) and across the three dimensions of quality (safety, effectiveness and experience).
- 2.10. An initial conclusion was that a large amount of data is collected routinely, which clearly requires significant staff time and effort. However, much of it is difficult to interpret and of questionable significance. In addition, data quality is often poor: for example, the status of over 10% of births was not recorded in Hospital Episode Statistics.¹⁵ A smaller number of more relevant indicators would promote greater focus on collecting information that matters and on improving accuracy and completeness of data collection. Recommendations to address this are set out in Chapter 5.

¹² HSCIC Indicator Portal NHS Outcomes Framework Indicator 1c

¹³ MBRRACE-UK Confidential Enquiry into Maternal Death 2015. Figures exclude coincidental maternal deaths

¹⁴ ONS, Conception Statistics, England and Wales, 2013

¹⁵ HSCIC Hospital Episodes Statistics.

Safety

- 2.11. There was evidence from the data of opportunities for improvement in the safety of maternity services. For example:
- a. a recent audit of stillbirths found that half of all term, singleton, normally-formed antepartum stillbirths had at least one element of care that required improvement and that may have made a difference to the outcome; almost half of the women had concerns over reduced or altered movements by the baby, and in half of these there were missed opportunities that may have saved the baby, such as lack of investigation, misinterpretation of the baby's heart trace or a failure to respond appropriately to other factors;¹⁶
 - b. in first-time mothers the proportion of instrumental deliveries resulting in third and fourth degree perineal tears varied from 3% in the lowest decile and 11% in the highest. In women having a second or subsequent child, the variation between lowest and highest deciles was from 0.4% to 4.6%;¹⁷ and
 - c. almost half of CQC inspections of maternity services result in safety assessments that are either 'inadequate' (7%) or 'requires improvement' (41%),¹⁸ Although maternity and gynaecology services perform second best in these respects of all eight service areas in the CQC's acute hospital inspections.
- 2.12. Improving safety depends crucially on recognising when something has gone wrong, carrying out a safety investigation, and learning lessons to improve services and reduce the risk of future recurrence. However, the numbers of incidents reported by Trusts vary greatly. Figure 4 illustrates Trust reporting of incidents causing harm, but similar variation is found for all incidents as well as those causing moderate or more severe harm. This degree of variation is impossible to reconcile with differences in the underlying occurrence of adverse events, and it is clear that under-reporting of safety incidents is widespread.¹⁹

¹⁶ MBRRACE-UK Perinatal Confidential Enquiry Report 2015:
<https://www.npeu.ox.ac.uk/mbrance-uk>

¹⁷ RCOG Clinical Indicators Project 2011-12

¹⁸ CQC Inspection ratings December 2013 to May2015.

¹⁹ National Reporting and Learning System.

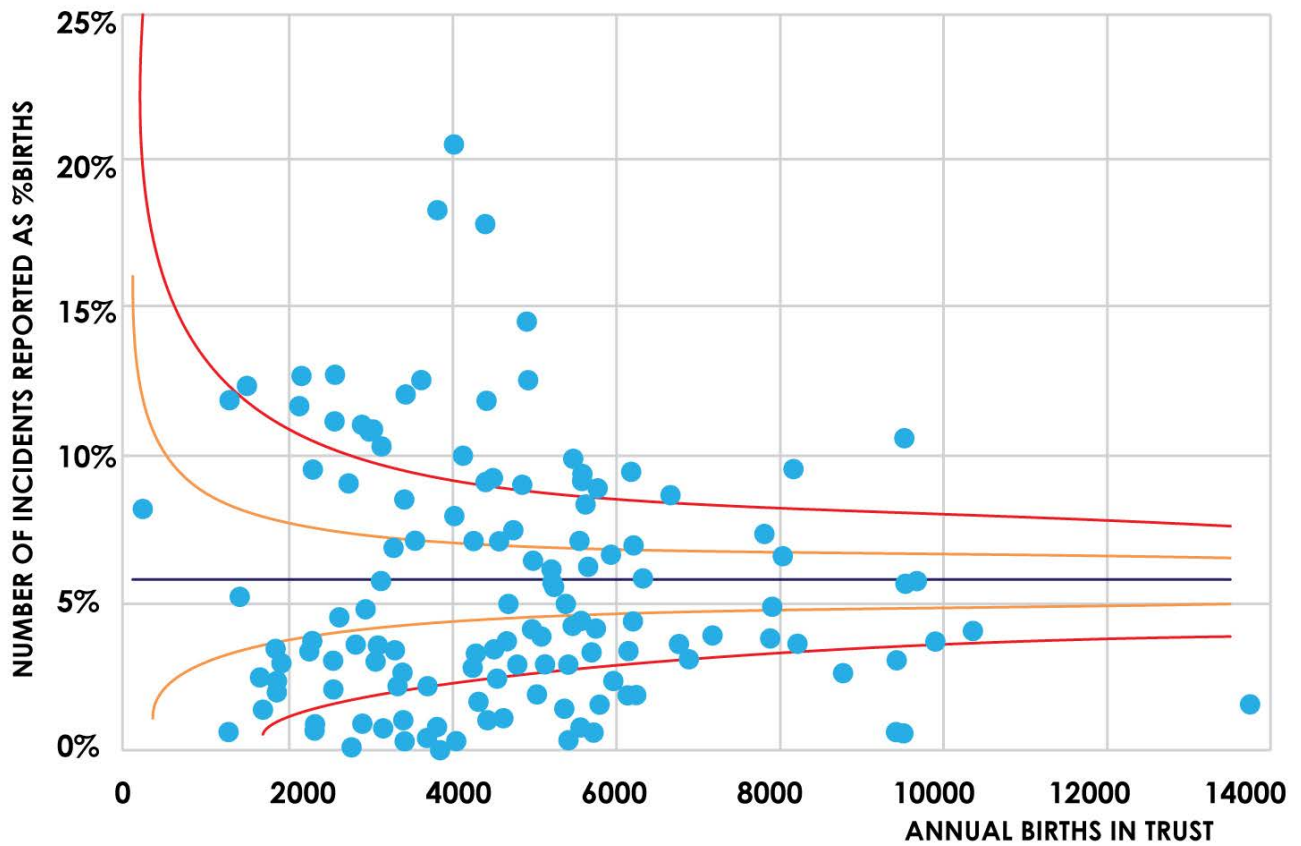


Figure 4: All incidents reported in 2014 causing harm as percentage of births, by Trust. Points show individual Trusts; blue line shows mean; yellow and red lines show 5/100 and 2/1000 expected levels respectively, if variation random. Data from National Reporting and Learning System.

2.13. This conclusion is reinforced by the MBRRACE-UK confidential enquiry into stillbirths. Their audit of term, singleton, normally-formed, antepartum stillbirths found that documentation indicating that an internal review had taken place was present in only one quarter of cases following stillbirth, and the quality of these reviews was highly variable.²⁰

2.14. When talking to maternity teams during visits, there were clear differences of approach between high and low reporting units. Those from higher-reporting units described a strong learning culture with good team working. Elsewhere, opportunities for learning and improvement were being ignored.

2.15. The combination of these two features is stark. Safety is inconsistent across maternity services, and there is scope for significant improvement in many. The

²⁰ MBRRACE-UK Perinatal Confidential Enquiry 2015

open culture that welcomes learning is also inconsistently distributed, with many units missing the opportunities for improvement that are needed. Recommendations have been made in Chapter 5 which seek to address these findings.

Effectiveness and outcomes

- 2.16. The effectiveness of services depends on offering care best suited to achieving a good outcome for mother and baby, and carrying it out well. Although much maternity care is effective, it is clear there is again considerable variation, and therefore scope for improvement.
- 2.17. The best recorded information available on the outcome of pregnancy is the occurrence of perinatal deaths.²¹ Although a wide range of other outcomes are also important, including the health and wellbeing of both baby and mother, they are not clearly defined nor recorded. Perinatal deaths are themselves subject to some inconsistency of data collection, particularly around the interpretation of those that occur early in pregnancy, which makes international comparison difficult.
- 2.18. In 2013 there were 4.3 stillbirths per thousand total births and 1.8 neonatal deaths per thousand live births in England; both have declined slowly over time. Marked geographical variation is evident, from around four per thousand perinatal deaths to over ten per thousand. Higher numbers occur in those areas with more deprived populations and greater proportions of older or younger mothers.²²
- 2.19. However, marked variation persists between areas after adjustment for the effects of deprivation and maternal age.²³ This otherwise unexplained variation is likely to be associated with differences in the effectiveness of care.
- 2.20. Perinatal mortality in England does not generally compare favourably with other countries that may be expected to be similar, for example in Europe. However, this must be interpreted with caution due to differences in reporting methods.²⁴

²¹ Perinatal deaths in this context comprise babies who are stillborn and those who die in the first week following birth. Extended perinatal deaths comprise babies stillborn and those who suffer neonatal death, within the 28 days following birth.

²² MBRRACE-UK Perinatal Mortality Surveillance Report 2015

²³ *ibid*

- 2.21. Maternal mortality²⁵ has declined progressively over time, to a level of nine deaths per 100,000 maternities in the UK in 2011-13.²⁶ This number of deaths is too low for variation between different services to be meaningful; however the recent MBRRACE-UK Confidential Enquiry into maternal death found that about half of deaths would have had a different outcome with better care. Late maternal mortality in the period 2011-13 was 14 per 100,000 maternities. Notably, 23% of these deaths were from mental health related causes, with one in seven dying through suicide.
- 2.22. Mental health problems are relatively common at a time of significant change in life. Depression and anxiety affect 15-20% of women in the first year after childbirth, but about half of all cases of perinatal depression and anxiety go undetected. Almost one in five women said that they had not been asked about their emotional and mental health state at the time of booking, or about past mental health problems and family history.²⁷ Many of those with mental health problems that are detected do not receive evidence-based treatment. There is a large geographical variation in service provision: an estimated 40% of women in England lack access to specialist perinatal mental health services.²⁸ Given the contribution of mental health causes to late maternal mortality, this is a significant concern, as also set out in NHS England's recently published Mental Health Taskforce report.
- 2.23. Other indicators of the effectiveness of care are less consistently recorded, but where relevant information is available it generally confirms significant variation in

²⁴ WHO and World Bank and Wang et al, 2013, Global, regional, and national levels of neonatal, infant and under-5 mortality during 1990- 2013: a systematic analysis for the Global Burden of Disease Study 2013, The Lancet.

²⁵ Maternal mortality is the death of a woman in or within 42 days of pregnancy, and may be direct (due to a pregnancy-related cause), indirect (due to another condition that may have been worsened by pregnancy) or coincidental (due to an entirely unrelated cause). Late maternal mortality is the death of a woman more than 42 days but less than one year after pregnancy.

²⁶ MBRRACE-UK Confidential Enquiry into Maternal Death 2015. Figures exclude coincidental maternal deaths.

²⁷ NPEU Safely Delivered: a national survey of women's experience of maternity care, 2014

²⁸ Bespoke data collection and analysis carried out by the NHS Benchmarking Network on perinatal mental health provision (2015) and everyonesbusiness.org.

the way that care is delivered that is not explicable on the basis of clinical need. For example:

- a. the 2011/12 RCOG Clinical Indicators project found marked differences in the proportion of women having an emergency caesarean section following spontaneous onset of labour, taking into account clinical risk factors and socio-demographic differences; there was a 2.5 fold variation in first-time mothers, from 7% in the lowest tenth of Trusts to 17% in the highest tenth; amongst women not in their first pregnancy, the variation was 4.2 fold, with proportions varying between 1.2% and 5% from lowest to highest tenths;²⁹ and
- b. the 2015 MBRRACE-UK confidential enquiry into stillbirths found that two thirds of women with a risk factor for developing diabetes in pregnancy were not offered testing which could have identified the need for treatment; the same enquiry found that national guidance for screening and monitoring the growth of the baby had not been followed in two thirds of women whose babies were stillborn.³⁰

2.24. The information that is available shows marked variation in effectiveness and outcomes that is not explicable by underlying differences such as age and deprivation. It is clear that there is scope for significant improvement, but the lack of a consistent approach to learning and improvement already described limits the opportunity. Recommendations to address this are set out in Chapter 5.

Experience and workforce

- 2.25. Women's experience of maternity services, is a product of the quality of caring,³¹ which depends particularly on the staff providing maternity care. **The experience of care is reported for the most part in positive terms by the majority of women.** There are two significant exceptions, however.
- 2.26. The first exception is the extent to which women are offered choice of place of birth and type of birth. 16% of respondents to the 2015 CQC Maternity Survey reported that they had been offered no choice.³² 25% of respondents to the NPEU

²⁹ RCOG Clinical Indicators Project 2011-12

³⁰ MBRRACE-UK Perinatal Confidential Enquiry 2015

³¹ Department of Health. High quality care for all: NHS Next Stage Review final report. Department of Health. 2008. P.47.

³² CQC Maternity Survey 2015

Safely Delivered survey were unaware of all four possible choices.³³ 14% of women felt that they were not provided with sufficient information to enable a choice of where to have their baby.³⁴

- 2.27. The second exception to the generally favourable picture of women's experience of maternity services is the reservations that are expressed concerning care following birth, for themselves and their babies. Overall, patient experience data suggests this part of the maternity pathway shows significant scope for improvement.
- 2.28. Women saw a midwife an average of 3.1 times at home after birth, with 97% of women having at least one visit from a midwife at home.³⁵ However, 40% of women had not previously met any of the midwives who made home visits, and 32% saw three or more different midwives after the birth.³⁶ One in four women who saw a midwife at home after birth wanted to see the same midwife on all visits but did not.³⁷ Only 77% of women had the name and telephone number of a 'named midwife' or health visitor they could contact.³⁸
- 2.29. Maternity staff are central to the experience of maternity care, but also to its safety and effectiveness. Providing health care is by nature demanding and stressful, but the NHS Staff Survey provides evidence that this affects maternity staff more than most. Fewer midwives are satisfied with the quality of their work than the overall NHS workforce.³⁹ Midwives are more likely to report feeling pressured at work than other NHS staff, with almost half recording having suffered from work-related stress.⁴⁰ More midwives and trainee obstetricians report feeling

³³ NPEU Safely Delivered 2014

³⁴ CQC Maternity Survey 2015.

³⁵ *ibid*

³⁶ NPEU Safely Delivered: a national survey of women's experience of maternity care, 2014

³⁷ CQC Maternity Survey 2015.

³⁸ NPEU-Safely Delivered: a national survey of women's experience of maternity care, 2014

³⁹ Royal College of Midwives analysis of NHS Staff Survey 2014 responses from midwives.

⁴⁰ *ibid*

unsupported in the workplace compared with other clinicians,⁴¹ although midwives report feeling slightly more supported by their managers than in previous years.⁴²

Summary conclusions

- 2.30. Too much data of questionable relevance is being routinely collected, too often incompletely and inaccurately. Focusing on a smaller amount of relevant information would allow more robust assessment of quality as well as reducing the burden on staff and improving accuracy and completeness.
- 2.31. The quality of maternity services has been improving but not all are provided to a consistent, high level of quality. There is significant variation in safety, effectiveness and outcomes between providers that cannot be explained on the basis of differences in demography, deprivation or clinical complexity.
- 2.32. The safety of maternity services must be improved. The number of unsatisfactory safety assessments and frequency of audit findings of poor care indicate a clear need for improvement. However, the prevalent lack of an open culture that investigates adverse events in order to learn, stands in the way of the improvement that is needed.
- 2.33. The recognition and care of those with mental health problems around birth is not consistently effective, and a significant number of late maternal deaths have mental health causes.
- 2.34. Women's experience of maternity care is generally positive, but there are reservations over the availability of choice and the provision of care following birth. Maternity staff report higher levels of perceived stress and a less supportive work environment than other NHS staff.

⁴¹ General Medical Council National Training Survey: Bullying and Harassment (2014).

⁴² Royal College of Midwives analysis of NHS Staff Survey 2014 responses from midwives

Evidence review by the National Perinatal Epidemiology Unit

2.35. The National Perinatal Epidemiology Unit (NPEU) was asked to summarise and add to the evidence where possible on the following questions:

- Safety of place of birth
- Effectiveness of 24/7 consultant labour ward cover in large units
- Factors which influence women's choice of planned place of birth
- International evidence on the delivery of and outcomes from maternity services

2.36. The NPEU's full reports were submitted to the review in October 2015. The key findings which have been particularly informative and relevant to the findings of the review team include:

- a. Overall, midwifery style services can provide good care for low risk women having a second or subsequent baby: planning a birth at home or in a midwifery unit results in fewer interventions, the chances of transfer are low, and there is no evidence that outcomes are worse. The woman's ethnicity and the level of deprivation where she lives make no difference, although the chances of transfer increase according to her age. Moreover, freestanding midwifery units appear comparable with alongside midwifery units: there is no evidence that outcomes are worse for babies, and women who plan births in freestanding units have a lower likelihood of intervention. In addition, trusts which supported more home births achieved better maternal outcomes compared with trusts which supported fewer home births.
- b. The picture is slightly different for low risk women having their first baby. Overall, such women planning births at home or in midwifery units have fewer interventions, but there is a higher risk of transfer and with home births a small increased chance of an adverse outcome for the baby. This is reflected in the NICE guidelines.⁴³
- c. Maternity services need to consider how best to provide care for women with complications who nonetheless want to choose midwife-led care. Flexibility in entry criteria to alongside midwifery units may help to offer such women the

⁴³ NICE clinical guideline 190: Intrapartum care for healthy women and babies

type of birth they would like, ensuring specialists are on hand should their presence be needed.

- d. There does not appear to be sufficient evidence, based on birth outcomes, to support a model of 24 hour resident consultant presence on the labour ward, compared with other models of consultant cover. Such a model appears to be viable only in large urban hospitals where the highest payment under the tariff is received for a large proportion of women. What is required is 24/7 residence for a doctor or doctors with the appropriate training and in numbers equivalent to the workload.
- e. In France, Sweden and Scotland they use a network system whereby units are tiered according to the services they provide and there are rules for transfer of care between the different tiers. However, it is not possible to discern a clear relationship between tiering and outcome data.
- f. Women need clear unbiased information to help them make decisions about where to give birth, including: the chances of receiving interventions; availability of pain management; on site availability of obstetric and neonatal services; and the frequency and likely duration of transfer. Such information needs to be personalised according to their individual circumstances.
- g. Factors which influence decisions include local service availability, knowledge that they can make choices about their care, support provided, and the personal views of the health professionals advising. Women almost universally value local services, being seen by the same midwife or group of midwives before the birth, and having continuity of carer during labour (either by a known midwife, or by the same midwife throughout labour). Women's preferences for other service attributes vary more.

Learning from the Morecambe Bay investigation report

- 2.37. Dr Bill Kirkup led the independent investigation into the serious failings in maternity services at Morecambe Bay NHS Trust, which reported in March 2015.⁴⁴ It provided a clear and detailed account of what went wrong in the provision of those services and why, identifying failings and improvements needed by the trust, commissioner, wider health economy, regulators and national bodies. It also set out lessons that the rest of the health service needed to learn in order to ensure that such failings were not repeated.
- 2.38. This National Maternity Review was in part commissioned to ensure that the system as a whole could learn those lessons. The key lessons that this review has sought to address are:
- a. Professional culture matters enormously and where it is dysfunctional it has a direct impact on the quality of services. At Furness General Hospital there were unchallenged failures in clinical competence; poor relationships between obstetricians, paediatricians and midwives; a culture of midwives promoting normal childbirth 'at any cost'; failures of risk assessment and care planning; failure to escalate concerns; and a failure to investigate adverse incidents and learn lessons.
 - b. Establishing the right culture needs leadership and commitment from everyone: individual health professionals and teams, as well as senior management. Above all, it requires individuals to operate as part of a team across professional disciplines.
 - c. It is more difficult to ensure a positive culture in units that are isolated, either clinically or geographically. It can be more difficult to recruit staff who may then have fewer opportunities to learn from the variety of other professionals, experiences and training available in larger units. Poor practice can go unchallenged. Small units should therefore not operate in isolation.

⁴⁴ The Report of the Morecambe Bay Investigation, Dr Bill Kirkup CBE, March 2015

CHAPTER 3: WHAT WE HEARD

3.1. Through the engagement approaches outlined in Chapter 1, the review gathered a great deal of information and insight which the team has considered carefully and that has informed this report. This chapter sets out the key themes that we heard from each of the following groups:

- Women and families (and the organisations that represent them)
- Healthcare professionals
- Providers and commissioners.

What we heard from women and their families

Safe and personalised care

- 3.2. Women and families whom we spoke to or who contacted the review through another route told us that they want to access maternity services that are safe and that keep them as safe as possible. They understand that birth is not risk-free, but that advances made over the last decades in medicine and healthcare have made giving birth safer than it has ever been.
- 3.3. We also heard equally strongly that women want to be able to choose the care that is right for them, their family and their circumstances, and that they want the care to wrap around them. They understand that there are finite resources, however they expect that their needs are able to be supported. We were told that women do not always feel like the choice is theirs and that too often they felt pressurised by their midwives and obstetricians to make choices that fitted their services. They resented the implications for their care of being labelled high, medium or low risk. Above all, women wanted to be listened to: about what they want for themselves and their baby, and to be taken seriously when they raise concerns.
- 3.4. Women told us 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 the maternity journey. It was felt that this could provide better support for women, and enable midwives to better meet their needs, identify problems and provide a safer service. Continuity was also important for obstetric care, especially after a traumatic experience.

- 3.5. Women wanted to know that all the healthcare professionals caring for them are fully trained and competent in carrying out tests and monitoring to assess their own and their baby's wellbeing throughout pregnancy, in recognising signs of changing risk and escalating the care when necessary in a timely manner. Women talked about there being a lack of awareness of risk and a reluctance to discuss it honestly.
- 3.6. Some fathers told us that they had felt excluded, that their role had not been recognised and so opportunities were missed to support the family and to have as positive an experience as possible. Some women told us that they relied on their partner to support them in pregnancy and with the care of the baby and the NHS needed to recognise this and help their partners to help them.
- 3.7. We heard that services should be designed in a way which put women, their babies and their families at the centre. Maternity Service Liaison Committees (MSLCs) provide a means of ensuring the needs of women and professionals are listened to and we saw how effective they could be when properly supported and led. We also heard about the range of voluntary and third sector organisations providing valued and necessary care and support to women, babies and families across the country.

Communication

- 3.8. Many women told us about the importance of good quality and consistent communication and emphasised how vital it is for professionals to communicate with each other. There is widespread interest in using electronic records so that women would not have to explain their situation to every new healthcare professional they meet. Women wanted healthcare professionals to have read the notes before meeting with them. This is particularly important if they have had a stillbirth, miscarriage or experienced complications.
- 3.9. Many women expressed frustration over receiving conflicting advice from different healthcare professionals throughout their care. Women and their families told us they need to be able to access appropriate information to enable them to make genuinely informed decisions about their care and where to give birth. They wanted information to be evidence-based and available to them in a range of formats, including online. They wanted information to be accessible when they needed it, to include locally relevant information about the services available, and for there to be time to discuss the information with a healthcare professional.

- 3.10. Through research by the Department of Health,⁴⁵ women told us about their expectations for digital communication during pregnancy. The vast majority of pregnant women are “savvy consumers” of online information; they expect digital tools to help empower them in their decision-making. Without user-friendly digital tools, however, women found it difficult to process and make decisions based on the vast array of pregnancy related material available online. The more empowered women felt by their digital experience, the more likely they were to ask for help during face to face interactions with healthcare professionals. Women also told us that being able to trust digital information was as important to their care experience as trusting the healthcare professional delivering the information.
- 3.11. Women who had experienced stillbirth consistently said that they wished they had been better informed about the risks, especially those symptoms they might have acted upon such as reduced fetal movements. Particularly during their first pregnancy, women found it difficult to know what signs to look out for. Parents said they wanted to be listened to and taken seriously when they expressed concerns about their baby. We heard from parents who had felt something was wrong with their baby, but when they raised their worries they were ignored or patronised, and no action was taken.

Care when a baby dies

- 3.12. When a baby dies, nothing can take away the pain for the families, but we heard many accounts of kind, compassionate care that made the experience better and helped parents to create positive memories. On the other hand we heard too from families who said they were treated with a lack of care and kindness. Insensitive language and dismissive remarks lodged in parents’ minds, causing hurt and polluting memories of the often very short time they had with their baby.
- 3.13. When their baby had died, families said the environment where they were looked after made a big difference. Many parents told us they were made to share facilities on labour wards with those who had just given birth and therefore within earshot of crying new-borns, which greatly added to their trauma and distress. In contrast other families greatly appreciated being cared for in the privacy and calm of a bereavement suite.
- 3.14. Parents told us that they would have liked more time to come to terms with their loss before having to leave the hospital, leave their baby, or decide what would happen to their baby. Many felt rushed through the process and not treated with the kindness and compassion that they needed.

⁴⁵ <https://digitalhealthblog.gov.uk/2015/08/12/having-a-baby-intro/>

Care when complications arise which affect the health of the mother or baby

- 3.15. Women and families told us that they did not always have confidence that complications would be picked up and staff would understand the impact on women and their families. When they have concerns about their or their baby's health, they want to be listened to and taken seriously. Where their baby is harmed, women expect high quality investigations that are factually correct, unbiased and framed in a way which shows sympathy towards them and their families.
- 3.16. They told us that better facilities could significantly improve the experience and help to alleviate the trauma of the complication occurring. Women want to be located close to their baby if it is in a Neonatal Intensive Care Unit (NICU) when they are still a patient themselves. Care needed to be sensitive and respectful, and facilities should be of a suitable standard.

Care for women expecting more than one baby

- 3.17. Tamba (the Twins and Multiple Births Association) and the National Childbirth Trust (NCT) told us that there needs to be greater recognition of high risk groups such as those who have multiple births.⁴⁶ 10-15% of babies have an unexpected admission to a neonatal unit. The Multiple Births Foundation told us that risks and complications associated with multiple births are still poorly understood by the public and underestimated by professionals. Multiple births have gone up and the mortality rate is higher among women who have multiple births.

Care for women with different backgrounds

- 3.18. We heard from a number of women from a wide variety of different backgrounds and while their needs and circumstances were distinct, their requests of healthcare professionals were similar, and echo what we heard from the majority of women. Key for all groups was that healthcare professionals understand and respect their cultural and personal circumstances as well as their decisions.
- 3.19. The review also heard about how services might need to tailor their approach for different groups:

⁴⁶ Tamba and NCT Maternity Services Report: Multiple births, November 2015
<http://www.tamba.org.uk/document.doc?id=681>

- a. For families from black and minority ethnic (BME) backgrounds, this might mean greater engagement between service providers and their communities. On an individual level, it might mean taking the extra time to gauge understanding of the language being used at an appointment or to understand cultural differences and the additional support that might be needed for fathers to play a supportive role in the birth process, particularly during the antenatal stage.
- b. For those who have difficulty communicating, it might mean providing information in a format which is easy to read and understand, free from complex concepts or medical terminology. Alternatively, it might mean providing an interpreter or translating the key points into their native language.
- c. For women in the Gypsy and Traveller communities this might mean professionals taking extra time to discuss and understand their lifestyle choices and not make assumptions about their feeding preferences or about the safety of their home environment.
- d. People with learning disabilities would benefit from the option of accessing information in easy-read format, and healthcare professionals taking time to ensure that they understand what is happening and the choices they can make.
- e. For the particularly vulnerable, such as drug and alcohol users, sex workers and homeless people, services (not available everywhere) where staff with specialist expertise are employed and provide outreach, had better outcomes. For drug or alcohol users this meant that a health professional would take the time to listen to them, determine their individual needs and establish whether referral to a drug and alcohol recovery team and mental health specialist might be necessary.
- f. For young parents,⁴⁷ who are disproportionately more likely to have experienced poverty, poor housing, and educational underachievement⁴⁸ and

⁴⁷ About one in 25 births in England are to young women under 20. The majority of their babies' fathers are under 25.

⁴⁸ Teenage mothers and the health of their children, Botting B, Rosato M & Wood R. *Population Trends* 1998, 93: 19-28;. Evaluating the social determinants of teenage pregnancy: a temporal analysis using a UK obstetric database from 1950 to 2010, McCall SJ, Bhattacharya S, Okpo E, Macfarlane GJ. *J Epidemiol Community Health*. 2014 Sep 16; Truancy and teenage pregnancy in English adolescent girls:

are less likely to access health and maternity services at an early stage in their pregnancy, dedicated support and experienced health professionals were key. Our consultation showed that, women under the age of 25 cited more frequently than older mothers the need to be listened to, respected, given support and communicated with appropriately as key things that would have improved their experience during labour and birth.

Postnatal care

- 3.20. Across the country, women asked for more postnatal support and shared a feeling that services are inadequately resourced for midwives to provide empathetic and comprehensive care.
- 3.21. The six week postnatal check was felt to be inadequate.⁴⁹ Many women said that they received lots of care and support in the antenatal period which is not continued after birth. For some women, additional support – sometimes simply someone to talk to – could prevent the onset of depression and other mental health conditions, particularly in relation to the days spent in hospital which can often be a low point for women.
- 3.22. We were told that there is a need for improved support in breast-feeding, with many mothers telling us that they had received conflicting information and as a result felt confused, and at times pressurised. We know that 90% of women say they stopped breastfeeding before they wanted to.⁵⁰
- 3.23. We also heard that there is a need for more support and better access over a longer term to counselling and therapy for those who have difficult or traumatic experiences, particularly families who have had a stillborn baby or whose baby has died after birth. Bereaved parents told us how communication between the hospital and community based services were poor. Many encountered health professionals who did not know their baby had died.

can we identify those at risk? Zhou Y, Puradiredja DI, Abel G J Public Health (Oxf). 2015 Mar 16.

⁴⁹ <https://www.nct.org.uk/press-release/nct-netmums-research-finds-six-week-postnatal-check-unsatisfactory>

⁵⁰ Infant feeding 2005, Bolling K, Grant C, Hamlyn B et al. 2007.

What we heard from healthcare professionals

Teamwork and respect between professions

- 3.24. During our service visits across England we saw at first hand many examples of service provision where multi-professional teams worked seamlessly and cooperatively together to deliver high quality care. However, we also heard about a culture of silo working and a lack of respect across disciplines, particularly between obstetricians and midwives.
- 3.25. Both midwives and obstetricians highlighted the need to improve working relationships between their professions and with other groups such as GPs, health visitors, nurses, neonatologists, paediatricians and anaesthetists. The problems identified included issues of communication, handovers and disagreements about how to handle specific situations such as the transition to more specialist care. What was clear is that everyone involved had the interests of the woman and baby as their priority – where they differed was their perspectives on how to secure the best possible care for them.
- 3.26. Professionals told us that there is a need for better investment in education and training. This included the importance of multi-professional education and training at all stages of pre and post registration careers, training to address some of the ‘cultural tensions’ that currently exist and training professionals to improve skills such as perinatal mental health care.

Professional support and work load

- 3.27. The availability of obstetricians and midwives is a significant issue for some units, presenting risks of ‘burnout’ for those who work in services where there are shortages. Professionals voiced concerns about poor working environments leading to low morale and motivation. We were told that there is a need for better, more creative workforce design and for providers and commissioners to work together much more in workforce planning.
- 3.28. We also heard about the challenges caused by sometimes inefficient working practices, with an increasing administrative burden cited as a particular difficulty. This reduced the amount of time that could be spent with women, increasing the likelihood of mistakes and missed opportunities to spot problems. A perceived litigious culture was partly to blame, as well as paper based records systems, and data collections not being aligned.

- 3.29. There was widespread agreement that a digital and accessible maternity record which is available to all those who need to see it would be highly beneficial, providing that the right arrangements for informed consent are in place. We were told by a range of people that there is a need to integrate IT systems so that there are better connections between different data sets, particularly between those held in primary care and those by maternity service providers.
- 3.30. There was debate across the country about the removal of statutory status of supervisors of midwives, with many midwives expressing concern that it would leave them vulnerable and unsupported in their role. On the other hand, professionals questioned whether the existence of a separate and distinct oversight mechanism for one part of the workforce might undermine the principle of the multi-professional team.

Role of general practice

- 3.31. We heard from many GPs as we travelled the country and we held a focussed discussion with members of the Royal College of General Practitioners. Many GPs told us that they felt it was to the detriment of care for women and babies that they were no longer as involved as they once had been in maternity care. They saw the importance of joining up with their midwifery and obstetric colleagues to deliver care in the community tailored to the needs of their patients. And they would welcome becoming more involved in maternity services once again. However, we also heard from GPs who felt that it was necessary for them to be less involved in these services, partly due to their expertise and partly due to the competing pressures on their time. They were reluctant to take on additional responsibilities as they were already stretched.

Litigious and blame culture

- 3.32. Professionals also told us that the threat of litigation and the high costs associated with it could encourage obstetricians and midwives to practise in a risk-averse way, inhibiting their ability to support some of the choices that women may want to make, contributed to the administrative and data collection burden, and undermined multi-professional working. We also heard overwhelmingly from families whose baby died that litigation was a last resort, and that they only turned to litigation when they had failed to get answers about their baby's death through any other channels. They repeatedly told us that they were not motivated by the money, but they desperately wanted to make sure the same mistakes were not repeated with future families. The litigation process caused them considerable stress as it inhibited the clinicians from discussing openly what had gone wrong,

and by needing to involve legal representatives, the process took longer to resolve, often many years.

Continuity

- 3.33. Some midwives commented positively on the option of a 'case-loading' model, particularly for vulnerable women. They felt that having a relationship with the individual women they were caring for would improve safety and their job satisfaction. The same can also be said for obstetricians.
- 3.34. At the same time, staff expressed concerns that providing continuity of carer would be difficult to deliver as the system is currently configured, with particular fears being expressed about work/life balance. There was concern that without additional resources, it might not be possible. A large proportion of midwives work part time which made continuity models more difficult to manage.
- 3.35. We heard that there are several elements which can help ensure the success of the continuity of a professional caring for the woman and her baby:
- Midwives who work in a continuity of care caseload team need their time to be ring-fenced, and not diverted to other services – the ebb and flow of the workload needs to be understood and respected.
 - Capping caseload numbers to a manageable level so that teams can plan and midwives are not overburdened.
 - Flexible working – midwives should be able to manage their own diary, in conjunction with the rest of their team.
 - A culture of shared trust and personal responsibility.
 - Rotations of midwives between hospital and community (e.g. supporting home births) to maintain skills and promote a continuity model.

What we heard from commissioners and provider organisations

Mental health support

- 3.36. There was a consistent message from all groups that mental health care for women, before, during and after pregnancy was not good enough. There are a small number of areas where high quality mental health care is provided, but across a large part of the country this care is either inadequate or non-existent. The implications of this are that mental health conditions are not identified and in some cases this has led to harm to the baby and/or suicide by the mother.⁵¹
- 3.37. We heard that although perinatal mental health⁵² is gathering a profile, there is insufficient activity on the ground to improve care. There is a need for training and sharing of best practice to reduce variation and the standardisation of service provision across the country.

Payment systems

- 3.38. Commissioners and providers told us frequently that the maternity tariff system is not fit for purpose and could act as a barrier to choice. Providers of maternity services told us that the tariffs were not sufficiently sensitive to the costs of providing different types of care. The categorisation of women as high, medium or low risk was inappropriate and acted against personalisation of care.

Provision of services for rural populations

- 3.39. We heard much agreement that localising where possible and centralising where necessary is the right principle to follow, but that resource and geographic limitations make that difficult to deliver. In a number of areas that we visited, such as Cumbria, Lincolnshire, Devon and Northumberland, challenges have arisen through the difficulty in providing local services that are accessible for as many people as possible, but also safe and sustainable. In a number of rural areas, small obstetric units see a low number of births and face challenges in employing sufficient numbers of staff as well as ensuring that staff are exposed to enough cases to maintain and develop their skills and thereby deliver safer care.

⁵¹ MBRRACE-UK Confidential Enquiry Into Maternal Deaths 2015

⁵² Mental illness occurring amongst women in the period from conception to the baby's first birthday

CHAPTER 4: SHAPING THE FUTURE

Our vision is for maternity services to become safer, more personalised, kinder, professional and more family friendly; where every woman is able to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances.

And for all staff to be supported to deliver care which is women centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries.

- 4.1. Every woman, every pregnancy, every baby and every family is different. Therefore, quality services (by which we mean safe, clinically effective and providing a good experience) must be personalised.
- 4.2. We know that women are more likely to report a positive experience of childbirth, regardless of the outcome, if their care is personalised, if they are treated with respect and if they are involved in decision making. However personalised care and choice are not just about a woman's experience. It is increasingly evident that personalised care means safer care and better outcomes. We also know that when staff work in well led, positive environments and are supported to take pride in their work and to deliver high quality care, outcomes for women and their babies improve.
- 4.3. The review is not seeking to dictate how services are structured in every community, but to set out several key tenets which should be present universally to ensure that safer, personalised maternity services are available to all:
 - **Personalised care**, centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information.
 - **Continuity of carer**, to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions.
 - **Safer care**, with professionals working together across boundaries to ensure rapid referral, and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation, honesty and learning when things go wrong.

- **Better postnatal and perinatal mental health care**, to address the historic underfunding and provision in these two vital areas, which can have a significant impact on the life changes and wellbeing of the woman, baby and family.
- **Multi-professional working**, breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies.
- **Working across boundaries** to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed.
- **A payment system** that fairly and efficiently compensates providers for delivering high quality care to all women, whilst supporting commissioners to commission for personalisation, safety and choice.

4.4. This vision will require a new deal for women, babies and families; a new deal for healthcare professionals; and a new deal between organisations.

A new deal for women, babies and families

Personalised care

- 4.5. Women's maternity care should be personalised to their needs and those of her baby and family. Every woman is different, and will be starting on their pregnancy journey from different places – some may be first time mothers, others may have had babies before. Some will have had previous traumatic experiences. Some will be very young, others at the older end of the childbearing period. Some will have childcare to worry about. Some will have support from family nearby, others will not have any support.
- 4.6. Women should be able to make decisions about their care during pregnancy, during birth and after their baby's birth, through an ongoing dialogue with professionals that empowers them. They should feel supported to make well informed decisions through a relationship of mutual trust and respect with health professionals, and their choices should be acted upon.

4.7. Personalised care means:

- The development of a personalised care plan by the woman and midwife, built on the decisions each woman makes, and informed by an assessment of the type of care she might need. This will accommodate the risk involved, which recognises that risk is not binary or absolute, but seeks to accommodate that risk. The woman will have an honest, open and unbiased dialogue with health professionals, supported by evidence based information being available about their choices which are easily accessible. There must be sufficient time to have this dialogue.
- Choices being made available to all woman in terms of antenatal care and postnatal care; and of the type and place of birth (i.e. homebirth; in a midwifery unit; or in an obstetric unit in hospital) even if it means crossing traditional boundaries.
- Access to an NHS Personal Maternity Care Budget to ensure women are able to make their choices with the knowledge they will be realised.

4.8. Choice is not a tick box exercise and is not just about place of birth, although that is important for many women. Women want to make decisions about a range of aspects of their care, such as how to manage the pain of labour, the role that their birth partner will play, the type of postnatal support, how to feed their baby and many other things.⁵³

4.9. In practice this means choice begins as soon as a woman makes initial contact with maternity services and continues throughout her journey. When a woman makes contact with maternity services, her midwife should begin the dialogue with the woman and she should expect to have sufficient time and knowledge to discuss options. She may need to make some initial decisions about the antenatal care she wants; as her antenatal care progresses, possibly due to changing circumstances, she will need to discuss these decisions and make further decisions, including about care in labour and in the postnatal period. She should be able to change her mind as her pregnancy continues. Where appropriate, these discussions will require input from her obstetrician.

4.10. Every woman should develop a personalised care plan with her midwife. Where she needs more complex care, her obstetric team or other specialist should advise her in drawing up the plan. Where appropriate her partner or family

⁵³ National Perinatal Epidemiology Unit, Evidence Review

members should also be involved. The plan should be kept up to date and reviewed every time she seeks advice from a professional. It will help her understand her pregnancy and what it might mean for her care. It will help her manage her own health and that of her baby into the long term. It is vital that women have evidence based, unbiased information to make their decisions and develop their personalised care plan.

- 4.11. There has been a longstanding expectation that women should be given a full choice of place of birth: home birth, midwifery unit and obstetric unit, and this is endorsed by NICE guidelines.⁵⁴ However, as the National Perinatal Epidemiology Unit found in its 2014 survey of women's experience of maternity care,⁵⁵ it is not happening everywhere. Of the women surveyed, 25% were aware of all 4 options for place of birth, a further 40% were aware of 2 or 3 options and 33% had one choice only.⁵⁶ Clinical Commissioning Groups must make available maternity services that offer women the choice of home birth, birth in a midwifery unit and birth in an obstetric unit, and may need to commission collaboratively with others, or work across traditional boundaries. They may need to look to alternative and innovative providers such as midwifery practices and social enterprises to provide genuine choice for their community – Neighbourhood Midwives is one such provider in London.

Neighbourhood Midwives

Neighbourhood Midwives is an employee-owned social enterprise midwifery service offering personalised care packages for women throughout their pregnancy, birth and beyond. Almost all women have known their midwife at birth (98% in 2013/14), with just over half of births taking place outside of an obstetric unit. The organisation reports high numbers of babies breastfeeding at birth (95%) and breastfeeding at 6-8 weeks (82%), which research indicates can improve the health of both mother and baby.

⁵⁴ NICE clinical guideline 190: Intrapartum care for healthy women and babies, section 1.1

⁵⁵ Safety delivered: survey of women's experience of maternity care, Maggie Redshaw, Jane Henderson, National Perinatal Epidemiology Unit, University of Oxford, February 2015, section 3.9

⁵⁶ *ibid*, p 13.

4.12. To help women achieve their personalised care plans, an NHS Personal Maternity Care Budget should be introduced. This scheme would provide a simple mechanism to enable women to make a choice electronically. It could initially be trialled in several areas within 2016-17, supported by NHS England. Evaluation of the impact made in these areas would then take place, with a view to moving to widespread availability from autumn 2017. If the trial is shown to be successful, women who choose to use the NHS Personal Maternity Care Budget could use it to select their chosen provider who is accredited and integrated within the local governance arrangements. If a woman needs more complex care, procedures need to be established to transfer care to other providers. Annex C sets out more detail on this proposal.

Coordination and continuity

- 4.13. Women told the review team that they see too many midwives and doctors over the course of their pregnancy and the birth, and that they do not always know who they are and what their role is. For some women this leads to confusion and they are not able to build up a rapport with healthcare professionals. Relationship or personal continuity over time has been found to have a positive effect on user experience and outcome.⁵⁷
- 4.14. Just as importantly for safety and clinical effectiveness, if too many health professionals are involved without proper coordination, there may not be effective oversight of the care provided. Evidence shows that continuity models have an impact on improving safety, clinical outcomes, as well as a better experience.⁵⁸ In particular, there is evidence that for women who find services hard to access and navigate, they have improved access to care, and there is better coordination of their care between midwifery, specialist and obstetric services.⁵⁹ Pre-term births have also been found to be reduced through continuity of the care.⁶⁰

⁵⁷ The contribution of continuity of midwifery care to high quality maternity care: a report by Professor Jane Sandall for the Royal College of Midwives, April 2014, p6.

⁵⁸ Jane Sandall, Hora Soltani, Simon Gates, Andrew Shennan, Declan Devane, Midwife-led continuity models versus other models of care for childbearing women, Cochrane Library, September 2015

⁵⁹ The contribution of continuity of midwifery care to high quality maternity care: a report by Professor Jane Sandall for the Royal College of Midwives, April 2014

⁶⁰ Sandall, J. S. H, Gates S, Shennan A, Devane D, 2013. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews, CD004667.).

4.15. Therefore, the NHS should offer greater continuity of the healthcare professional supporting the woman, her baby and the family. It should involve:

- a midwife who will normally provide continuity throughout a woman's journey, if that is what she and her partner want;
- the midwife will usually work in and be supported by a small team of four to six midwives, one of whom could be a buddy and take responsibility for the woman's care if her midwife is not available;
- each team of midwives should have an identified obstetrician who can get to know and understand their service and can advise on issues as appropriate;
- having a midwife the woman knows at the birth. Ideally this will be her own midwife, but if that is not possible, a midwife from the same team of four to six; and
- where a woman needs on-going obstetric support, this should be from a single obstetric team and the care should be fully integrated across the midwifery and obstetric services.

4.16. The aim of providing continuity of carer is to ensure a woman will normally be looked after or supported by professionals she knows and trusts. A need for hospital based care should not mean a woman has to forego continuity. Where a woman knows from the very start of her pregnancy that she will have to go to the hospital most of the time because she needs specialist expertise or to be seen by a multi-professional team, she should be able to have a midwife based at the hospital and get to know the team there. There will be times when due to her circumstances she is looked after by staff she has not met if, for example, an unexpected complication or an emergency arises and she needs to stay in the obstetric unit. If possible the woman's midwife should be with her in the hospital to deliver the baby, working as part of the team with midwives and obstetricians working in these services, and helping to coordinate her care.

Safer care

4.17. Most women who contacted the review said that the safety of their baby and themselves was their primary concern. They expected that the health services and professionals caring for them would also have their safety as their priority.

4.18. Safety has underpinned a number of the key findings and conclusions from this review, which are set out in this chapter. They can be summarised as follows:

- **Women should be informed of risks and be supported to make decisions which would keep them as safe as possible.** This means that they must have their needs assessed by their midwife, and obstetrician if appropriate, as part of developing their personalised care plan; and provided with unbiased information to help them make their decisions as described in paragraph 4.10.
- **Once a woman has made her decisions, she should be respected and the services should wrap around her.**
- **There should be rapid referral and access to more specialist services when they are needed,** including: obstetric services in hospital, and in more specialist centres; perinatal mental health services; fetal medicine; and neonatal and paediatric services if they are needed once the baby is born, as described in paragraphs 4.33-4.36. If a woman is concerned about her health or that of her baby, these concerns must be listened to and professionals should act accordingly.
- **Women should have continuity in the person who is caring for them, their midwife and, where appropriate, their obstetrician.** Through a relationship of knowledge and understanding, the woman and her professional will be better equipped to recognise any changes to risk factors or where something might not be quite right, to ensure appropriate referral, as described in paragraphs 4.13-4.16.
- **Professionals should work together in a multi-professional team in the interests of the woman and her baby, seeking to keep them as safe as possible.** They should learn and train together, and never be reluctant to seek help or to provide help. Time should be made for multi-professional training, its uptake should be monitored and impact evaluated, as described in paragraphs 4.67-3.73.

- **Staff and teams must continuously measure the quality of their services,** they must learn from any serious incidents and mistakes, and seek to constantly improve the quality and outcomes they are delivering, as described in paragraphs 4.81-4.85.
- **When things go wrong, there should be a rapid investigation, support for staff involved, openness and honesty with the family, and provision made for their needs through a rapid resolution and redress system,** as described in paragraphs 4.61-4.63.
- **The leadership of all provider organisations must take responsibility for and attach priority to the safety of their maternity services.** They should have a board level champion for maternity services, regularly reviewing the measures of quality. Safety should be a priority item at Board meetings. The Board should take action where it is necessary. They should seek to promote collective leadership and a culture of multi-professional working and learning in their organisation, as described in paragraph 4.74-4.77.
- **Providers should work together as part of a Local Maternity System** to ensure that services are provided to meet the woman's choices and ensure that women and their babies are kept as safe as possible. Specialist care should be accessible when needed, and all providers should operate under shared clinical governance and protocols, as described in paragraphs 4.93-4.98.

Initiatives to reduce still births and pre-term births

In November 2015, the Department of Health announced a new ambition to reduce the rate of stillbirths, neonatal and maternal deaths in England by 50% by 2030. The government has committed to work with national and international experts to ensure that best practice is applied consistently across the NHS and that staff can review and learn from every stillbirth and neonatal death. As part of this commitment, maternity services will be asked to come up with initiatives that can be more widely adopted across the country as part of a national approach – such as appointing maternity safety champions to report to the board and ensuring all staff have the right training to enable them to identify the risks and symptoms of perinatal mental health.

Saving Babies' Lives is a care bundle designed to tackle stillbirth and early neonatal death in a focused way, and is the first national policy initiative which has sought to do this. It originated from a collective intent to improve care for babies in the antenatal and intrapartum periods, with the specific objective of reducing stillbirths. The four elements of Saving Babies' Lives are designed to improve practice in the areas of: smoking in pregnancy; fetal growth restriction; reduced fetal movement; and fetal monitoring during labour.

Digital information for improved choice and care

- 4.19. To improve quality of care, learning and productivity, the NHS needs to make it much easier for health professionals to collect and share data with each other and with those for whom they care. This means two things.
- 4.20. Firstly, this means investing in electronic, interoperable maternity records, from which data can be inputted once and can feed the data demands made of the service from Trusts, CCGs and the Maternity and Children's Data Set (MCDS). At the same time, it means investing in simple interfaces that minimise data entry time and allow health professionals to spend more time with women and their babies, as is happening in South Warwickshire.
- 4.21. NHS providers should invest in technological solutions that observe the following principles:
- Women, families and professionals should be able to access it, with the appropriate permissions from the woman
 - It should be accessible via a mobile device so that midwives can use it at booking and that it is accessible in community hubs and at home

- It should be accessible by staff at the community hub and hospital services, and connect with hospital records systems
- It should be accessible by all providers of maternity and maternity-related care within the local maternity system.

South Warwickshire - electronic notes system for maternity care

South Warwickshire midwives use a tablet computer to enter information into the electronic record. All referrals for ongoing care and specialist input are made via this portal. Where required, obstetricians, anaesthetists and neonatologists can access the record to plan their care interaction. This portal is updated for all subsequent appointments including scans and blood results. There is a homepage which includes a summary of the woman's care.

Data is recorded once and can be immediately shared with staff at the hospital. A patient portal is being developed allowing women to access their electronic record. The system has the potential to be more useful once current constraints are resolved, such as Wi-Fi coverage and information governance. The electronic record could link to GP and hospital systems allowing seamless transfer of information

4.22. Secondly, it means ensuring that all women have access to comprehensive digital sources of information. Most women and their families now rely on digital sources of information in all parts of their lives. Maternity care should be no different.

4.23. A number of websites and apps have already been developed by public, private and third sector organisations) to help women manage their pregnancy and childcare, such as the Baby Buddy App, by the charity Best Beginnings. This is to be encouraged.

Baby Buddy App

Baby Buddy is a free, electronically delivered health intervention produced by the charity Best Beginnings which guides women through pregnancy and for the first six months of their child's life. The app, which is endorsed by the Department of Health and many professional bodies, provides tailored information and interactive, health promoting features designed to inform and empower expectant and new mothers to encourage them to use local services and to help make "every contact count". Baby Buddy delivers pregnancy and parenting information and prompts for reflection and action, in the voice of a chatty, knowledgeable friend. This digital friend or "Buddy" is created by the user at download. Early evaluation of the application has indicated that the app is helping to increase parents' knowledge and confidence, look after

their own health, feel more prepared for the arrival of their baby, feel closer to their baby and get more out of appointments. Evaluation of the app has shown impact with all ages, but particularly among women under the age of 25. Best Beginnings plans to develop a version for fathers.

4.24. All women should have access to a comprehensive digital tool that offers them the information they need throughout pregnancy. It should help women and their families to:

- find the best information and advice to support each woman during her pregnancy;
- understand the choices and find the best service to meet each woman's needs;
- connect with peers online to share and learn from others' experiences;
- manage their own care, and book and access services; and
- enable women to feed back on their experiences of using NHS services.

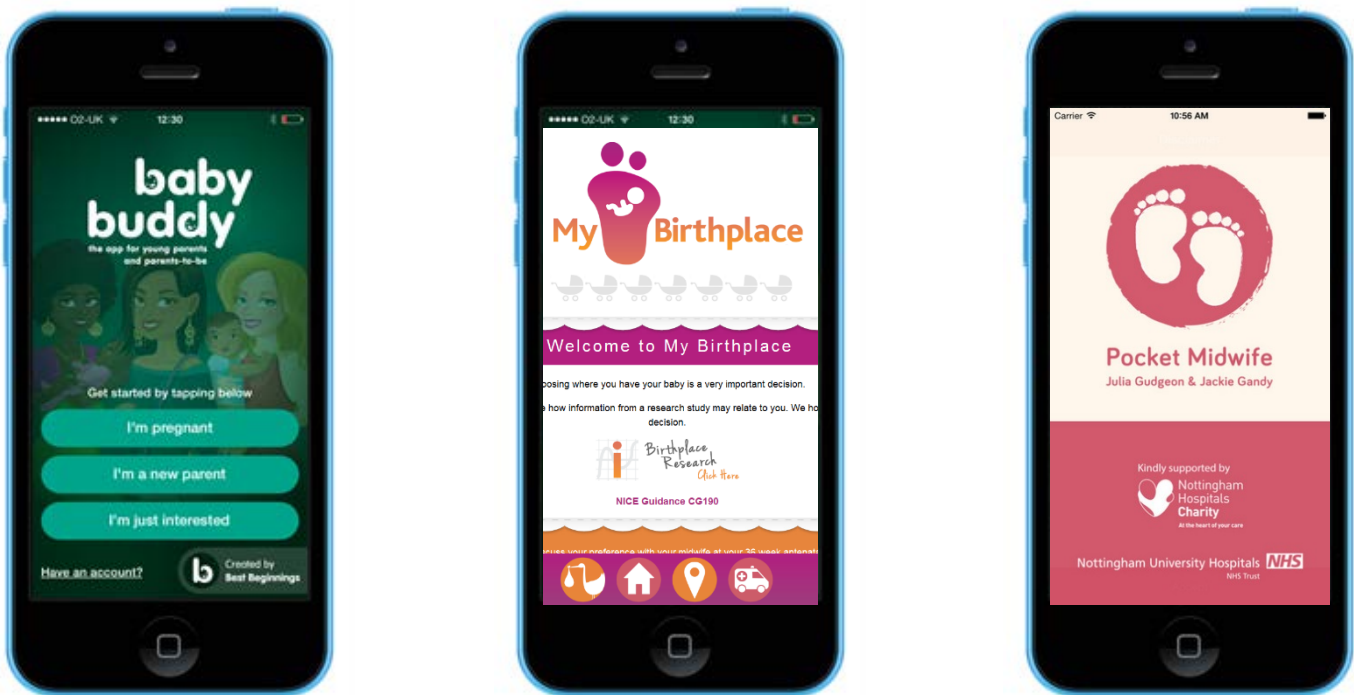
4.25. The digital tool should observe the following principles:

- harness the value and trust of the NHS brand and the traffic going to the NHS.UK domain (www.nhs.uk) to increase audience and broaden reach;
- bring together the best existing digital services, apps/tools and online information from the NHS and from other organisations to support high quality access to information and resources;
- be clinically supported and assured;
- be accessible and multi-channel – in plain English and use a combination of mediums (e.g. video, email, social media) to support accessibility needs and broaden reach; and
- It should leave nobody behind – it should align with digital inclusion and skills programmes and on-going work to promote digital accessibility.

4.26. Such a digital tool will have much greater value if it enables the personalisation of information. To that end, it must provide an interface with the woman's electronic

maternity record, so that she can access her own record and receive information that is tailored to her needs.

4.27. Research commissioned by the Department of Health confirms that women and staff see the potential value in an interoperable record and digital tool or app if the products or systems succeed in freeing up staff time to care and provide the woman with unbiased, reliable information. NHS England and the National Information Board (NIB) should as an urgent priority support the national roll out of interoperable electronic maternity records for professional use combined with support for a digital tool (or personal health record) for women.



Examples of currently available maternity apps: Baby Buddy (national), My Birthplace (Portsmouth) and Pocket Midwife (Nottingham)

Bringing care together in community hubs

4.28. The NHS needs to organise its services around women and families. Community hubs should be identified to help every woman access the services she needs, with obstetric units providing care if she needs more specialised services. Hubs, hospitals and other services will need to work together to wrap the care around each woman.

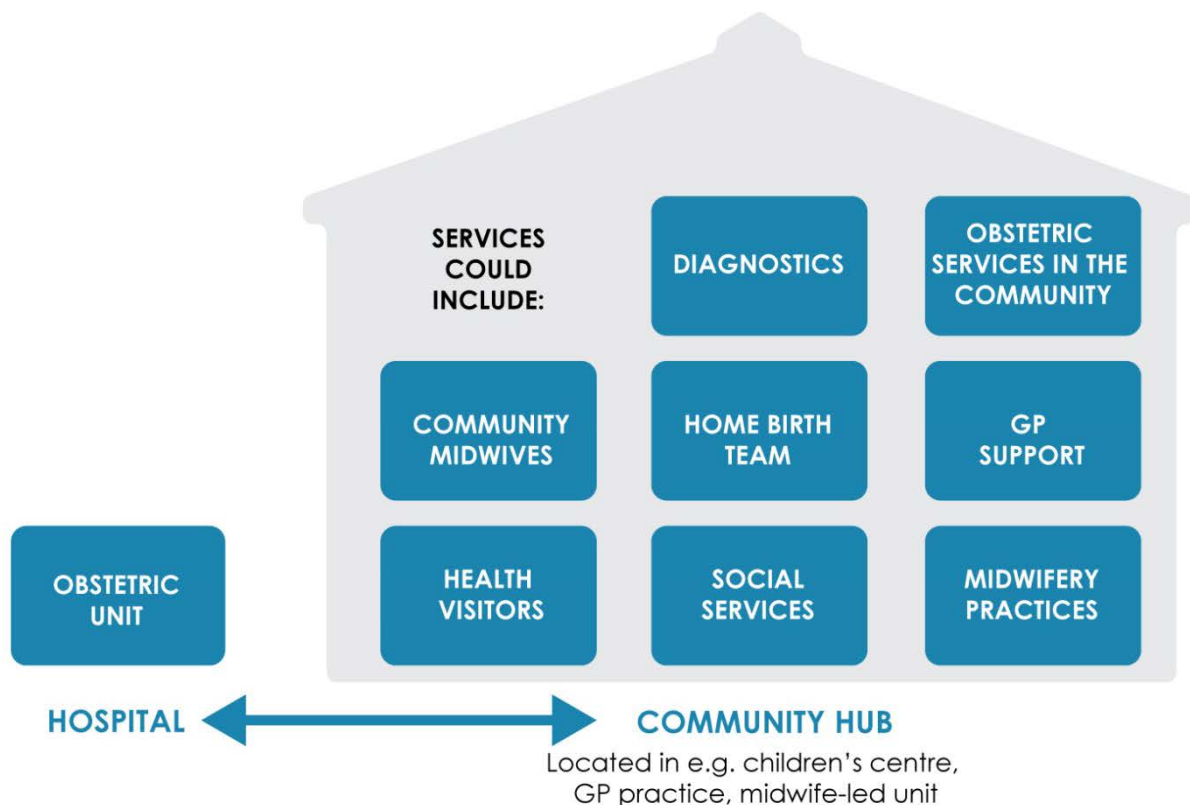


Figure 5: Community hubs

4.29. The concept of a community hub is that it is a local centre where women can access various elements of their maternity care, such as the Portsmouth Birth Centre. They could be located in a children's centre, or in a freestanding midwifery unit. They could be embedded in new at-scale models of primary care, including multispecialty community provider models being adopted by many GPs as part of the NHS Five Year Forward View implementation.

4.30. Different providers of care can work from a community hub, offering midwifery, obstetric and other services easily accessible for women. These might be ultrasound services, smoking cessation services or voluntary services providing peer support. Women may also be able to meet professionals who will be involved with them after childbirth, for example, their health visitor. In some community hubs there may be birthing facilities.

Barkantine Birth Centre, Barts Health NHS Trust, London

The Barkantine is a small freestanding midwifery unit co-located with a GP practice, dental surgery and a pharmacy. Although not physically connected to a hospital maternity unit, the birth centre is a part of the maternity services provided by the Royal London Hospital. They are well supported by the obstetric team and work closely with the London Ambulance Service in case a transfer is needed. All midwives use a common framework to explain birth choices and risks. The service provides active birth workshops including information on feeding and water birth, birth centre tours to help familiarise families with the centre and rooms and a 24 hour telephone support and advice. The Barkantine can support up to 600 births a year.

4.31. Community hubs will have two key purposes:

- **To act as “one stop shops” for many services.** This means different teams operating out of the same facility. Bringing services together in this way will make it easier for women to get the care they need, and achieve the choices they want.
- **To provide a fast and effective referral service to the right expert if a woman and her baby need more specialised services.** If a woman and/or her baby need specialist care or develop a complication, she will be referred quickly to her obstetrician (with whom the midwifery team has an existing working relationship). Or if she has or develops a mental health condition, she will be offered appropriate care.

4.32. This report does not seek to overly dictate the model of community hubs. Their nature and location will be dependent on what services are already available locally and what makes sense for the community. There should be close liaison between all community hubs within the local maternity system, and between the community hubs and obstetric units to ensure a seamless service for all women.

Community based maternity care in Portsmouth

At the Portsmouth Maternity Centre efforts are being made to encourage women with low risk pregnancies to consider a community based birth, either at the centre – a free-standing midwifery unit (FMU), in an alongside MLU (AMU) or at home. Women have evidenced based information via an app called ‘My Birthplace’. Midwives are integrated between the hospital and maternity centre, to ensure safe care for women in labour. The team includes maternity support workers who provide postnatal care in a clinic setting, allowing greater midwifery flexibility to support women’s choice.

Rapid referral when needed

- 4.33. A community hub approach will only work if it is supplemented by rapid identification of complications and referral to more specialist care, as it is at the Barkantine Birth Centre in East London. Around four out of every ten women will develop a complication that requires some form of more specialist expertise.
- 4.34. Crucial to rapid identification of complications will be the drawing up and continual review of the personalised care plan. Recent reports by MBRRACE-UK have highlighted that in many cases with adverse outcomes improved care may have made a difference simply by following national guidelines and recognising ill health in a timely fashion. This means in particular:
- Listening to women who express concerns and acting on what they say.
 - Joining up repeated presentations and identifying patterns (more continuity of carer should help with this).
 - Screening and identification of women to detect those at risk of developing conditions such as diabetes in pregnancy.
 - Taking risk factors adequately into account, such as the mother's age or ethnicity.
 - Taking account of pre-existing physical and mental health conditions and providing specialist care.
 - Undertaking basic observations when symptoms arise, such as reduced fetal movement.
 - Accurate measurement of the baby's growth.
 - Providing appropriate care for women pregnant with more than one baby.
- 4.35. Women who require more specialist care, perhaps due to pre-existing conditions or because complications arise, may need care provided by obstetricians, midwives and other specialists in the hospital. This should be offered as soon as complications are identified, and care should be personalised around the needs of the woman and her baby. For example, diabetic mothers may be offered appointments at least every 4 weeks in the diabetic clinic where care from the multi-professional team, including diabetologists, sonographers, specialist nurses,

obstetricians and midwives will work together.

4.36. Services need to be planned to allow for high quality consultation between professionals and referral from one level of care to another as appropriate. High quality consultation can be assisted by each team of midwives having an identified obstetrician who can get to know and understand their service and can advise on issues as appropriate. Transfers between services should be facilitated by establishing clear referral protocols, although a care pathway needs to be flexible. Women may be suitable for antenatal care in the community but may be advised to give birth in the obstetric unit or others may need specialised care in the antenatal period but be able to give birth in a midwifery unit.

Improving prevention and reducing health inequalities

4.37. Most babies and children in England are healthy and well but there are significant variations and inequalities in health, education and social outcomes across the country with children from poorer backgrounds more likely to have poorer outcomes. Too many children do not have the start in life they need, leading to inequalities in later life, high costs for society, multi-generational cycles of disadvantage and too many affected lives.

4.38. There is evidence indicating real inequalities in outcomes for babies, for example:

- A baby born in Blackpool is more than nine times more likely to be born to a mother who smokes than a baby born in Westminster.
- A six to eight week old baby in Wandsworth is nearly four times more likely to be breastfed than a baby of the same age born in Knowsley.
- A child in Tower Hamlets is more than five times more likely to be living in poverty than a child born in Wokingham.
- Babies that are Black or Black British Asian or Asian British have a more than 50% higher risk of perinatal mortality.
- Babies whose mothers live in poverty have a 57% higher risk of perinatal mortality.

- 4.39. Smoking is the single biggest modifiable risk factor for poor birth outcomes and a major cause of inequality in child and maternal health outcomes.⁶¹ Smoking during pregnancy causes up to 2,200 premature births, 5,000 miscarriages and 300 perinatal deaths every year in the UK.⁶² It also increases the risk of developing a number of respiratory conditions, still birth, giving birth to a child with a congenital malformation, gastrointestinal defects, learning disabilities such as impaired general reasoning and verbal competence, and obesity.⁶³
- 4.40. The Chief Medical Officer's 2015 annual report highlighted serious concerns about the effects of obesity in women before and during pregnancy. It explains that the recent increase in obesity among women of reproductive age not only influences their health, but also increases the risk of complications during pregnancy and is likely to compromise the health of their children:⁶⁴
- For the mother – decreased fertility; increased risk of miscarriage, gestational diabetes and perinatal complications.
 - For the foetus – increased risk of stillbirth, metabolic abnormalities and developmental abnormalities.
 - For the child – increased risk of obesity, diabetes and hypertension (high blood pressure).
- 4.41. For many people, pregnancy may be the first time they have sustained contact with health services. To reduce health inequalities families of all backgrounds need the right care, support and information that take account of individual needs and barriers to health.
- 4.42. Maternity services must recognise the unique role they can play in supporting parents of all backgrounds to maximise their own mental and physical health whilst also equipping parents with the skills, information and confidence to maximise their child's emotional, physical and cognitive development.⁶⁵ The proposals in this report are designed to enable maternity services and health

⁶¹ The Health of the 51%: Women, p55

⁶² *ibid*

⁶³ *ibid*

⁶⁴ *ibid*

⁶⁵ Guidance for NHS commissioners on equality and health inequalities legal duties
<https://www.england.nhs.uk/wp.../hlth-inqual-guid-comms-dec15.pdf>

professionals to fulfil this role, in particular: those relating to information and technology to support women in making choices; delivering care closer to home through community hubs; more continuity in care; and a systematic upgrade in mental health support and postnatal care.

- 4.43. In addition, the Healthy Child Programme for the early life stages focuses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews and advice around health, wellbeing and parenting. The programme is led and provided by health visitors (qualified nurses and/or midwives with additional training in child and family health).
- 4.44. After the birth of the baby, the midwife will hand over to the health visitor. The importance of maternity services working with and ensuring a proper handover to health visitors has already been outlined. Good outcomes are seen when midwives and health visitors work together on issues like breast feeding and maternal mental health in pregnancy. Health visitors provide expert information and support to families, developing relationships that enable difficulties to be identified early and help to be offered when needed. The health visiting service provides health reviews including those at 28 weeks of pregnancy, within 14 days of birth and 6-8 weeks. There are six high impact areas for health visiting services of which three are in the perinatal period: transition to parenthood, breast feeding support and perinatal mental health.

Choto Moni Children's Centre, Leeds

Choto Moni Children's Centre and the National Childbirth Trust have worked in partnership to provide antenatal courses and support for families for ten years. The courses are delivered in a deprived area of the city and are primarily attended by women who are refugees or seeking asylum. Choto Moni provides a drop-in, rolling programme, run weekly for two and a half hours. Each session starts with introductions to break down barriers. The content is totally group-led which requires skills in flexibility and adaptability from the facilitator. This ensures the parents take responsibility for their own learning rather than being told what to do. Discussion and practice of physical skills for pregnancy, birth and parenting takes place for 90 minutes followed by one hour of sewing led by a local mum, offering socialising and support for individuals. During this time, parents mix together and individuals can receive support from the facilitator, the children's centre manager or a breastfeeding peer supporter.

In addition to maternity issues, parents seek help with form filling, housing, domestic abuse and other difficulties and may need referring to appropriate services. During antenatal sessions, a free crèche is provided in an adjoining room, alongside the postnatal group. This enables women with children to attend and have space to focus on their unborn child.

Mental health support for all

- 4.45. The mental wellbeing of women and their families is as important as the physical wellbeing of the women and developing baby – the NHS needs to consider this in an integrated way. Up to 20% of women will experience a mental health problem during pregnancy or within the first year after having a baby. In this situation, women and their families need timely access to high quality, evidence-based care. Although there has been progress in recent years, there is more to do to ensure that women in all areas of the country have access to the right care, closer to home, when they need it.
- 4.46. Maternity services have a key role to play in the system, both in terms of identification and provision of support. As the report of the Mental Health Taskforce⁶⁶ makes clear, an integrated response to mental and physical health needs is vital to provide personalised care built around the needs of the individual. This is absolutely true for maternity services and some of the key improvement measures outlined in this report will also improve identification and access to mental health support for women.
- 4.47. Firstly, mental health should always be considered as part of the personalised care plan and reviewed at every contact. Midwives must have sufficient time to have quality conversations with women before and after birth. More continuity of carer should help by enabling midwives to get to know women better and increase mutual trust. The community hub may provide opportunities to make it easier for women to access a range of services and support in one place, or have swift, onward referral where specialist input is required.
- 4.48. In addition to these universal improvements, professionals need the right training and skills to be able to identify, manage and refer to appropriate specialist support for perinatal mental health conditions. The Mental Health Taskforce set the ambition of at least 30,000 more women each year having access to evidence-based specialist mental health care during the perinatal period by 2020/21. The maternity review strongly supports this. Care should include access to psychological therapies and the right range of specialist community or inpatient

⁶⁶ The Five Year Forward View for Mental Health, Mental Health Taskforce, February 2016. <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

care so that comprehensive, high-quality services are in place across England in line with NICE guidelines.⁶⁷

North East London Foundation Trust (NELFT) Perinatal Parent Infant Mental Health Service

This multi-professional service enables women in the London boroughs of Barking and Dagenham, Havering, Waltham Forest and Redbridge to access a wide range of support including psychiatry, psychology, psychotherapy, counselling and a range of joint clinics between mental health specialists and obstetricians. The service remit covers maternal and infant mental health from pre-conception advice and psychiatric treatment until 1 year postnatally and parent infant psychotherapy up until the infant reaches 3 years of age. The services are commissioned by CCGs, NHS England and Local Authorities (public health and children's services). The area covered by the service serves around 17,000 births each year, with a budget of £1,077,559 for 2015/16.

The NELFT Service is an integrated Perinatal and Parent-Infant Service, so is able to offer a range of treatment. NELFT offers services across CCGs making it easier when patients move boroughs and more economical through cross-borough cover and sharing of resources. A single referral system improves efficiency and access. Outcomes include less likelihood of relapse in psychotic illness; less likelihood of the need for ongoing secondary mental health services upon discharge from the service; a high rate of service user satisfaction; and compelling evidence of improved attachment security in many of the babies at 12 months.

More support after the birth

- 4.49. Caring for the woman and baby after birth is equally as important as during pregnancy and birth. Current postnatal services are under-resourced and overlooked and,⁶⁸ in the view of the Chief Medical Officer, unfit for purpose.⁶⁹ Commissioners and providers must attach sufficient importance to securing high quality neonatal and postnatal care in order to give women and their babies the best start in family life.

⁶⁷ NICE clinical guideline 192: Antenatal and postnatal mental health: clinical management and service guidance

⁶⁸ <https://www.rcm.org.uk/news-views-and-analysis/news/postnatal-care-%E2%80%98starved%E2%80%99-of-resources>

⁶⁹ The Health of the 51%: Women, p97.

4.50. Postnatal care should be led by the woman's own midwife, who should help her to develop the element of her postnatal personalised care plan, and provide care alongside others, including as appropriate maternity support workers, to:

- Support her to care for herself and her baby including ensuring she knows when to contact her midwife for support and advice.
- Perform the new-born examination.
- Facilitate minor common medical interventions without separating her from her baby ('transitional care').
- Support her in feeding her baby in accordance with her personalised care plan.
- Involve her partner, family and friends who will play a key part in supporting her to raise her child.
- Signpost her to voluntary sector and other community support.
- Keep under review the physical and mental health of the mother and provide rapid referral to more specialised services including when complications or trauma have arisen during labour and mental health services.
- Keep under review the health of the baby, including difficulties in feeding and responsiveness that may indicate underlying concerns (such as sepsis and jaundice).
- Include a comprehensive handover to the health visitor for the baby and to the GP or other health professionals involved in care prior to pregnancy for the woman's own ongoing health.

4.51. For most women, postnatal care should consist mainly of support for transition to motherhood, including breastfeeding, but it has a crucial role to play in identifying complications and ensuring referral to specialist care. Local maternity systems need to be organised to support midwives to identify and respond to these complications, including ongoing hypertension, deep vein thrombosis, developing sepsis of mother and baby and postnatal mental health concerns. For mental health, this means asking about maternal wellbeing and looking for early signs of mental health issues needing referral.

- 4.52. The six week appointment by GPs is a particularly crucial element of post-natal care. From research carried out by NCT and Netmums, 45% of mothers surveyed felt their six week postnatal check-up was not thorough enough and, with appointments typically lasting less than 10 minutes, a quarter (26%) felt their check was rushed. Three out of ten women (29%) said their GP did not ask them about any emotional or mental health issues.⁷⁰
- 4.53. Women need to be clear about what the appointment will cover and that a separate time will be available for the baby's check. The check should include assessing:
- how a woman has made the transition to motherhood, including her mental health;
 - her recovery from the birth, using direct questions about common morbidities;
 - longer term health risks for any morbidity identified;
 - any further help she might need whether connected with the birth or not; and
 - what advice she might need about future family planning.
- 4.54. Where a woman suffers a pregnancy or birth related trauma, there should be a multi-professional de-brief and handover between labour and postnatal care, and her personalised care plan should be updated in discussion with the woman to ensure that her physical, psychological and emotional needs are met. This is particularly true of perineal damage where early intervention can make a big difference in long term morbidity. It is important that the mother gets appropriate advice and support.
- 4.55. The benefits of breastfeeding are clear. Breastfeeding improves children's physical health by reducing infections, obesity, diabetes, allergic diseases, and sudden infant death; but it can also improve educational achievements and reduce social inequalities. Neuroscience research is showing that the baby's brain develops in close bodily contact with the mother and that their hormones are physiologically programmed to work together to form stable, trusting, primary attachments. This can provide the child with a natural safety net against the worst

⁷⁰ <https://www.nct.org.uk/press-release/nct-netmums-research-finds-six-week-postnatal-check-unsatisfactory>

effects of poverty.⁷¹ The mother's health will also benefit from reduced incidences of breast and ovarian cancers, diabetes, osteoporosis and coronary artery disease.⁷² Despite this women told us that care was poor. There needs to be much better support for breastfeeding focused on practical help that supports and empowers women, rather than pressurises them.

Encouragement of breastfeeding in Harrow

In Harrow, a multi-ethnic London borough with high infant mortality rates, and areas of deprivation and poverty, the Director of Public Health identified breastfeeding as a top priority for 2006. A multi-professional approach was adopted with Harrow Community Health Services working with the local hospital to improve breastfeeding rates. UNICEF Baby Friendly training was commissioned for midwives, health visitors and support staff in 2007. A peer support training programme began and mothers were recruited from a local support group. A network of breastfeeding support groups was established running from children's centres, eventually achieving one every day within walking distance for all mothers. In 2008, Bump to Breastfeeding DVDs were given to every pregnant woman by midwives, health visitors and peer supporters. Harrow became accredited as Baby Friendly in 2012 and the local hospital gained the award in 2013.

The staff training, peer support programme and free DVDs increased breastfeeding rates, so by 2010 initiation rates had risen to 82% and 6-8 weeks to 73%. By 2013, Harrow had 87% of mothers initiating and 75% breastfeeding at 6-8 weeks (50% exclusively), with one of the lowest drop-off rates in the UK. UNICEF assessed Harrow for its re-accreditation in 2014 and stated that it was the only local authority in the UK where breastfeeding was the 'normal' way to feed babies.

Neonatal care

- 4.56. Maternity services cannot be considered in isolation and are inextricably linked to neonatal services, which are key in delivering optimal outcomes for babies. Nationally these are delivered by operational delivery networks with well-defined

⁷¹ <http://www.unicef.org.uk/Media-centre/Press-releases/Support-breastfeeding-to-reduce-effects-of-poverty-says-new-report/>

⁷² <http://www.unicef.org.uk/BabyFriendly/News-and-Research/Research/Breastfeeding-research---An-overview/>

service standards for all levels of neonatal care,⁷³ within the NHS England Maternity, Children and Young People Managed Clinical Networks. These are intended to provide appropriate levels of care for all babies identified with problems both before and following delivery.

- 4.57. In the event of neonatal complications, there needs to be quick referral and availability of world class specialist services for the woman and her baby. This might involve care in a specialist neonatal unit where the doctors and nurses with the greatest expertise work. However, the baby will be cared for as close to home as possible at the nearest appropriate centre. So that the woman is not separated from her baby, any ongoing care she needs should be transferred to the same location and neonatal services should include accommodation and assistance for parents. Parents should be actively encouraged to participate in their baby's care on the neonatal unit and in discussions and decision-making with the neonatal team.
- 4.58. Difficulties have been highlighted with medical and nurse staffing numbers, nurse training, provision of support staff and cot capacity.⁷⁴ A review of the safety and sustainability of neonatal services (particularly in remote and rural settings) was specifically recommended in the Report of the Morecambe Bay Investigation.⁷⁵ In the time frame in which the National Maternity Review was conducted, it was not possible to review neonatal services concurrently. A dedicated review should be taken forward, in light of the findings of this review and its consequences for neonatal services. The neonatal review should include the payment arrangements for neonatal services, in the context of the wider payment system for maternity services, and whether a neonatal tariff should be developed.

When things go wrong

- 4.59. Occasionally something goes wrong before, during or after labour and a child is left severely disabled or dies. This is a very rare occurrence, but the results are extremely serious and have a lasting impact on the woman, her baby and her family. This lasting damage for parents can be made worse by poor communication, failure to investigate properly and to learn. In the most serious cases, lengthy, repetitive processes to establish fault and the right to

⁷³ The Toolkit for high quality neonatal services – NHS and Department of Health, 2009.

⁷⁴ Bliss baby report 2015: hanging in the balance, 2015

⁷⁵ Recommendation 20

compensation through the courts can have an unacceptable toll on the family. Staff involved in the incident can be emotionally damaged too and feel unsupported in dealing with the aftermath.

- 4.60. After such incidents there must be a comprehensive multi-professional investigation resulting in local learning, and an open and honest explanation. At present there is no standard approach to investigating when something goes wrong, and therefore it is undertaken very differently across different organisations. Some involve external, independent input; others do not. Some involve families in a compassionate and caring way; others do not. Some approach the exercise with a genuine desire to learn and improve quickly; others do not. Some can demonstrate genuine action plans leading to changes in practice; others cannot. This cannot be acceptable, when the implications for families of such incidents are so great. Furthermore, the financial implications for the NHS are significant.
- 4.61. There needs to be much greater consistency in the standard of local investigations of perinatal mortality, neonatal mortality, maternal death and serious morbidity. The new Health Safety Investigation Branch (HSIB) should set a common, national standard for high quality serious incident investigations. These should be carried out under the auspices of regional maternity clinical networks as described in paragraph 4.99 to ensure that they are carried out by experienced experts and that the learning is shared widely.
- 4.62. The review supports the underpinning principles for perinatal mortality review as developed by the Perinatal Mortality Review Task and Finish Group and welcomes the Department of Health's funding of a standardised nationally accepted tool for perinatal mortality review. The Department of Health should consider how this tool could be expanded to cover neonatal mortality, maternal death and serious morbidity.
- 4.63. Where the harm was caused by acts or omissions related to care during term labour, a financial settlement should be provided to support the baby's care. To provide a more rapid, caring response to serious harm and develop a stronger learning culture and improved outcomes, the Department of Health should give serious consideration to the introduction of a "rapid resolution and redress" scheme, similar to the administrative compensation model in place in Sweden. Such a scheme would pay out for birth injuries without families needing to go to court and prove negligence in a lengthy and difficult process. Removing the threat of individual clinicians being branded negligent would improve the effectiveness of serious incident investigations, and help ensure that similar

mistakes were avoided. Proposals on how this scheme might be constructed are set out at Annex C.

Swedish insurance model - a base for improved learning and outcomes

Sweden introduced an insurance system, covering all medical injuries, in 1975. Under this scheme injuries are compensated by healthcare insurers on the basis of whether or not the harm was considered to have been avoidable rather than on the basis of fault.

Sweden has seen a 50% reduction in avoidable serious birth injuries over the past 6-7 years. The Swedish insurers attribute this reduction, in part, to the introduction of the insurance model. In their view this helped build trust and transparency amongst the different maternity professions, making subsequent training, data collection and peer review initiatives more successful.

4.64. Families whose baby has suffered harm or has died will inevitably experience extreme distress. While staff cannot remove that distress they can ensure that the care families receive is compassionate and does not further add to their grief. Healthcare professionals should consider the principles of good care that have been developed by Sands, from which we have drawn out the following:⁷⁶

- Acknowledge what has happened and the impact on parents, treating them with dignity, respect and genuine empathy.
- Care should be parent-led, ensuring parents have time, information and additional support to make decisions that are right for them and their baby.
- Communicate clearly, sensitively and honestly with families, without making assumptions about the significance of their loss or their preferences regarding their care.
- The hand-over of care from hospital to primary care staff should ensure that support and care for parents are seamless.
- Give clear information about the next steps regarding the investigation of the incident and keep families involved and informed throughout the investigation process.

⁷⁶ Pregnancy Loss and the Death of a Baby: Guidelines for professionals - Schott J, Henley A, Kohner N, 2007 Sands.

- After a robust investigation of the incident, if any failures of care are identified these should be honestly acknowledged to the parents in line with NHS Duty of Candour requirements, and a sincere apology offered.
- Recognise the impact on staff and have appropriate support structures in place to support them to report adverse events and to deal with their own emotional reaction to the incident.

4.65. In conjunction with the Sands principles, NHS staff should consider the MBRRACE report on term antepartum stillbirths⁷⁷ which highlights key areas for action, including:

- Obstetric and midwifery care during labour for women following stillbirth should be of the same in quality and content to that of women having a healthy birth.
- All parents of a stillborn baby should be offered a post-mortem. This offer should be clearly documented in the mother's notes.
- All parents should be offered a timely follow-up appointment with a consultant obstetrician to discuss their care, the actual or potential cause, chances of recurrence and plans for any future pregnancy.
- A summary of the follow-up appointment should be written in plain English and sent to the parents and their GP.

4.66. Specific training programmes on this type of communication and specialist bereavement services for families and staff are also valuable in allowing for high quality care to continue to be delivered in these circumstances, as is the case at St Mary's Hospital in Manchester.

⁷⁷ Perinatal Confidential Enquiry 2015, November 2015

St Mary's Hospital, Manchester – Preventing Stillbirth and Improving Care for Bereaved Parents

To prevent stillbirths and improve care for bereaved parents, St Mary's Hospital, Manchester has implemented a programme of perinatal audit, a dedicated bereavement service and specialist clinics which translate research into clinical practice for women at increased risk of stillbirth such as those with small for gestational age infants, women with a history of stillbirth and women with hypertension.

Central to this approach is partnerships with key stakeholders such as Tommy's and Sands.

In this programme, all perinatal deaths are reviewed by a multidisciplinary team and the cause of death classified. These data can be compared to previous years and areas identified for improvement. This combined programme of audit and research has seen a reduction in stillbirth by 29% in five years from 6.9 per 1,000 live births to 4.8 per 1,000 live births in 2014.

Since 2011, a specialist bereavement team including bereavement midwives, family services, obstetrician, neonatologist, mortuary staff and pathologists have developed care, including introduction of a new post mortem consent form, a standardised care pathway and peer support for parents. This approach is associated with improvements in patient experience after stillbirth.

This model of care is being extended across the North West region by dissemination of the specialist clinical services and implementation of a guideline and integrated care pathway for stillbirth.

A new deal for healthcare professionals

Multi-professional team working

- 4.67. Nobody goes to work intending to provide poor care. However, barriers placed between people (professional and organisational) can result in care being delivered in silos; where communication and trust between professions and with pregnant women is poor; where learning and reflection are not supported; and there is a lack of accountability for outcomes. Maternity services by their nature are multi-professional – midwives will provide much of the ongoing care during pregnancy and after the birth, but most women will require medical input at some point during their pregnancy and birth. There are at least 18 specialities and professional groups involved in maternity care.
- 4.68. Therefore, professionals must work together. Care delivered in silos is not safe care and the Morecambe Bay investigation report showed how serious the results of this type of closed culture can be. The most important factor in securing a safe and personalised service is an effective multi-professional team.
- 4.69. Our ambition is for multi-professional teams to be working effectively and respectfully within and across organisational boundaries to provide seamless, high quality, responsive and kind care to women and their babies.
- 4.70. Effective or “real” multi-professional teams train together to improve outcomes for women and babies, and enjoy increased job satisfaction as a result.⁷⁸ Real teams share common rituals and practices: as well as training together they often socialise together; they are respectful of input from different professions; they communicate well in a variety of different situations (every-day and emergency); they have clear protocols in place for dealing with emergencies and transfers; they share leadership according to the situation and are not dominated by one individual; they regularly review case data in an open and inquisitive way that allows them to improve their practice; and they work in partnership with women wherever possible.⁷⁹

⁷⁸ Attitudes Toward Safety and Teamwork in a Maternity Unit With Embedded Team Training, Siassakos et al. American Journal of Medical Quality, October 8 2010

⁷⁹ Real teams or pseudo teams? The changing landscape needs a better map, West, Michael; Lyubovnikova, J.R. Industrial and Organizational Psychology, Vol. 5, No. 1, 2012, p. 25-28

4.71. The NHS should support multi-professional team based learning, mutually respectful relationships and therefore quality improvement by:

- increasing training opportunities for shared learning and reflection (paragraphs 4.72 and 4.73);
- removing unnecessary data burdens to increase the time available for reflection and quality improvement (paragraph 4.82);
- encouraging teams to proactively ask for outside help, e.g. from the Royal Colleges (paragraph 4.79);
- following a consistent process for serious incident investigation (paragraphs 4.60-4.62); and
- encouraging greater involvement of women in their decisions (as described in paragraphs 4.5-4.10).

Education and training

4.72. The NHS should use education and training to break down the boundaries between professional groups and establish greater team working. The importance of multi-professional working should be introduced to students from the very start of their careers. Students of all disciplines should be exposed to a range of practice situations which allow them to gain insight into each other's roles and responsibilities and all aspects of maternity services provision.

4.73. Shared training should continue as a part of continuous professional development. The maxim must be "If you work together you train together." This should embrace education around day to day practice and coping with emergencies including: supporting women to make informed choices; implementation of new guidelines; human factors training; communication with each other and with women; high quality team working; and learning from reflection. Most importantly, training undertaken must have been proven to have been effective in improving outcomes or other aspects of quality and its impact monitored locally.

North Bristol NHS Trust – a framework for learning

The maternity team at Southmead Hospital have designed an evidence-based multi-professional training programme (PRactical Obstetric Multi-Professional Training, “PROMPT”) to improve outcomes for women and babies. The training, which takes place locally in clinical areas and a homebirth setting, is attended annually by all maternity staff: midwives, maternity theatre staff, maternity support workers, obstetricians and anaesthetists. Using practice-based tools, workshops and emergency drills with simple props, high fidelity mannequins and patient actors, PROMPT aims to optimize management of obstetric emergencies. Published research has demonstrated an association between PROMPT at Southmead and: a 50% reduction in babies born with a low Apgar score,⁸⁰ a 45% reduction in school-age cerebral palsy, a 100% reduction in permanent brachial plexus injury after shoulder dystocia, and a 91% reduction in litigation claims. PROMPT has been introduced in other countries – including the USA, Australia, and Zimbabwe – with similar published improvements in perinatal outcomes.

Early findings of an independent study led by the University of Leicester confirm that PROMPT develops high level technical skills as well as excellent team skills. But PROMPT cannot be treated as a one-off intervention; achieving safety requires constant effort and attention and genuine commitment by all team members, regardless of specialty or role. Early analysis also indicates that other features of the way the team at Southmead operates are important in the outcomes it has achieved, including: intelligent use of data, engagement in continuous improvement, and high-quality communication and relationships between team members. The full findings of this independent study are expected to be published in 2016.

Collective leadership for a multi-professional, learning culture

- 4.74. Front line teams do not operate in a vacuum; leadership is the key determinant of the organisational culture in which front line teams operate. In maternity services, where there are clear leadership roles and channels for both midwifery and obstetric professionals, it is vital that there is collective leadership to create a multi-professional and learning culture.
- 4.75. Midwives and obstetricians, including their management and leadership, must work together as part of a single team focussed on the needs of the women and babies in their care.

⁸⁰ The Apgar score is a practical method for assessing the condition of the new born infant and is calculated by scoring the heart rate, respiratory effort, muscle tone, skin colour, and reflex irritability.

- 4.76. It is ultimately the responsibility of the boards of provider organisations to ensure that the culture, systems and processes exist within their organisations to ensure the provision of excellent maternity care and to monitor the quality of the care provided and its associated outcomes on a regular basis. They should identify a board level champion for maternity services.
- 4.77. Provider leadership needs to actively encourage, support and monitor the culture and leadership within their organisations. Teams and individuals must be actively supported and recognised. Organisations could use cultural barometer tools to understand and track their cultural development. A learning culture will also be supported by the routine and systematic measurement and analysis of data on quality and outcomes to drive improvement, as described in the following section.
- 4.78. Commissioners should take an interest in the culture of the maternity services that they are commissioning for their communities, as this will be a key determinant of quality and outcomes. They should look at the outputs of any cultural barometer tools used by the organisation, as well as regularly reviewing quality and outcomes data.
- 4.79. There should be multi-disciplinary peer support, through multi-professional teams on a regional basis offering advice and support when requested from services, local maternity systems or commissioners. Local teams and professionals should be encouraged to ask for help from colleagues and from external sources to support them to improve, such as the Royal Colleges.

Cultures of High Quality and Compassionate Care

Extensive research has demonstrated key elements of NHS cultures vital for ensuring cultures where high quality, continually improving and compassionate care are the norm – ‘it is the way we do things around here’.^{81, 82} These elements are:

1. Prioritising an inspirational vision and narrative – focused on care quality and compassion

This means leaders from the top and throughout the organisation focusing on, understanding, supporting and prioritising ways of supporting staff to deliver high quality compassionate care and modelling and embodying the values of the NHS and their organisation.

2. Clear aligned goals and objectives at every level

Visions and strategies must be translated into a limited number (no more than five or six) of clear, agreed, challenging objectives for every team and every individual throughout the organisation focused on high quality care, compassion and improving quality. This includes the executive team and the board. Helpful and accurate data on performance against those objectives should be provided for all in order that they can improve performance.

3. Good people management and employee engagement

If we want staff to treat patients with respect, care, compassion and dignity, we must treat staff with respect, care, compassion and dignity. Levels of staff stress in the NHS are the highest of any sector and staff consistently report a lack of compassion shown to them from leaders and managers within their organisations. Creating conditions for high levels of staff engagement is vital and that requires positive, supportive, appreciative environments while ensuring staff are accountable for safe, compassionate care.

4. Continuous learning and quality improvement

In learning organisations, staff are encouraged and motivated to focus on improving quality; there is team learning and cross boundary cooperation, trust, and openness;

⁸¹ Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study. Dixon-Woods, M., Baker, R., Charles, K., Dawson, J., Jerzembek, G., Martin, G., McCarthy, I., McKee, L., Minion, J., Ozieranski, P., Willars, J., Wilkie, P., & West, M. (2013). *British Medical Journal Quality and Safety*, 23, 106-115. doi:10.1136/bmjqs-2013-001947

⁸² Collective leadership for cultures of high quality health care. West, M. A., Lyubovnikova, J., Eckert, R., & Denis, J.L. , (2014), *Journal of Organizational Effectiveness: People and Performance*, 1, 240 – 260. <http://dx.doi.org/10.1108/JOEPP-07-2014-0039>

and there are high levels of dialogue and discussion, end to end and top to bottom within cultures of high quality care.

5. Team-working, cooperation and integration

Multi-professional team working is fundamental to the delivery of high quality, continually improving and compassionate care to patients and service users. Teams should agree clear, challenging, shared objectives with data on performance in relation to these objectives; roles must be clear within the team; and they must take time out on a regular basis to review their performance and how it can be improved. Moreover, multi-professional groups should train together within their organisations to build trust, respect and collaboration.

6. Via a values-based, collective leadership strategy

The highly skilled and highly motivated workforce that constitutes the NHS will respond positively to a collective leadership approach rather than a directive, controlling approach. This means everyone understanding their leadership responsibility; shared leadership in multi-professional teams; collaboration between leaders focused on prioritising patient care overall rather than just their areas of operations; and consistent styles of leadership that ensure cultures of high quality, continually improving and compassionate care.

4.80. A key element of a multi-professional, learning culture is fostering a just culture in which discussion of mistakes can take place. The new approach to investigating incidents and compensating families when things go wrong, described at paragraphs 4.59-4.63 above are designed to help promote such a culture.

Data to support and foster a learning culture

4.81. If teams, organisations and systems are to improve, they must know where they are, how they compare to others and to the best, and how they are improving over time. Collecting the right information and making the best use of it is therefore vital.

4.82. This review has heard from many staff and services who believe that they are spending too much time collecting information which is not useful; yet in other areas they do not have information that they need. Unnecessary bureaucracy, collecting data which will never be used, ticking boxes to feed organisational needs all detract from staff having time to care for women and their babies.

4.83. This review has also been inspired by many teams and services who are actively collecting data that they find useful and using it to learn about the quality of their care, and where they can make changes to deliver even better care and outcomes. A nationally agreed set of indicators would help local maternity systems to track, benchmark and improve the quality of maternity services. This

needs to be endorsed by the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives. It needs to be capable of being adapted and built upon locally into dashboards, such as that which is in use in the South West.

- 4.84. Multi-professional teams should get together regularly to review these indicators and other clinical outcome and patient experience data to understand how they can improve services. The data should be considered alongside other sources of information, such as training, case reviews, practice improvements, risk management meetings and audits.
- 4.85. One aspect of measuring quality which is proving challenging for teams and organisations is in appropriately, regularly and accurately capturing outcomes of their care as reported by women and families – known in other settings as patient reported outcome or experience measures (PROMs/PREMs). These can provide regular formative and summative information to feed into services to help them improve their care; for commissioners to help them understand the quality of care being delivered for their communities; and nationally to understand variation and where national support and levers could add value. These should be developed for maternity services building on existing measures, and included in the nationally agreed set of indicators.

Sharing and benchmarking data to improve quality in the South West

The South West Maternity and Children's Strategic Clinical Network, which covers 14 Acute Trusts, has developed a dashboard of indicators for maternity services. The Network's Maternity Working Group developed the data definitions and the quality and consistency of data supplied has improved through ongoing use. Co-production was necessary in getting support for the initiative. The information collected is available to Acute Trusts, Clinical Commissioning Groups, local authorities and public health colleagues via the dashboard's webtool within a 2 month timeframe.

The sharing and benchmarking of data is being used to help drive the improvement of outcomes in the South West. The dashboard enables comparable, timely, pertinent and quality assured data to be provided by trusts across the region. The Network looks at a range of data to highlight variation as well as benchmark and better inform its quality improvement work, such as reduction of stillbirths, place of birth and rates of caesarean section.

- 4.86. Teams should proactively share their data with other teams to benchmark and understand how they can learn, improve or innovate, working across their Regional Maternity Clinical Network as described in paragraph 4.99 and as exemplified in the South West.
- 4.87. Commissioners will wish to regularly review data about the quality and outcomes of services, and should include quality indicators as key performance indicators in their contracts with providers.

New staffing models

- 4.88. Healthcare professionals should be able to work in an environment of empowered professionalism where their skills are valued and they can see the impact they have on women and their families. However, breaking care up into episodes with each one being managed by a different professional has made it difficult, as have hierarchical, bureaucratic organisational structures.
- 4.89. As set out at paragraphs 4.13-4.16, moving to greater continuity of the person looking after the woman and her baby would help to solve this. It would allow midwives to accompany the individual woman, build up a long term relationship with her, support her during labour and see things through to handover to the health visitor and GP. But this cannot happen within current staffing models. It requires more radical approaches – for example, small groups of midwives taking responsibility for a number of women and planning their workload around them..
- 4.90. Improving continuity of carer is not an optional luxury. If we are to improve quality, we must improve this. However the review recognises that this requires a step change across maternity services. It is likely to be challenging, and is likely to require two to three years to put into widespread practice. Local solutions as to how it happens and how quickly will need to be developed. Support to develop different models of service provision should be provided by Maternity Clinical Networks, the Royal colleges and national bodies. The Buurtzorg model from the Netherlands illustrates the potential of such ways of working, which can operate very successfully at scale.

Buurtzorg, Netherlands

Buurtzorg provides neighbourhood care built around the person. The organisation values professional autonomy and delivers care through small self-managing nursing teams. Each team has a maximum of 12 staff and works at a neighbourhood level (5-10,000 population) to provide holistic care. This equates to a caseload of about 140 people a year. All members of the team have access to each other's notes.

By building services which are tailored to the person and their neighbourhood, the model has the ability to use all resources which exist in that neighbourhood, including GPs, pharmacists and voluntary services. The teams of nurses develop close relationships with their clients so can offer personalised care and support people to take more responsibility for their own care, keeping people out of hospital. The operation of Buurtzorg is streamlined and each team handles every aspect of care and business, from client assessment to staff recruitment. As a consequence of these factors, the model is able to deliver better outcomes at a lower cost per patient. Buurtzorg's British partners, Public World, are supporting adaption of the model to various health and social care settings, including midwifery services.

4.91. To develop new staffing models successfully will require certain preconditions:

- Staffing levels across the local maternity system have to be adequate otherwise new models will fail because of the need to ask staff to work in those parts of the system which deal with emergencies.
- High quality maternity leadership which supports innovation is essential.
- Evidence demonstrates that if continuity of carer models are to flourish, staff must be monitored against agreed indicators of quality, as opposed to day to day processes.
- Staff must be empowered and supported to establish their own ways of working.
- Small teams of midwives will also need educational support around how to work together successfully in a small team, how to be supportive, how to challenge, how to reach consensus, and how to self-manage.
- Different approaches to staffing will need to be considered, such as the use of Maternity Support Workers to assist at home births in Birmingham, or midwives as part of the ambulance telephone services team in Hampshire.

Using staff differently – maternity support workers in Birmingham

In order to increase homebirths from 0.31% to 3% within three years, a more flexible workforce was required. A new staffing model was implemented employing a ratio of almost 1:1 Maternity Support Workers (MSWs) to midwives. MSWs, as higher apprentices, undertook modules within a Health and Social Care Maternity Pathway Foundation Degree, in order to obtain the theoretical knowledge and clinical skills to become a midwife's assistant at a home birth; a role formerly undertaken by another midwife. The MSWs assist the midwife with both maternal and neonatal emergencies and provide holistic care for mothers and babies throughout pregnancy, birth and beyond within their scope of practice. This has improved access and long term sustainability of the homebirth service and provides good training opportunities and career progression for bands 1-4.

Labour Line in Hampshire

Labour Line is a 24 hour telephone service that allows pregnant women to call a midwife at any time of day or night should they go into labour. Developed by Hampshire Hospitals NHS Foundation Trust (HHFT) and South Central Ambulance Service (SCAS), the service is based in SCAS Emergency Operations Centre in Hampshire and is staffed 24 hours a day, seven days a week by experienced midwives.

At each point of contact with Labour Line, women and partners have the opportunity to talk to a midwife who will offer the same consistent approach to advice, support and information covering choice for face to face assessment and birthplace. Having a midwife based in the ambulance service has improved safety and through the provision of advice and support has meant that a number of ambulances could be stood down, having a positive impact on the availability of ambulances for emergency situations. Over the last year, Labour Line has diverted 18,000 calls that would have been made to labour wards at HHFT and also reduced unnecessary 999 calls to SCAS. This allows emergency operations centre staff and frontline paramedics to have more time to respond to other non-pregnancy related emergency and non-emergency calls that come in.

A new deal between professionals and organisations

4.92. The NHS needs to come up with new ways of delivering services built around the community and across organisational boundaries, as highlighted by the NHS Five Year Forward View. These do not need to be designed at the centre; local commissioners and providers should have the space to innovate and design their own services. They should come together at two levels to improve the quality of care they are able to offer to their communities.

Local Maternity Systems

4.93. On a more local level, providers and commissioners should operate as local maternity systems, with the aim of ensuring that women, babies and families are able to access the services they need and choose, in the community, as close to home as possible.



Figure 6: Local Maternity Systems

4.94. This report does not seek to prescribe the size of any individual local maternity system, as this will need to be determined according to what makes sense locally. We would envisage that at least two Clinical Commissioning Groups (CCGs) would be involved in a local maternity system, and that the population size would be between 500,000-1.5 million, being coterminous with existing local neonatal networks where it makes sense to do so.

4.95. Local maternity systems should be responsible for:

- developing a local vision for improved maternity services and outcomes based on the principles contained within this report; which ensure that there is access to services for women and their babies, regardless of where they live;
- helping to develop the maternity elements of the local sustainability and transformation plans being developed in each area of England. The plan should describe how providers will work together so that the needs and preferences of women and families are paramount, as opposed to needs or preferences of professional groups or organisations. A summary of considerations for planning is set out in chapter 5;
- including all providers involved in the delivery of maternity and neonatal care, as well as relevant senior clinicians, commissioners, operational managers, and primary care. Local maternity systems will therefore need to include for example, the ambulance service and any midwifery practices who are eligible to provide NHS-funded care locally;
- ensuring that they co-design services with service users and local communities. Patient groups and Maternity Services Liaison Committees provide opportunities for engagement; and
- putting in place the infrastructure that is needed to support services to work together effectively, including interfacing with other services that have a role to play in supporting woman and families before, during and after birth, such as health visitors, GPs and other primary care services.

4.96. Local maternity systems should have as their central principle the concept of ‘defaulting to the community’, as described in this report, by which women can receive clinically appropriate care as close to home as possible. This will mean that they need to promote and support the establishment of community hubs across their network, connecting them with obstetric and specialist services, and developing clinical governance, including standards and protocols to ensure that women and babies get the care they need, when they need it.

4.97. By virtue of their membership, local maternity systems will be uniquely placed to address the challenges in care that are difficult for organisations to address in isolation. For example, the agreement of ambulance protocols, offering clinical decision making support, and developing guidelines concerning access and referral to specialised services. They will enable services to work together to

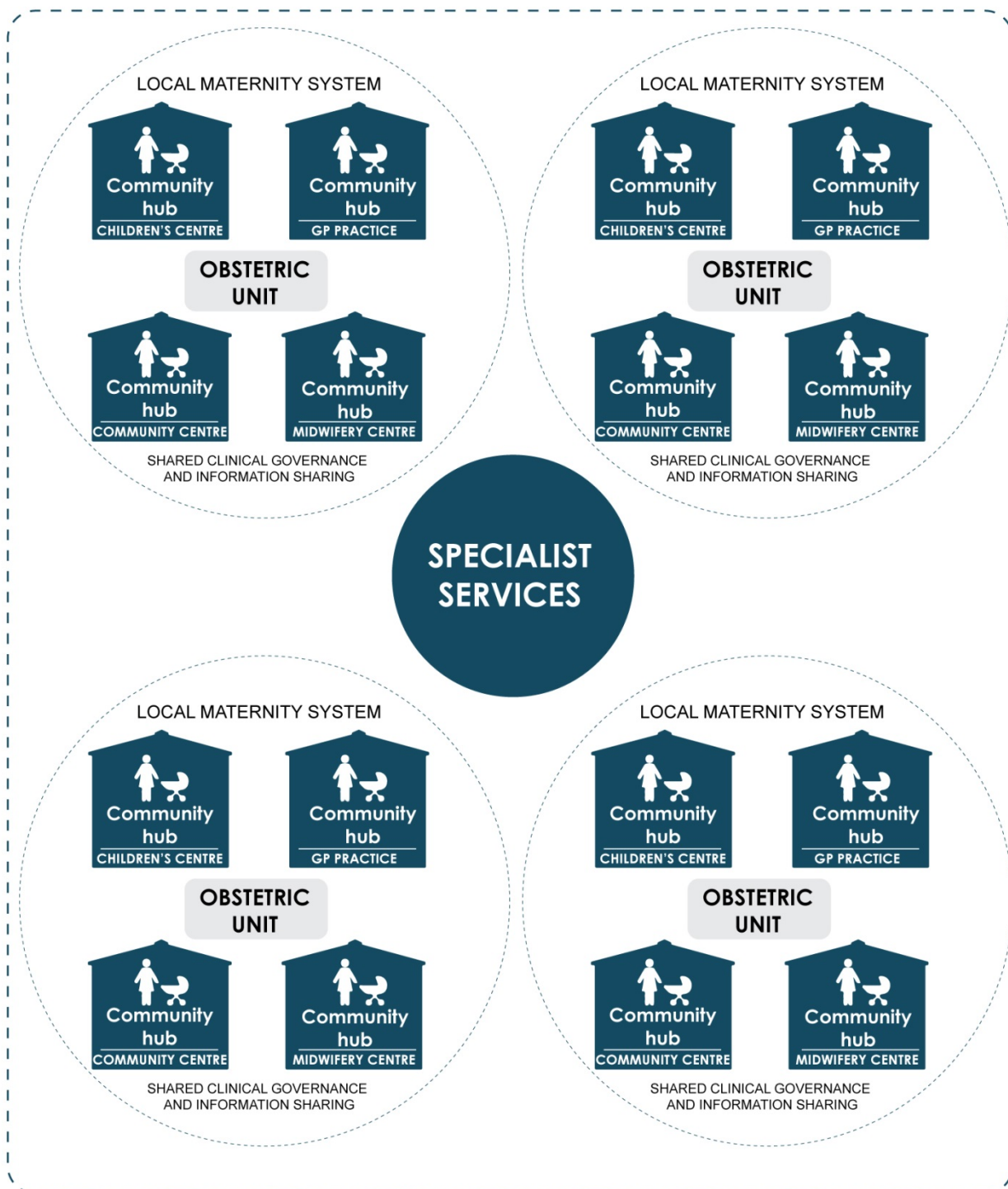
develop interoperable electronic maternity records to support the sharing of information with each other and with women.

4.98. Local maternity systems will also be key in supporting the development of a learning culture. They should maintain a focus on experience and outcomes, and enable healthcare professionals who work together to train together across professional and organisational boundaries. They will need to foster workforce co-ordination and training, to ensure that there is adequate clinical cover across all providers, and that resources can be shared across the system where necessary.

Maternity clinical networks

4.99. On a regional footprint, through the 12 current Maternity Clinical Networks (formerly Strategic Clinical Networks) supported by NHS England, commissioners, providers and professionals should come together for two purposes:

- To share information, best practice and learning, to benchmark against each other and drive improvement in the quality of services across the region, with a relentless focus on the outcomes of care.
- To ensure that specialist services are available to women and babies with more complex needs, and that they receive consistently high quality treatment in centres with the right facilities and expertise, as close to their homes as possible. These services will include but not be limited to maternal and fetal medicine, specialist mental health services, and neonatal care.



Maternity clinical network

Organising specialist services | Sharing best practice and benchmarking network

Figure 7: Maternity Clinical Network

CHAPTER 5: MAKING THE FUTURE

- 5.1. This chapter sets out some of the key actions to deliver the vision for the future of maternity services outlined in this report over the next five years. It is not meant to be a full implementation plan, nor is it a recipe with a series of specific steps. There are three broad categories of action which this chapter goes through: people; models of care; and resources.
- 5.2. Although there are things which can be done centrally to support and incentivise change, translating the ideas set out into reality will have to be done by commissioners, managers and healthcare professionals with an understanding of local opportunities and challenges. These individuals will need to have the vision to see what needs to be done locally and the courage to break out of existing silos. They will need to work together for the purpose of building care around women, their babies and families.
- 5.3. In order to implement this vision, national NHS organisations will need to recognise and support the need for local adaptation and leadership.

People

Individual responsibility

- 5.4. The vision outlined in this report will only become reality if individual midwives, obstetricians and other healthcare professionals act on it. There needs to be a grass roots movement to improve maternity care. This means every individual taking personal responsibility for supporting improvement whether it be by engaging with local improvement initiatives, constructively challenging poor practice, building better relationships with members of other professions or making the most of opportunities to learn and improve skills. The Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives should promote and encourage such a movement and demonstrate by example that multi-professionalism is the way forward. They should be supported by the national NHS bodies, including Health Education England, NHS England and NHS Improvement.
- 5.5. Similarly, women and their families can be powerful agents for change. They can help to shape their own care by making well-informed choices to ensure safe, personalised care is built around them (although we recognise that vulnerable women may need extra support to do this). Each woman needs to engage in a

relationship with her own midwife and other health professionals, acting on advice where she can make a difference, e.g., by accepting help to give up smoking, having a healthy diet and being physically active. Public Health England should use their resources, levers and campaigns to actively encourage this. Some women may wish to be involved further in their local maternity systems, by joining a local maternity users group or a Maternity Services Liaison Committee.

Leadership

- 5.6. Nevertheless, individuals will only be able to make a difference if they are nurtured and supported by strong leadership at local level. To ensure that this happens, boards of provider organisations should designate a board member as the lead for maternity services. The Board should routinely monitor information, including safety and take necessary action to improve quality.
- 5.7. As part of their approach in inspecting and rating maternity services, the Care Quality Commission should pay particular attention to the achievement of stated outcomes. In addition, it should consider the culture within maternity services, in particular whether it is multi-professional, actively promotes and supports leaders to develop, and is fostering a culture of learning and improvement.

Multi-professional education and training

- 5.8. The importance of working in multi-professional teams should be embedded from the beginning of a new midwife's or doctor's studies. The Nursing and Midwifery Council and the Royal College of Obstetricians and Gynaecologists should review pre-registration education to ensure that it promotes multi-professionalism and that there are shared elements where practical and sensible.
- 5.9. Training should also be made available to help teams of midwives, doctors and other health professionals who work together, to learn with and from each other, as part of continuous professional development. This is the responsibility of provider organisations. Health Education England should look into how funds can be made available to providers to roll out such training initially. Local provider leadership should ensure there is an ongoing focus on training. This should include making sure that healthcare professionals are free from clinical duties to use the time for continuous professional development. Given the importance of this, provider boards and commissioners should seek to assure themselves that multi-professional training is happening and the Care Quality Commission should consider the issue during inspections.

Collecting, sharing and learning from information

- 5.10. To help the NHS to reduce the burden of data collection, to make it useful and easier to share with women and between health professionals, and to support learning, there are a number of things that should take place urgently.
- 5.11. NHS England should make it an urgent priority to roll out use of electronic maternity records nationally. They should be developed in a way that enables them to be accessed through digital maternity tools that offer women a comprehensive information package as outlined in Chapter 4. At the same time, commissioners and providers should invest in the right software, equipment and infrastructure to collect data and share information.
- 5.12. NHS England should convene, as a matter of urgency, a group to draw up a nationally recommended set of quality indicators which could be used locally and regionally. The group should also take the opportunity to review overall data collection with a view to supporting the refocusing of effort on collecting the most useful data, and feeding into the ongoing evolution of the Maternity and Children's Minimum Data Set.
- 5.13. As part of developing quality indicators, NHS England should consider commissioning the development of (a) patient reported outcome/experience measure(s). Local services should supplement this with in-depth qualitative discussions with individual women to get into the detail of how they feel about services. Similarly, data on feedback from staff should be built into the learning process. The results of feedback, and what changes have been made as a result, should inform board reports.
- 5.14. To support learning, the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives should offer multi-disciplinary peer support through multi- professional teams on a regional basis offering advice and support when requested from services, local maternity systems or commissioners. Providers should ensure that staff are released to take part in these reviews, and to work with others across their region as part of the Clinical Networks. The Care Quality Commission should take account of this during inspections. In particular, note should be taken of where peer support has been sought and acted upon, and the extent to which providers free up their professionals to be involved in such support, as indicators of well led organisations.

When things go wrong

- 5.15. To ensure that there is learning when things go wrong and to support a change in culture, the Department of Health should give serious consideration to the introduction of a “rapid resolution and redress” insurance scheme which will pay out for birth injuries caused to term babies during labour without families needing to go to court and prove negligence in a lengthy and difficult process. This would ensure that learning from incidents is rapid, and that similar mistakes can be avoided.
- 5.16. At the same time, to ensure greater consistency in investigations, the Health Care Safety Investigation Branch should devise a national standardised investigation process (for local use) for when things go wrong, to get to the bottom of what went wrong and why and how future services can be improved as a consequence. The learning from reviews should be nationally collected and benchmarked so that learning can be spread.

Models of care

Early adopters leading the way

- 5.17. The review has seen at first-hand the enthusiasm of those who already share the vision described in this report. This must be harnessed and supported for the benefit of all. NHS England should therefore seek volunteer localities to act as early adopters with a view to testing the model of care described in this report over two years. This would provide the opportunity to test out different approaches, determine which flexibilities are required, and identify the most viable solutions for the long term. This is of particular importance for issues such as payment system reform, which are complex and can result in perverse consequences if not tested before wider rollout.

Planning for delivery of this vision over five years

- 5.18. This is not a signal that other localities can sit on their hands and wait for the early adopters to produce results. In *Delivering the Forward View: NHS planning guidance 2016/17-2020/21*⁸³ localities have been asked to produce “Sustainability and Transformation Plans” over the first half of 2016 to show how local services should transform and ensure they are sustainable over the next five years. As part of this, local health economies have been asked to plan how they will

⁸³ <https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/>

transform their maternity services in line with the vision outlined within this report. The following box highlights key elements of this vision which commissioners will particularly wish to consider as they develop these plans.

- 5.19. NHS England will be reviewing how well commissioners are planning for delivery of this vision in signing-off plans; and how well those plans are being put into action and on an ongoing basis through its CCG Assessment Framework, and annual Ofsted-style rating of each CCG on its commissioning of maternity services. This focus on maternity services presents a unique opportunity to ensure that real change happens across the country over the next five years.

Planning for transformation

When developing Sustainability and Transformation Plans, commissioners will need to consider how local maternity services need to evolve and change over the next five years to meet the vision set out in this report. There are several elements within this report that commissioners will particularly need to consider:

- Key to success will be commissioners focussing on the outcomes that are being achieved for the women and babies in their community, and commissioning services from providers which seek to improve these. They should be routinely measured and monitored, and become the currency of maternity commissioning.
- Commissioners will wish to look beyond their own boundaries to develop services that meet the needs of their communities and those of neighbouring CCGs. This report recommends that commissioners commission on a footprint of at least two CCGs, and for populations of between 500,000-1,500,000 depending on the nature of the geography. This larger geography should provide additional flexibility in shaping services, greater choice of provider and type of service for women, and more diverse opportunities and learning for professionals
- Providers will need to evolve the nature of the service offering, looking beyond the traditional boundary of the acute settings and into the community. Commissioners and providers should work towards bringing services together in community hubs and providing continuity of carer for an increasing proportion of their community. This will require changes to workforce practices, and how services are designed and work with each other.
- This report envisages more births taking place in the community, i.e. in midwifery care and at home. Commissioners will need to ensure there are services available to support this additional community-based demand. As a result, there may be lower demand for obstetric services, which must nevertheless remain easily accessible to

those who need them. Obstetric units will require appropriate local configuration to satisfy demands for safety as well as access.

- Commissioners will wish to use the NHS Personal Maternity Care Budget mechanism to support women in their community to take control of their decisions and their maternity care.
- Together, commissioners and providers will need to develop shared clinical governance, including standards and protocols which can guide providers and professionals in how they work together across organisational boundaries in the best interests of women and babies. These will need to include NHS and other providers, ambulance services, specialist centres, mental health and services in the community.

Remote and rural areas

For remote and rural areas, where there can be particular challenges in commissioning safe and sustainable services, commissioners and providers need to take into account the above considerations in thinking innovatively about how to cater for the needs of their communities. They will also wish to take into account the following:

- There is no clinical reason why an obstetric unit cannot operate safely in a remote and rural area with a relatively low number of births each year, providing that it has sufficient staff and access to 24/7 support services, clear pathways and transfer guidelines for specialist care, and support across a local maternity system (e.g., to aid staff deployment and professional development). However, there are not, nor are there likely to be, nor would it be desirable for there to be, enough obstetricians in the NHS to support a large number of such units. Therefore, there are only likely to be a small handful of such units in the most remote areas of England.
- They should not be restrained by what might be perceived to be gold standard service models – whilst these might provide best care in some places, they may not provide sufficient clinical benefits to justify the investment everywhere. For example, the NPEU evidence review finds insufficient evidence to support a model of 24 hour resident consultant presence on the labour ward, which is only recommended for large urban units.
- Remote and rural areas should think about how they can use their workforce innovatively, for example:
 - Sharing staff across multiple sites or providers within a local maternity system
 - Making use of on-call systems in place of 24 hour medical staff residency, but which are able to respond in a timely manner to provide safe care
 - Upskilling generalist medical staff in remote areas to provide specialty services

- Enhancing the consultant workforce with a view to reducing reliance on other grades of doctors
- Remote and rural areas can introduce innovative working practices such as:
 - Robust triage and transferring the care of women with more serious complications at an appropriate time in the pregnancy to a more specialised unit
 - Defining which types of women should be advised to give birth at which units across the local maternity system
 - Providing transport facilities for women needing to travel to more specialist units and enhanced transfer services for women or their babies experiencing unexpected serious complications
 - Making use of technology, e.g., consultations by video link between the centre and smaller unit

5.20. To underpin the delivery of this vision and their own plans, commissioners should more assertively drive action to improve outcomes, by commissioning against clear outcome measures, empowering providers to make service improvements and monitoring progress regularly.

Resources

5.21. Delivering the kind of care envisioned in this report will require the right financial resources, targeted in the right place. The next few paragraphs set out some principles for how funding for maternity care should be distributed and flow through the system.

Payment system reform

5.22. The main role of the payment system is to reimburse providers for the costs of the care they provide, but at the same time it can either incentivise or act as a barrier to the kinds of changes the NHS needs to make to improve care. The payment system would ideally:

- adequately and accurately compensate providers for the cost of providing safe, efficient and sustainable care;
- facilitate choice;
- incentivise the delivery of high quality care, in particular, continuity of carer;

- support providers to work together across a local maternity system, where care can be transferred between providers at any point;
- incentivise community deliveries where clinically appropriate ;
- reflect the sensitivities around the variation in clinical need between and within geographical areas and in particular support the sustainability of services in remote areas where there is lower volume but greater distance to travel;
- enable all providers to participate in the networked model, including in the required clinical governance arrangements and in sharing care records;
- ensure access to specialist services, including neonatal, complex maternal medicine and fetal medicine services across all geographies;
- provide adequate funding for services included in the maternity currencies, including postnatal services, while incentivising greater efficiencies wherever possible; and
- ensure access to perinatal mental health services (these are subject to a separate pathway payment).

5.23. There are a number of related steps that the NHS should make to the payment system. Each element should be taken forward as part of an overall package, as each on its own provides only part of the solution.

5.24. As a first step, NHS Improvement and NHS England should undertake a comprehensive review, looking in detail at the different cost structures of maternity care. This involves working with providers to undertake a bottom-up costing exercise and proposing adjustments to the existing tariff in light of this so as to more accurately reflect relative costs. This could include potentially introducing different prices for home births, freestanding midwifery units, alongside midwifery units and obstetric units.

5.25. In the longer term, NHS Improvement and NHS England should test more radical changes to the payment system to more accurately reflect the different cost structures. This is likely to involve using early adopters to test new models of payment systems.

5.26. The review team believes that there is a case for shaping the payment system to reflect the different cost structures of different models of providing care. This means taking into consideration four issues:

- A large proportion of the costs of obstetric units are fixed because they need to be available 24 hours a day, seven days a week regardless of the volume of services they provide. A much greater proportion of the costs of providing midwifery services are variable.
- Nevertheless, there is a need to ensure that the money follows the woman as far as possible, so as to ensure women's choices drive the flow of money. This means an element based on volume of care provided, as now.
- Quality of care should be built in to make it easy for commissioners to provide incentives here – this should be measured by the delivery of quality and outcome measures.
- As the work of Lord Carter has shown, there are large variations in the efficiency of care across the NHS, and this includes maternity services. Providers should be encouraged to drive out waste across maternity care.

5.27. The future payment system should be flexible, allowing for localities to decide on the basis of local circumstances the payment structure which will best enable the money to flow locally and improve care. The choice of outcome measures should be made locally, taking account of local circumstances. These could include measures of experience, such as reported experience of continuity of carer.

NHS Personal Maternity Care Budget

5.28. NHS Personal Maternity Care Budgets would give impetus to choice by giving a woman control of the money used to buy her care. Women would have the opportunity to make use of an electronic mechanism to select their chosen care provider. More details of how it might work are set out in Annex C. The scheme should be demonstrated in a number of pioneer sites before any national rollout. These could be the same areas that are identified as early adopters of the overall vision set out in this report, or different areas.

Flexibilities for remote and rural areas

5.29. The Review concludes that there is a need to address the difficulties for very remote localities in sustaining obstetric services. In a small number of cases, innovative working alone may not make a small unit financially sustainable without

extra resources. We therefore welcome NHS England's recent decision to introduce a 'sparsity adjustment' into the funding formula used to allocate CCG budgets.

- 5.30. Specifically, in the 2016/17 CCG allocations, NHS England has made a change to the allocation funding formulae for remoteness. A portion of this funding is in recognition that maternity services in remote areas have unavoidably higher costs because the level of activity is too low for services to operate at an efficient scale. This will result in more funding for maternity in the areas that meet the remoteness requirements.⁸⁴

Continuity incentive

- 5.31. Depending on the outcome of the testing of new payment models, and in particular the viability of incorporating outcome measures into the mainstream payment system, a separate incentive to encourage greater continuity of carer may be needed. The two options are a best practice tariff or a CQUIN incentive. NHS England should look into this. This includes ensuring that robust data sources exist to measure delivery.

⁸⁴ As set out in the NHS England allocation board paper 17 December 2015, <https://www.england.nhs.uk/2015/12/board-meeting-17-nov-2015/>

CHAPTER 6: HOW MUCH WILL IT COST?

- 6.1. NHS England has estimated that the total NHS cost for delivering maternity services in 2013/14 was £4.7bn.⁸⁵ This does not capture some costs, such as expenditure on perinatal mental health, which was taken into account as part of the work by the Mental Health Taskforce. It also does not include costs incurred by the private and voluntary sectors.
- 6.2. The Five Year Forward View⁸⁶ published in October 2014 identified that there would be a £30bn gap between patient needs and NHS resources assuming no further efficiencies and flat funding. To close this, the NHS has committed to finding £22bn of efficiencies and the Government has recently agreed to provide £8.4bn of extra funding in the Comprehensive Spending Review.

Summary analysis of the cost implications of this report

- 6.3. This report includes some initiatives that would add incremental costs to those included in the Five Year Forward View baseline, some which would result in savings, and some of which require a small amount of capital expenditure.
- 6.4. Our economic modelling assumes that implementation of the review will work on a two phase basis: establishing proof of concept via the maternity early adopter sites; followed by a national rollout phase. More detailed costing should be completed in partnership with the sites to inform the national rollout of the new maternity care model.

Early adopters

- 6.5. In the first phase the NHS should trial the conclusions of the review with a number of volunteer health economies in order to establish the barriers, work out the potential solutions and share the learning widely. We are expecting that there will be up to four sites, they will run from September 2016 to September 2018 and that NHS England will make available to them a total of £8m over three financial years.

⁸⁵ This is more than the £2.6bn the National Audit Office identified as being spent on NHS maternity care in 2012/13 (November 2013) (<https://www.nao.org.uk/report/maternity-services-england-2/>) because it considers all costs from maternity, not just reference costs.

⁸⁶ <https://www.england.nhs.uk/ourwork/futurenhs/>

NHS Personal Maternity Care Budget

- 6.6. NHS England with selected CCGs should pilot the NHS Personal Maternity Care Budget scheme before national rollout. We estimate this starting by 2017 and approximately 4 CCGs or groups of CCGs will act as pioneer sites testing this model, for which £0.6m should be allocated. Following successful testing, national rollout would begin in 2018/19. The proven model to be rolled out nationally will need to be delivered within existing funding allocations by NHS England and CCGs.

Multi-professional training

- 6.7. The NHS should begin rolling out funding for multi-professional training from April 2016, this has been estimated to cost £2m per year. This covers costs to upskill approximately 5% of all maternity staff in a train the trainer scheme and then for these local multi-professional teams to deliver training to all local teams in a multi-professional setting. We have assumed that staff will use one day from their existing allocation of training days.

Rapid resolution and redress scheme and robust investigation

- 6.8. As outlined in Annex D of the report, a new rapid resolution and redress scheme is proposed. The costs would fall to two broad areas. Firstly, a new independent body should be established to administer the rapid resolution and redress scheme at an estimated cost of £1m per year. This has been estimated based on the operating costs of the NHS Litigation Authority (including staff costs, facilities, etc.). The scheme is expected to come into place from 2017/18 and as such there should be a small amount of start-up funding made available in 16/17.
- 6.9. The review proposes that a new investigatory system is established when avoidable harm has occurred. All incidents resulting in serious injury and late stillbirth, neonatal and maternal deaths would need to be investigated. The number of investigations would gradually reduce, enabling a reduction in costs over time. As in the RRS the investigations are not expected to come into place until 2017/18, funding should be made available in 16/17 for training and other formation costs of a new programme.

Continuity of care (caseload midwifery, and increased antenatal and postnatal time)

- 6.10. The second phase will involve rollout of the conclusions of the review across the NHS. The NHS will begin testing this new maternity care model via early adopter sites, but we expect the national changes to take place in 2018/19.
- 6.11. There will need to be changes to midwifery staffing models:

- This report calls for the NHS to move to a continuity of carer model of midwifery staffing. Once rollout begins the NHS should achieve an annual increase of 20% of births having continuity of carer each year. In line with the NHS funding settlement, we have assumed that national rollout will begin in 2018/19. Continuity of carer will be delivered by a caseload model of midwives working in small teams of 4-6. International literature on caseloads per midwife generally implies a range from 30-40 births per midwife. However, there may be opportunities to test more flexible models.
- This report calls for midwives to have more time to be able to explain a woman's choices and personalise the advice she receives. We have estimated this requires on average increasing the length of antenatal appointments by 10 minutes but not the number of appointments (in practice midwives may distribute this time according to need rather than evenly).
- This report calls for an upgrade to postnatal services. We have estimated that this requires increasing the length of postnatal appointments by 10 minutes but not the number of appointments (again, in practice midwives may distribute this time according to need rather than evenly).

6.12. Modelling has been performed to estimate the size of the midwifery workforce likely to be required to deliver these three improvements. Although it is based on a number of assumptions and different challenges are likely to occur in different parts of England, it suggests that a significant increase in the midwifery workforce is not required. Moreover, it suggests that increasing the number of midwives has only a small impact on the proportion of women who could expect to receive care from a midwife they know in labour. The challenge is likely therefore to be related to moving staff to different models and ensuring that teams have their full complement of staff. This will be supported by non-recurrent funding to manage the change as set out in the next paragraph.

Transition to continuity

6.13. To fundamentally shift the model of maternity care, each local maternity system requires local leadership and support to manage the transition for a time limited period. This has been costed on the basis of project management and clinical resource to support change locally and training for all staff that will be moving to a continuity of carer model.

Running costs of maternity hubs, local maternity systems and strategic networks

6.14. The running of community hubs, local maternity systems and strategic networks will be a new way of working. Similar to urgent and emergency care networks, a small provision

for ongoing funding. is likely to be required to cover the administrative costs of local maternity systems coming together on a regular basis to manage the system across all care settings. Costs will cover staff time for local maternity leadership to participate in meetings and associated overhead costs. This will dovetail with the new perinatal mental health funding for networks.

Digital information

- 6.15. The report makes two key recommendations. Firstly, electronic health records for maternity should enable paper-free records and allow health care professionals to minimise data entry. The National Information Board recommendation on an electronic health record and its five year work programme covers this initiative. The NHS should prioritise this system being available for maternity services.
- 6.16. Secondly, there should be a digital tool that offers women the information they need throughout pregnancy and birth in order to make choices about their care and how they look after themselves. The cost of developing such a platform has been estimated as approximately £0.4m, although further work would be required to link the platform to electronic health records so as to enable personalisation of information. Costs of this are difficult to estimate in the absence of electronic health records.

Perinatal mental health

- 6.17. This recommendation supports the Mental Health Taskforce report to deliver NICE concordant care for perinatal mental health. The delivery of this recommendation has strong synergies with the new model of care proposed in this report, especially the multi-disciplinary working, care in the community and the local maternity systems.

Incremental capital costs

- 6.18. If we match services to meet women's choices more clearly, it will result in an increase in the proportion of births at home, in a freestanding midwifery unit or in an alongside midwifery unit. Our assumption is that women should have access to each of the birth settings recommended in NICE guidelines,⁸⁷ although all four may not necessarily be available within each local maternity system. To support this aim, there may be some capital costs in some local maternity systems, depending on what changes may need to be made to the local configuration of services.

⁸⁷ NICE clinical guideline 190: Intrapartum care for healthy women and babies, section 1.1

Savings

- 6.19. To contribute to the coming efficiency challenge the review has identified a number a savings opportunities that are realisable over the next five years. This emphasises that change is not only required to deliver great safety and choice but is also essential to maintain the financial sustainability of NHS funded maternity services.

Harm reduction

- 6.20. Savings will accrue from a number of initiatives which will reinforce each other to reduce avoidable harm, including the rapid resolution and redress scheme, more consistent investigations, and rollout of multi-professional training. Although more detailed modelling is required, initial modelling based on international evidence from Sweden and local evidence from North Bristol suggests the target of a 50% reduction in incidences could be achievable.

Digital information

- 6.21. The development and rollout of an electronic care record will make recording and sharing information with women and between professionals much easier, reducing the amount of staff time involved in data processing. Time savings will be made from frontline staff only needing to enter information once.

Increasing community births

- 6.22. If we match services to meet women's choices more clearly, it will result in a significant increase in the proportion of births at home, in a freestanding midwifery unit and in an alongside midwifery unit. As well as reflecting what some women want, care in these settings costs less when accompanied by service transformation across the local health economy. This would need to be carefully managed by local maternity systems but is essential to meet the coming efficiency challenge.
- 6.23. Similarly, the NPEU evidence reports commissioned for this review show that midwifery care results in fewer interventions. If we can increase the proportion of births supported by midwifery care, we will be able to reduce the cost of medical interventions.

Reduction in use of agency staff

- 6.24. The review considers that the implementation of its recommendations are essential to deliver maternity services' share of the agency spending reductions announced by the Department of Health. This new way of working should be done with a view to securing improved workforce satisfaction, retention and recruitment of permanent staff.

Savings which are difficult to measure

6.25. In addition, we expect there to be substantial savings in a number of areas which are difficult to measure. In particular, it has been difficult to assess “whole-system” implications, such as those which would result from the recommendations around improved post-natal care. They would accrue from:

- Savings in ongoing (lifetime) healthcare costs for women and babies if complications are better managed and there are fewer injuries and deaths;
- Getting family life off to the best start (resulting in better long term health for women and their babies);
- Greater job satisfaction for healthcare professionals and reduced staff turnover; and
- Increases in breastfeeding rates leading to better health for women and their babies.

ANNEXES

Annex A – Summary table of recommendations, owners and proposed timeframes

Annex B – List of visits and events

Annex C – Potential scope of NHS Personal Maternity Care Budget

Annex D – Potential scope of insurance rapid resolution and redress scheme

ANNEX A: SUMMARY TABLE OF RECOMMENDATIONS, OWNERS AND PROPOSED TIMEFRAMES

Number	Recommendation / action	Owner(s)	Timeframe / scale of ambition	How will we know?
1.	Personalised care centred on the woman her baby and her family based around their needs and their decisions where they have genuine choice informed by unbiased information			
1.1	Every woman should develop a personalised care plan, with their midwife and other health professionals, which sets out her decisions about her care, reflects her wider health needs and is kept up to date as her pregnancy progresses and after the birth.	Providers and CGGs	100% of women by 2020	Maternity survey e-referral data
1.2	Unbiased information should be made available to all women to help them make their decisions and develop their care plan drawing on the latest evidence, and assessment of their individual needs, and what services are available locally. This should be through their digital maternity tool.	National Information Board (NIB) and NHS England	By April 2017	Maternity survey and NIB monitoring

Number	Recommendation / action	Owner(s)	Timeframe / scale of ambition	How will we know?
1.3	Women should be able to choose the provider of their antenatal, intrapartum and postnatal care and be in control of exercising those choices through their own NHS Personal Maternity Care Budget.	NHS England and CCGs	Pioneer sites in 2016/17. Potential full roll out from 2017/18	Maternity survey, e-referral data and CCG Assessment
1.4	Women should be able to make decisions about the support they need during birth and where they would prefer to give birth, whether this is at home, in a midwifery unit or in an obstetric unit after full discussion of the benefits and risks associated with each option.	CCGs	Most women should have access to three types of birthplace by 2020	Maternity survey, e-referral data and CCG Assessment
2	Continuity of carer, to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions			
2.1	Every woman should have a midwife, who is part of a small team of 4 to 6 midwives based in the community who know the women and family, and can provide continuity throughout the pregnancy, birth and postnatally.	Providers and CCGs	Early adopters to roll out from 2016/17. Across the country by 2020	Maternity survey

Number	Recommendation / action	Owner(s)	Timeframe / scale of ambition	How will we know?
2.2	Each team of midwives should have an identified obstetrician who can get to know and understand their service and can advise on issues as appropriate.	Providers and CCGs	By 2020	Staff feedback
2.3	Community hubs should enable them to access care in the community from their midwife and from a range of others services, particularly for antenatal and postnatal care.	NHS England - national support and guidance; CCGs and providers - local implementation	Plans for community hubs to be in place and agreed by end 2016/17, for roll out by 2020	CCG Assessment
2.4	The woman's midwife should liaise closely with obstetric, neonatal and other services ensuring that they get the care they need and that it is joined up with the care they are receiving in the community.	Providers	From now	Maternity survey, Local Maternity System governance

Number	Recommendation / action	Owner(s)	Timeframe / scale of ambition	How will we know?
3	Safer care, with professionals working together across boundaries to ensure rapid referral, and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation, honesty and learning when things go wrong.			
3.1	Provider organisation boards should designate a board member as the board level lead for maternity services. The Board should routinely monitor information about quality, including safety and take necessary action to improve quality.	Providers	By 1 April 2016/17	CQC inspections
3.2	Boards should promote a culture of learning and continuous improvement to maximise quality and outcomes from their services, including multi-professional training. CQC should consider these issues during inspections.	Providers and CQC	From 2016/17	CQC inspections
3.3	There should be rapid referral protocols in place between professionals and across organisations to ensure that the woman and her baby can access more specialist care when they need it.	Providers and CCG	Timetable to coincide with establishment of local maternity systems. Full roll out by end 2018/19.	Local maternity system governance

Number	Recommendation / action	Owner(s)	Timeframe / scale of ambition	How will we know?
3.4	Teams should collect data on the quality and outcomes of their services routinely, to measure their own performance and to benchmark against others' to improve the quality and outcomes of their services.	Providers and regional networks	From 1 April 2017, following publication of national guidance	Regional clinical network monitoring, CQC inspections
3.5	There should be a national standardised investigation process when things go wrong, to get to the bottom of what went wrong and why and how future services can be improved as a consequence.	Health Care Safety Investigation Branch, NHS Improvement, Maternity Clinical Networks	By end 2016/17	DH / NHS Improvement / HCSIB monitoring
3.6	There is already an expectation of openness and honesty between professionals and families, which should be supported by a rapid redress and resolution scheme, encouraging rapid learning and to ensure that families receive the help they need quickly.	DH and NHS Litigation Authority	By 2020	DH implementation

Number	Recommendation / action	Owner(s)	Timeframe / scale of ambition	How will we know?
4	Better postnatal and perinatal mental health care, to address the historic underfunding and provision in these two vital areas, which can have a significant impact on the life chances and wellbeing of the woman, baby and family.			
4.1	There should be significant investment in perinatal mental health services ⁸⁸ in the community and in specialist care.	Mental Health Implementation Board, NHS England and CCGs	By 2020	CCG Assessment Framework, Mental Health Minimum Dataset (MHMDS), MCMDS
4.2	Postnatal care must be resourced appropriately. Women should have access to their midwife as they require after having had their baby.	CCGs and providers	By end 2018/19	Maternity survey, MCMDS
4.3	Maternity services should ensure smooth transition between midwife and obstetric and neonatal care, and when appropriate to ongoing care in the community from their GP and health visitor.	CCGs and providers	By end 2016/17	Maternity survey
4.4	A dedicated review of neonatal services should be taken forward in light of the findings of this review	NHS England	By end 2016/17	NHS England reporting

⁸⁸ Perinatal mental health services care for women during pregnancy and in the first year after birth

Number	Recommendation / action	Owner(s)	Timeframe / scale of ambition	How will we know?
5	Multi-professional working, breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies			
5.1	Those who work together should train together. The Nursing and Midwifery Council and the Royal College of Obstetricians and Gynaecologists should review education to ensure that it promotes multi-professionalism and that there are shared elements where practical and sensible.	NMC, RCOG	Review to be complete by end 2016/17 NMC and RCOG to include in their education from now and from Sept 2017 at the latest	NMC and RCOG reporting
5.2	Multi-professional training should be a standard part of professionals' continuous professional development, both in routine situations in emergencies.	NHS England, HEE, RCM, RCOG, employers	DH and HEE fund post-registration training in 2016/17 Thereafter responsibility of employers	HEE reporting CQC inspection Board reporting
5.3	Use of electronic maternity records should be rolled out nationally, to support sharing of data and information between professionals, organisations and with the woman. Commissioners and providers should invest in the right software,	NHS England, providers	By 2020	Digital Maturity Self-Assessment will cover electronic records generally

Number	Recommendation / action	Owner(s)	Timeframe / scale of ambition	How will we know?
	equipment and infrastructure to collect data and share information.			
5.4	A nationally agreed set of indicators should be developed to help local maternity systems to track, benchmark and improve the quality of maternity services. This should include the possible development of PROMS/PREMs measures for maternity.	NHS England, RCM, RCOG	Convene by Spring 2016, report by end 2016/17	NHS England reporting
5.5	Multi-professional peer review of services should be available to support and spread learning. Providers should actively seek out this support to help them improve, and they must release their staff to be part of these reviews. CQC should consider the issue as part of inspections.	RCOG and RCM to provide support, employers to release professionals	By end 2017/18	RCM and RCOG reporting CQC Inspection

Number	Recommendation / action	Owner(s)	Timeframe / scale of ambition	How will we know?
6	Working across boundaries to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed			
6.1	Providers and commissioners should come together in local maternity systems covering populations of 500,000 to 1.5 million, with shared standards and protocols agreed by all.	NHS England - national support and guidance; CCGs and providers - local implementation	Planning for working in this way 2016/17; begin to work in this way from 2017/18. Full roll out by end 2020	CCG Assessment
6.2	Professionals, providers and commissioners should come together on a larger geographical area through Clinical Networks, ⁸⁹ coterminous for both maternity and neonatal services, to share information, best practice and learning, to provide support and to advise about the commissioning of specialist services which support local maternity systems.	NHS England national and regional funding and support; CCGs and providers are members	From now	NHS England assurance of Clinical Networks

⁸⁹ formerly Strategic Clinical Networks

Number	Recommendation / action	Owner(s)	Timeframe / scale of ambition	How will we know?
6.3	Commissioners should take greater responsibility for improving outcomes, by commissioning against clear outcome measures, empowering providers to make service improvements and monitoring progress regularly.	CCGs	From now – with demonstrable progress by end 2020/2021	CCG Assessment
6.4	NHS England should seek volunteer localities to act as early adopter sites.	NHS England	A two year programme to start in September 2016.	NHS England reporting
7	A payment system that fairly and adequately compensates providers for delivering high quality care to all woman, whilst supporting commissioners to commission for personalisation, safety and choice			
7.1	<p>The payment system for maternity services should be reformed. In particular, it should take into account:</p> <ul style="list-style-type: none"> The different cost structures different services have, i.e., a large proportion of the costs of obstetric units are fixed because they need to be available 24 hours a day, seven days a week regardless 	NHS England and NHS Improvement	Develop proposals for reforming payment system 2016/17; pilot new system 2017/18; implement new system 2018/19	NHS England and NHS Improvement reporting

Number	Recommendation / action	Owner(s)	Timeframe / scale of ambition	How will we know?
	<p>of the volume of services they provide.</p> <ul style="list-style-type: none"> • The need to ensure that the money follows the woman and her baby as far as possible, so as to ensure women’s choices drive the flow of money, whilst supporting organisations to work together. • The need to incentivise the delivery of high quality and efficient care for all women, regardless of where they live or their health needs. • The challenges of providing sustainable services in certain remote and rural areas. 			

ANNEX B: MATERNITY REVIEW VISITS AND EVENTS

Date	Type	Location	Details
09/04/2015	Service Visit	Bristol	Southmead Hospital North Bristol NHS Trust
02/06/2015	Service Visit	Liverpool Merseyside	Liverpool Women's NHS Foundation Trust Cheshire and Merseyside Commissioners
22/06/2015- 23/06/2015	Overseas Visit	Sweden	Swedish Midwife Association; Stockholm County Council; Södra BB, Stockholm South Hospital; Danderyds Hospital
24/06/2015	Overseas Visit	Denmark	Sundhedsstyrelsen – Danish Health and Medicines Authority; Rigshospitalet
23/7/15	Stakeholder Engagement Event	London	Birth Tank 1
24/07/2015	Service Visit	Crowborough Sussex	Crowborough Birthing Centre East Sussex Healthcare NHS Trust
27/07/2015- 29/07/2015	Overseas Visit	Netherlands	Royal Dutch Midwives Association; Buurtzorg; Andreas Lucas Hospital, Amsterdam
04/08/2015	Regional Event	Preston Lancashire	Preston Guildhall Conference Centre
05/08/2015	Service Visit	Preston Lancashire	Preston Birth Centre Royal Preston Hospital

Date	Type	Location	Details
05/08/2015	Service Visit	Blackpool Lancashire	Maternity Services, Women's Unit, Blackpool Victoria Hospital
06/08/2015	Service Visit	Kendal Cumbria	Westmoreland Hospital Kendal University Hospitals of Morecombe Bay
06/08/2015	Service Visit	Barrow in Furness Cumbria	Furness General Hospital University Hospitals of Morecombe Bay NHS Foundation Trust
06/08/2015	Service Visit	Whitehaven Cumbria	West Cumberland Hospital, Whitehaven North Cumbria University Hospitals NHS Trust
07/08/2015	Regional Event	Carlisle Cumbria	Morton Park Family & Community Centre
13/08/2015	Service Visit	Birmingham West Midlands	Assessment and Birthing Centre Birmingham Women's NHS Foundation Trust
13/08/2015	Regional Event	Birmingham West Midlands	St Thomas Children's Centre Birmingham
14/08/2015	Service Visit	Birmingham West Midlands	Serenity Birthing Centre Sandwell and West Birmingham NHS Trust
24/08/2015	Service Visit	Wolverhampton	Wolverhampton Maternity Unit New Cross Hospital Royal Wolverhampton NHS Trust
25/08/2015	Service Visit	Bristol Avon	Cossham Birth Centre North Bristol NHS Trust
25/08/2015	Service Visit	Bristol Avon	St Michael's Midwifery Led Unit University Hospitals Bristol NHS Foundation Trust

Date	Type	Location	Details
26/08/2015	Service Visit	Plymouth Devon	Jubilee Home Birth Team and "Curvy Mums" Group Derriford Maternity Unit Derriford Hospital, Plymouth Hospitals NHS Trust
26/08/2015	Regional Event	Plymouth Devon	Devonport Guildhall Plymouth
27/08/2015	Service Visit	Portsmouth	Jubilee Home Births Team Portsmouth Hospitals NHS Trust
01/09/2015	Regional Event	Ipswich Suffolk	St Nicholas Centre
01/09/2015	Service Visits	Ipswich Suffolk Eye, Suffolk	Ipswich Hospital NHS Trust (including meeting with HealthWatch Ipswich) Gilchrist Birthing Unit
02/09/2015	Service Visit	Great Yarmouth Norfolk	James Paget University Hospitals NHS Foundation Trust
02/09/2015	Regional Event	Norwich Norfolk	The Kings Centre
02/09/2015	Service Visit	Norwich Norfolk	Norfolk and Norwich University Hospitals NHS Foundation Trust
04/09/2015	Regional Event	St Albans Hertfordshire	Friends Meeting House
04/09/2015	Service Visit	Watford Hertfordshire	Meeting with Herts Valleys CCG Perinatal Mental Health, Watford General Hospital
16/09/15 – 17/09/15	Observation	Nottingham	CQC Inspection
17/09/15	Service Visit	Boston Lincolnshire	Pilgrim Hospital United Lincolnshire Hospitals NHS Trust

Date	Type	Location	Details
17/09/2015	Service Visit	Sheffield South Yorkshire	Maternity, SCBU and NCU, Jessop Hospital, Sheffield Teaching Hospitals NHS Foundation Trust, Tree Root Walk, Sheffield
17/09/2015	Regional Event	Sheffield South Yorkshire	The Workstation
18/09/2015	Regional Event	Manchester	Methodist Central Hall
21/09/2015	Service Visit	East London	Barkantine Birth Centre, Barts Health NHS Trust
21/09/2015	Regional Event	East London	Oxford House, Bethnal Green
21/09/2015	Service Visit	East London	Island House Community Centre
06/10/2015	Service Visit	North Yorkshire	Friarage Hospital, Northallerton
07/10/2015	Service Visit	Newcastle	Royal Victoria Infirmary
07/10/2015	Regional Event	Newcastle	Seven Stories, National Centre for Children's Books
09/10/2015	Service Visit	Tooting	St George's Hospital
12/10/2015	Regional Event	Croydon	Croydon College
12/10/2015	Service Visit	South London	Kingston Hospital
14/10/2015	Regional Event	Oxford	The Quaker Meeting House
14/10/2015	Service Visit	Oxford	John Radcliffe Hospital Oxford University Hospitals NHS Foundation Trust

Date	Type	Location	Details
22/10/15	Stakeholder Engagement Event	Birmingham	Birth Tank 2
27/10/2015	Regional Event	Stafford	Silkmore Children's Centre
28/10/2015	Site Visits	Stafford and Stoke	County Hospital in Stafford; Royal Stoke University Hospital
05/11/2015	Site Visit	North London	The Whittington Hospital
06/11/2015	Engagement Event	Manchester	Meeting with parents who have experienced loss or complications, facilitated by Sands and Bliss The Studio, Manchester
12/11/2015	Meeting with Baby Charity Network	London	Meeting with representatives from the Baby Charity Network (Best Beginnings, CBUK, Bliss, The Lullaby Trust, The Multiple Births Foundation, GBSS, Sands, Tamba, The Ectopic Pregnancy Trust and The Miscarriage Association).
13/11/2015	Seldom Heard Group Event	Brighton	Meeting with the Friends, Families and Travellers BMECP Centre
20/11/2015	Engagement Event	London	Meeting with parents who have experienced loss or complications, facilitated by Sands and Bliss Park Plaza Victoria
23/11/2015	Seldom Heard Group Event	London	Meeting with Race Equality Foundation
27/11/2015	Seldom Heard Group Event	London	Meeting with Open Doors St Leonards Hospital, Homerton University Hospital NHS Foundation Trust

ANNEX C: NHS PERSONAL MATERNITY CARE BUDGETS

This proposal for NHS Personal Maternity Care Budgets is designed to increase choice for women. It will enable them to have quality care in line with NICE guidelines and reflects their wishes. The basic principle is that the best way of making change happen is to give women direct control over which provider receives the money for their maternity care. This annex summarises how that might be achieved. The proposal is designed to be within the existing resource envelope, to have low transaction costs, and operate wherever possible within existing systems. As explained in the report, it is intended that there would be an initial phase with a small number of pioneer sites, followed by wider roll out.

This proposal sets out a broad policy framework and operational intent as a guide as to how the scheme might operate, and in response to the areas felt to be the most significant. It is entirely appropriate that those who will be charged with implementation have the space to shape how that is done, and ensure a fit with differing local circumstances

In this context, the Review proposes a core set of principles to which CCGs implementing NHS Personal Maternity Care Budgets would be expected to adhere:

- Scheme eligibility needs to be clear. NHS England should work with CCGs to determine whether it should be restricted to women receiving standard care or made available more widely.
- The personal budget can be used with accredited local providers for each of antenatal, intrapartum and postnatal care. The process of accreditation of potential providers that also facilitates an NHS contract for future services will reflect those providers approved by CQC.
- Information regarding locally available providers will be made available on the appropriate online platform e.g. NHS Choices or equivalent.
- The local commissioning mechanisms will enable access by accredited midwifery practices to ultrasound and pathology services, and potentially birthing suites.
- In the medium term, accredited providers will be required to participate in interoperable care records, complete national maternity data set returns to the Health and Care Information Centre if requested and provide data to the CCG on a set of locally determined outcome measures.
- Clear local routes of access by women to facilitate choice are agreed and publicised.

How the Personal Maternity Care budget might work

After carrying out a pregnancy test and receiving a positive result, a woman has a clear locally agreed publicised choice of routes to access care. This route for access may, for example, be made available at local pharmacies or online. This choice might include:

- Seeking advice from her GP or practice nurse.
- Making an appointment with a nurse or midwife (which could be through the community hub as outlined earlier in this report where multiple providers may have a presence) to have a conversation about options informed by an assessment of the type of care she might need. Children's centre personnel could also be trained to give the information to support women.
- Self-referral direct to a provider of maternity care.

Whatever her choice of route to access care, each woman would be told about and offered a NHS Personal Maternity Care Budget and would be provided with information about local providers of NHS care, their service offer, and contact details. Alternatively, the woman could access information online. In either case, the information must be given in a consistent, unbiased format. At this point the woman would receive, either direct from the GP or midwife, or by applying online, the means of making a choice, such as an electronic code to use on a secure website. . Midwives and GP practices would be expected to encourage and support women who may be less confident to access the scheme and help women without internet access. The scheme would be voluntary.

The scheme would empower the woman to make her choice of provider for her antenatal, birth and postnatal care. The woman would choose her provider(s) on the basis of the care they were offering, for example, she may choose a provider who will try to ensure she receives the continuity of the same professional throughout her pregnancy, birth and postnatal care. She may choose the same provider for the three elements of her care or separate providers. The chosen provider will process the decision and the woman's responsible clinical commissioning group (CCG) would be required to honour the woman's choice and reimburse the provider accordingly. The submission of invoices, coding and other normal contracting logistics would occur as now.

However she accesses care, she will want an assessment of the type of care she might need (a risk assessment) and the development of a personalised care plan. The woman will enter into a commitment to her chosen provider through an agreed process which will also trigger the necessary payments for the provider. At the beginning of her pregnancy, the woman would only need to make a decision about antenatal care, if that is what she wants. She could wait, seeking further advice and

considering her needs and preferences as her pregnancy progressed, before making decisions about who would provide her care at the birth and postnatal stages. If her care needs proved to be greater than standard care, her transfer to another provider would be expected, and the payments made pro-rata.

Accreditation of providers

Providers available for selection by women using their NHS Personal Maternity Care Budget might be an existing NHS trust, or a midwifery practice operating in a similar way to a GP practice.

It is important that potential new NHS providers of maternity services pass a system of accreditation that goes beyond professional (NMC) accreditation. This will ensure that such providers are capable of handling public monies, and providing a safe, high quality service. Accreditation should cover two parameters; quality and governance.

Quality: Baseline quality for accreditation should be addressed as now by CQC registration. Ongoing quality assessment should be determined by analysis of the performance and outcome measures obtained by any provider.

Governance: Governance arrangements need, of course, to be proportionate to the size of an organisation. However there are common parameters which might be captured by the umbrella term of "well led". Evidence such as the occurrence and handling of significant events, staff feedback, turnover and absence rates, and routine management data may be used.

Only accredited providers will be eligible under this scheme.

New providers which are accredited will need to be integrated into the local maternity system (as outlined earlier in this report). This means that they will:

- Be party to decision-making on, and will adhere to local clinical guidance. arrangements, including standards and protocols to ensure that women and babies get more specialised care they need, when they need it.
- Take part in local multi-professional training.
- Capture and share data locally to enable benchmarking of both the individual service and the local maternity system, in order to inform service improvement. As set out earlier in this report, the expectation is that (in the medium term) data should be managed electronically.
- Work with the relevant network to ensure that learning takes place when things go wrong.

This also means that midwifery practices should have access to NHS facilities, including the community hub and diagnostics either in the community hub or at the hospital. The diagnostic provider may charge a fee and commissioners should use contracting mechanisms to ensure that such fees are reasonable. New Zealand, for example, has similar formal access agreements.

Links to personal health budgets

There is a strong synergy between Review's proposal for NHS Personal Maternity Care Budgets to support increased choice and control for women, and the established purpose and objectives of the wider personal health budgets programme across health and social care.

Personal health budgets are an amount of money identified to support a person's health and wellbeing needs, planned and agreed with the local NHS team. They give people choice and control over the care they receive. They primarily focus on non-acute care and centre around a plan which includes details of what the agreed health needs/goals are, the amount of money in the budget and how this will be used. The plan brings clinical knowledge and expertise together with the individual's knowledge of their condition, how it affects them and what works best for them.

Frequently asked questions

How will people who don't use e-communication be supported? Paper versions can be similarly used and online access facilitated by a third person.

Will this help improve the care of women with complex pregnancies? NHS England will work with CCGs to work out how best women with complex pregnancies can be supported to make choices.

Will this help reduce inequality? Yes. The proposal may enable the creation of maternity services geared to particular less well served segments of the population.

How does this fit with moves to encourage greater integration, such as through local maternity systems? The accreditation and contractual process to be able to provide maternity care under this scheme means that a new provider would be locked into the local maternity system, standards, quality measures and data collection that hallmark coordination. The ability to share facilities will enhance cooperation. All these alternative providers are currently outside the NHS with few cooperative mechanisms, this proposal changes that. Becoming part of the NHS family has obligations as well as opportunities.

What impact will this have on existing providers? NHS England and CCGs will work with pioneer sites to get a good understanding of the impact on existing providers and what measures might need to be taken as a result.

Will women be able to use NHS money to pay independent midwives? Women will be able to choose from a wider range of providers than now, all of whom will have to provide maternity care that meets standards of safety and quality laid down in contractual arrangements and accreditation by the NHS. This could include independent midwifery practices, who already provide NHS services in some parts of the country. These midwifery practices will provide services to women in a similar way to other long-standing contracted providers, such as General Practitioners.

Is there enough detail for CCGs to be able to put this into operation? This proposal sets out a broad policy framework and operational intent as a helpful guide of how the scheme might operate, and in response to the areas felt to be the most significant. It is entirely appropriate that those who will be charged with implementation have the space to shape how that is done, and ensure a fit with differing local circumstances

ANNEX D: HOW A RAPID RESOLUTION AND REDRESS SCHEME FOR BIRTH INJURIES MIGHT WORK

The case for change

The current system for investigating and compensating birth injury is complex, costly (for families, the NHS and central government), varies extensively across the country and fails on the three objectives that it should fulfil: i) rapid, compassionate support to parents, ii) effective learning for staff and iii) improved outcomes and reduced incidences of harm (and therefore costs). With birth injury litigation costs projected to rise we simply cannot afford the status quo.

How would the scheme work?

The rapid resolution and redress scheme would be a new insurance based system where families whose babies who had suffered harm could claim redress without the need to go through the courts. The scheme would be limited to harm occurring in term babies (37 weeks or more gestation) who were considered healthy when labour commenced, and to harm resulting in serious injury to the baby. The nature of the rapid resolution and redress scheme is that it would not be necessary to establish negligence in order to secure financial redress. The test would be one of causation: whether the harm was the probable consequence of the treatment provided or not provided during birth. An insurance assessor, working with appropriate professional and legal advice would settle claims.

It is important to emphasise that the rapid resolution and redress scheme would be *an option* for affected parents; their right to pursue a tort law claim for negligence would not be affected. If already successful under the scheme we would expect that any subsequent payment made in respect of a successful negligence claim would deduct the payment previously made.

At the same time a high quality investigation should take place (see below). There should be a clear separation between the decision under the rapid resolution and redress scheme and the investigation.

Why move to a new type of scheme?

Based on empirical evidence demonstrating what has worked elsewhere to reduce incidences of serious birth injury we believe this insurance based scheme is a *critical part of a framework* to improve the effectiveness of learning because it will significantly reduce the anxiety associated with the need to prove an individual clinician negligent, a requirement for a court to award financial redress. Other initiatives such as those to improve the quality of serious incident investigations, more effective obstetric emergencies training and the duty of candour are important

but our learning from the Swedish success in reducing rates of serious birth injury claims (50% reduction over a 6-7 year period) is that a change of insurance model unlocks the potential of other initiatives. In light of this, it is important that the test used to determine eligibility for financial redress is one of causation, as outlined above, rather than any test based on negligence.

Who could run the scheme?

This is a decision for the Department of Health but we envisage the scheme being most effectively and usefully administered by a distinct public body with expertise in medical indemnity insurance.

What would trigger an investigation and how would it be carried out?

Serious incident investigations should be triggered for all cases of severe brain damage, all stillbirths where the baby was alive at onset of labour, as well as all neonatal deaths and all maternal deaths. This means that the number of investigations will be greater than the number of families eligible for compensation through the rapid resolution and redress scheme.

Investigations should be carried out through Clinical Networks (as outline in Chapter 4), by trained and experienced experts, and the learning should be shared widely.

We hope that the new Health Services Investigation Branch will set standards and promote best practice techniques for high quality investigations. We recommend this includes clear expectations that families are fully informed throughout the process.

Would compensation payments be lower than payments achievable with a successful tort claim?

Successful insurance schemes, as in Sweden, offer a capped amount of damages and are therefore considered only to be fair and efficient models of compensation in countries who have generous social security provisions. We maintain that England has such a social security system and therefore a lower compensation payment combined with the additional benefits to learning, speed of redress, reduced harm and costs make the scheme a worthwhile option for families, clinicians and government to seriously consider. However, this is a decision for the Department of Health. Another idea is to make staged payments to families. One payment could be made immediately, with further payments following when the child reaches school age and at transition to adulthood. This reflects the fact that the full impact of a birth injury often becomes apparent in stages at these points in a child's life. At all stages in the process families would have a right to opt out of the insurance based system and pursue a tort law claim through the NHS Litigation Authority.

What we don't know

Previous attempts to introduce similar insurance schemes have failed due to affordability concerns. We believe that our proposed scheme would be affordable because, as is the case in Sweden, moving to an insurance based system would unlock the potential of other training and wider safety initiatives. We are also proposing limiting it to cases each year of babies injured during birth. Thankfully they are few in number but the cost of such cases is very high. It is, however, worth observing that such a scheme could provide assistance to a small number of families who currently fail to establish their case through the negligence route. The extra costs incurred would be offset by the reduced number of cases as the learning is assimilated into practice and therefore future incidents avoided. The Department of Health is undertaking further modelling and research into the proposed scheme and it will be for them to decide whether (and how) to proceed.

NATIONAL MATERNITY REVIEW

The National Maternity Review
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