

Maternity Matters:

*Choice, access and continuity
of care in a safe service*



DH INFORMATION READER BOX

Policy	Estates HR/Workforce Management Planning Clinical	Performance IM & T Finance Partnership Working
Document purpose	Policy	
Gateway reference	7586	
Title	Maternity Matters: Choice, access and continuity of care in a safe service	
Author	Department of Health/Partnerships for Children, Families and Maternity	
Publication date	April 2007	
Target audience	PCT CEs, NHSS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, PCT PEC Chairs, NHSS Trust Board Chairs, Special HA CEs, Directors of HR, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs, Royal Colleges, Heads of Midwifery, Commissioners, Obstetricians, Midwives	
Circulation list	Voluntary Organisations/NDPBs	
Description	Maternity Matters: Choice, access and continuity of care in a safe service outlines a national framework for local improvements to choice, access and continuity of care in maternity services. It highlights how commissioners, providers and maternity professionals will be able to use the health reform agenda to shape provision to meet the needs of women and their families. A self-assessment tool for commissioners to identify the needs of their population accompanies the document.	
Cross reference	National Service Framework for Children, Young People and Maternity Services; Every Child Matters: Change for Children; Making it Better: For Mother and Baby	
Superseded documents	N/A	
Action required	N/A	
Timing	N/A	
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For recipient's use		

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Foreword



Giving birth to a healthy, happy baby is one of the most normal but supremely rewarding experiences of life. Millions of women and their partners are able to do this in NHSS facilities, and many exercise choice around how and where they have their child.

We want that positive experience for everyone. Good maternal health and high quality maternity care throughout pregnancy and after birth can have a marked effect on the health and life chances of newborn babies, on the healthy development of children and on their resilience to problems encountered later in life.

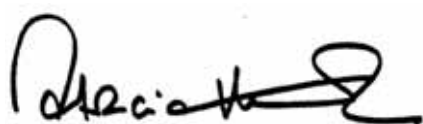
In 2005, the Government underlined the crucial importance of promoting such excellence in maternity care through its commitment to offer all women and their partners, a wider choice in maternity care. This commitment builds on our earlier vision for a modernised, woman-focused and family-centred, maternity service as described in the maternity standard of the National Service Framework (NSF) for Children, Young People and Maternity Services. This sets out the need for flexible services with a focus on the needs of the individual, especially those who are more vulnerable or disadvantaged. It also emphasises the need for all women to be supported and encouraged to have as normal a pregnancy and birth as possible.

Offering choice over where and how to give birth will lead to the more flexible, responsive and accessible maternity services that we envisaged in the NSF. New and different types of care will be developed and designed to meet the needs of all women; but particularly those women and families who need additional support. I also believe that increasing choice will improve the safety, quality and family friendliness of maternity services and encourage good services to improve even more.

Sadly some of our most deprived communities, have not always been well served in their maternity care. We want to change that. We want to ensure that the needs of these women, their partners and their families are treated with equal importance and respect.

High quality maternity care is not just about good professional care that ensures a healthy and safe pregnancy. It also involves access to a wide range of varied services that should work in partnership to help equip mothers and fathers with the skills they require to become confident and caring parents.

The future belongs to our children, with their mothers and fathers as custodians. *Maternity Matters* sets the context and vision for maternity care and implementation will empower, engage and involve parents in ensuring that every child has an equal, confident and healthy start to family life.



Patricia Hewitt
Secretary of State for Health



Every parent knows how much maternity matters. Bringing a new baby into the world is a truly special but also challenging experience.

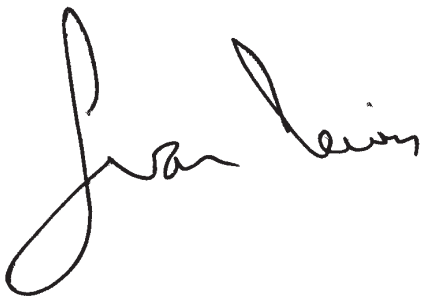
The quality of the advice, support and care provided from the early stages of pregnancy to the initial period of a baby's life is important for all families but especially those parents most at risk. Antenatal and postnatal care are crucial in ensuring parents feel adequately supported and equipped with the skills and knowledge to give their child the best possible start in life.

This exciting vision for the future of maternity services will enable the NHS to deliver the Government's commitment to offer choice to every parent by the end of 2009. Choice, quality and safety must be at the heart of a 21st century maternity service and must become a reality for all including those at the greatest risk as a result of health inequalities.

This framework is produced against the background of a public debate which too often fails to acknowledge that the vast majority of parents express a high level of satisfaction with care provided by midwives, nurses, doctors, health visitors and support staff on the frontline of the NHS. However, we accept there is still a great deal more to do. I believe individualised care offered by a midwife, specialist support provided to those most at risk and normal birth without medical intervention will become a more realistic option for every parent. Maternity should be integral to local early years strategies and where necessary, services should be reorganised to secure a choice of high quality, safe maternity provision in every locality.

Maternity Matters is an ambitious and practical framework which responds to the expectations of today's parents and asserts the status and value of the professionals who provide the support and medical expertise.

In a wider context, *Maternity Matters* is the foundation of *Every Child Matters*. It recognises that maternity care is the earliest intervention of them all and getting it right for babies and parents is an important part of supporting families and building our future national success.

A handwritten signature in black ink, appearing to read 'Ivan Lewis', with a large loop at the start of the first name.

Ivan Lewis MP
Minister for Care Services

Executive summary

The aim of health reform in England is “to develop a patient-led NHS that uses available resources as effectively and fairly as possible to promote health, reduce health inequalities and deliver the best and safest healthcare”¹. For maternity services this means providing high quality, safe and accessible services that are both women-focused and family-centred.

In 2005, the Government underlined the importance of providing high quality, safe and accessible maternity care through its commitment to offer all women and their partners, a wider choice of type and place of maternity care and birth. Building on this commitment, four national choice guarantees will be available for all women by the end of 2009 and women and their partners will have opportunities to make well-informed decisions about their care throughout pregnancy, birth and postnatally.

The national choice guarantees described in this document are:

1. Choice of how to access maternity care
2. Choice of type of antenatal care
3. Choice of place of birth – Depending on their circumstances, women and their partners will be able to choose between three different options. These are:
 - a home birth
 - birth in a local facility, including a hospital, under the care of a midwife
 - birth in a hospital supported by a local maternity care team including midwives, anaesthetists and consultant obstetricians. For some women this will be the safest option
4. Choice of place of postnatal care

As well as the choice of local options, a woman may choose to access maternity services outside her area with a provider that has available capacity. In addition, every woman will be supported by a midwife she knows and trusts throughout her pregnancy and after birth.

The priority for modern maternity services is to provide a choice of safe, high quality maternity care for all women and their partners. This is to enable pregnancy and birth to be as safe and satisfying as possible for both mother and baby and to support new parents to have a confident start to family life. For some, especially the more vulnerable and disadvantaged, the outcomes are unacceptable. Some women are up to 20 times more likely to die from a pregnancy related complication than other women and infant mortality rates are higher in more deprived areas of the country and in more vulnerable or disadvantaged groups.

Future maternity services must be planned to address current challenges including improving outcomes for more vulnerable and disadvantaged families, the reduction in working hours of doctors as a result of the Working Time Directive and demographic and lifestyle changes. At the same time, the principle should be that pregnancy and birth are normal life events supported by midwives.

Commissioners and providers will be able to use a number of the elements of the health reform agenda to facilitate improvements and innovation in the maternity services they offer. The challenge for local commissioners is to ensure that each element is sensitive to the specific nature and requirements of their population and service provision by:

- establishing an effective local commissioning framework
- ensuring tariffs support the effective commissioning of high quality and innovative services
- ensuring high quality and safe services are provided within the context of national standards
- ensuring an appropriately skilled maternity workforce with regular continuing professional development is in place
- developing the monitoring framework for the future

Individuals and organisations will play a pivotal role in achieving the Government commitment by the end of 2009 and the successful provision of the best possible maternity services. Their enthusiasm, engagement and ownership will drive this forward.

Maternity Matters describes a comprehensive programme for improving choice, access and continuity of care and it sets out a strategy that will put women and their partners at the centre of their local maternity service provision. It highlights how commissioners, providers and teams of maternity care professionals will be able to use the health reform agenda to shape the provision of services to meet the needs of women and their families. It emphasises the roles that each can play in providing women-focused, family-centred services and gives examples of what could be in place to achieve this. The key aim is to improve the quality of service, safety, outcomes and satisfaction for all women through offering informed choice around the type of care that they receive, and improved access to services whilst ensuring continuity of care and support.

1 Introduction

- 1.1 *Maternity Matters: choice, access and continuity of care in a safe service* sets out the Government's commitment for modern NHS maternity services and provides a national framework for its local delivery. The document focuses on meeting the Government commitment and provides practical guidance for local implementation.

Policy commitment to maternity services

- 1.2 The aim of health reform in England is “to develop a patient-led NHS that uses available resources as effectively and fairly as possible to promote health, reduce health inequalities and deliver the best and safest healthcare”¹. For maternity services this means providing high quality, safe and accessible services that are both women-focused and family-centred. Services should be accessible to all women and be designed to take full account of their individual needs, including different language, cultural, religious and social needs or particular needs related to disability, including learning disability.
- 1.3 *The National Service Framework (NSF) for Children, Young People and Maternity Services*² acknowledges the importance of addressing the needs of women and their partners before the woman becomes pregnant, throughout pregnancy and childbirth and as they embark on parenthood and family life. Healthy mothers tend to have healthy babies; a mother who has received high quality maternity care throughout her pregnancy is well placed to provide the best possible start for her baby.
- 1.4 The wider agenda for children and young people as outlined in *Every Child Matters: Change for Children*³ and as specified in the NSF, states what women can expect during pregnancy. The overarching maternity standard for the NSF is that:

Women have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies
- 1.5 Maternity care provides a unique opportunity for health care professionals to meet and support women, partners and their families who might otherwise never or rarely, access health services. In this respect, maternity services have a central part to play in contributing to the achievement of the Department of Health's (DH) Public Service Agreement (PSA) targets^{4, 5}. This link is reflected in the

PSA Target 1:

Substantially reduce mortality rates by 2010

- From suicide and undetermined injury by at least 20%

PSA Target 2:

Reduce health inequalities by 10% by 2010 as measured by infant mortality* and life expectancy** at birth

PSA Target 3:

Tackle the underlying determinants of ill health and health inequalities by:

- Reducing adult smoking rates to 21% or less by 2010 with a reduction in prevalence among routine and manual groups to 26% or less
- Halting the year on year rise in obesity among children under 11 by 2010 in the context of a broader strategy to tackle obesity as a whole
- Reducing the under-18 conception rate by 50% by 2010

Review of the Health Inequalities Infant Mortality PSA target⁶ which highlights the role of maternity services in delivering the PSA target on infant mortality.

- 1.6 Improved maternity services would also support the sign off criteria for two of the Local Delivery Plans (LDPs) that contribute to the monitoring of PSA target 2, namely:
- Smoking cessation: deliver a 1% point reduction per year in the proportion of women continuing to smoke throughout pregnancy, focusing especially on smokers from disadvantaged groups
 - Breastfeeding: deliver an increase of 2% points per year in breastfeeding initiation rate, focusing especially on women from disadvantaged groups***
- 1.7 The NSF² and *Every Child Matters: Change for Children*³, together with the PSA targets, highlight that supportive and high quality maternity care not only contributes to ensuring a healthy start for the newborn baby but can also help equip mothers and fathers with the skills to be confident and caring parents.
- 1.8 To enable the provision of high quality, safe and accessible services the Government has renewed its commitment, so that by the end of 2009:
- all women will have choice in where and how they have their baby and what pain relief to use, depending on their individual circumstances. This will be a national choice guarantee
- In addition:
- support will be linked closely to other services provided in the community, such as in Sure Start Children's Centres, to improve accessibility and promote early integration with other services
 - every woman will be supported by a midwife she knows and trusts throughout her pregnancy and afterwards so as to provide continuity of care
- 1.9 The maternity services commitment given here, and reinforced in the Government white paper, *Our health, our care, our say*⁷, underlines the

* Infant mortality target: 10% reduction in the relative gap in infant mortality rates between "routine and manual" socio-economic groups and England as a whole from the baseline year of 1997-99 to the target year 2010

** Life expectancy target starting with local authorities by 2010 to reduce by at least 10% the relative gap in life expectancy at birth between the fifth of areas with the worst health and deprivation indicators and the population as a whole

*** Achieving the PSA target on breastfeeding will contribute towards meeting the PSA target on reducing childhood obesity

importance of this NSF standard and helps to put in place the mechanisms to facilitate the reform of maternity services.

- 1.10 In preparing to meet the Government commitment by the end of 2009, *The NHS in England: the operating framework for 2007/08*⁸ outlines local action that needs to be taken by PCTs to lay the foundations for future improvements. These actions are included in section 4 of *Maternity Matters* under roles and responsibilities.

Influences on current service provision

- 1.11 A survey of women⁹ found that 80% were pleased with the care they received when they had their baby but would have preferred more choice about the type of care and about where to have their baby. Although many already receive this choice, the priority for modern maternity services is to provide a choice of safe, high quality maternity care for all women and their partners. This is to ensure pregnancy and birth are as safe and satisfying as possible for both mother and baby and to support new parents, including single parent families and same-sex couples, to have a confident start to family life.
- 1.12 There are challenges that need to be addressed to achieve the commitment by the end of 2009. Outcomes of pregnancy for the more vulnerable and disadvantaged are cause for concern:
- For maternal mortality, the confidential enquiry¹⁰ showed:
 - Women living in families where both partners were unemployed, many of whom had features of social exclusion, were up to 20 times more likely to die than women from the more advantaged groups
 - Single mothers were three times more likely to die than those in stable relationships
 - Women living in the most deprived areas of England had a 45% higher death rate compared to women living in more affluent areas
 - It is estimated 30% of domestic violence cases start or escalate during pregnancy¹¹ and domestic violence is associated with increases in rates of miscarriage, low birth weight, premature birth, fetal injury and fetal death
 - For infant mortality⁶:
 - Rates are still higher amongst routine and manual socio-economic groups
 - Higher than average death rates occur among babies born among black and minority ethnic populations, the babies of teenage mothers and those registered at birth by one parent rather than both
 - Babies born in the most deprived areas of the country are up to six times more likely to die in infancy

- 1.13 Around 16% of all pregnant women¹², including many of those under 18 years of age, delay seeking maternity care until they are five or more months pregnant, thus missing the crucial early days of maternity care. These women and their babies have worse outcomes than those who access maternity care at an earlier stage of their pregnancy. Commissioners need to understand what, in their current services, prevents these women from seeking care early or maintaining contact with maternity services and to overcome these barriers by providing more flexible services at times and places that meet the needs of these women.
- 1.14 Demographic and lifestyle challenges need to be taken into account. These include a rising birth rate, more women having babies later in life and more assisted conception with a greater likelihood of multiple births. Teenage mothers are three times more likely to smoke through their pregnancy than older mothers. Women from disadvantaged backgrounds may require additional services to meet their own particular needs. Each of these factors lead to an increase in the number of mothers and babies who may need more specialist medical care from obstetricians, anaesthetists, mental health practitioners, neonatologists or others, through maternity team care.
- 1.15 The introduction of the Working Time Directive (WTD) has resulted in a reduction in doctors' hours contributing to a requirement for different ways of working to provide maternity care. Maternity team care and more specialised services may need to be concentrated in fewer, more comprehensive facilities. At the same time, midwifery services are being strengthened in community settings for women with straightforward, low risk pregnancies.
- 1.16 It is important to recognise that pregnancy and birth are normal life events for most women. When specialist care is required, it must be readily available and of the highest possible quality. This means ensuring that all women have access to their midwife in their local community and should it be required, can have immediate transfer to a fully equipped local hospital with obstetricians, anaesthetists and other specialists in maternity or newborn care to provide a safe round the clock service that meets national standards. All midwives require the skills and up to date knowledge to know who to refer to as well as when and how to refer for more specialist opinion and care. Practice must be based on available evidence and according to relevant clinical guidelines.
- 1.17 Commissioners and providers involved in planning maternity services must take into account the challenges set out above and the diversity of the local population to ensure that the very best care is available to provide new parents and their babies with a better start to family life. Imaginative commissioning in some areas of the country has already shown how this can be achieved.

2 The maternity services commitment

The national choice guarantees

- 2.1 By the end of 2009, four national choice guarantees will be available to all women and their partners*. By having these guarantees, women and their partners are given the opportunity to make informed choices throughout pregnancy, birth** and during the postnatal period:
- i. **Choice of how to access maternity care** – When they first learn that they are pregnant, women and their partners will be able to go straight to a midwife if they wish, or to their General Practitioner. Self-referral into the local midwifery service is a choice that will speed up and enable earlier access to maternity services
 - ii. **Choice of type of antenatal care** – Depending on their circumstances, women and their partners will be able to choose between midwifery care or care provided by a team of maternity health professionals including midwives and obstetricians. For some women, team care will be the safest option
 - iii. **Choice of place of birth***** – Depending on their circumstances, women and their partners will be able to choose where they wish to give birth. In making their decision, women will need to understand that their choice of place of birth will affect the choice of pain relief available to them. For example, epidural anaesthesia will only be available in hospitals where there is a 24 hour obstetric anaesthetic service.

The options for place of birth are:

- birth supported by a midwife at home
- birth supported by a midwife in a local midwifery facility such as a designated local midwifery unit or birth centre. The unit might be based in the community, or in a hospital; patterns of care vary across the country to reflect different local needs. These units promote a philosophy of normal and natural labour and childbirth. Women will be able to choose any other available midwifery unit in England

* These choice guarantees are separate from choice in elective care

** Maternal requests for Caesarean Section should be managed in accordance with the NICE guidance on Caesarean Section

*** In addition to local options, providers that offer high quality services and can meet local needs are encouraged to increase capacity so that they can provide maternity services to women from outside their area. If those services are available, a woman may choose to access maternity services outside her area. This is already happening in some areas.

- birth supported by a maternity team in a hospital. The team may include midwives, obstetricians, paediatricians and anaesthetists. For some women, this type of care will be the safest option but they too should have a choice of hospital. All women will be able to choose any available hospital in England

iv. **Choice of postnatal care** – After going home, women and their partners will have a choice of how and where to access postnatal care. This will be provided either at home or in a community setting, such as a Sure Start Children’s Centre

Figure 1 illustrates the maternity pathway that is consistent with these guarantees.

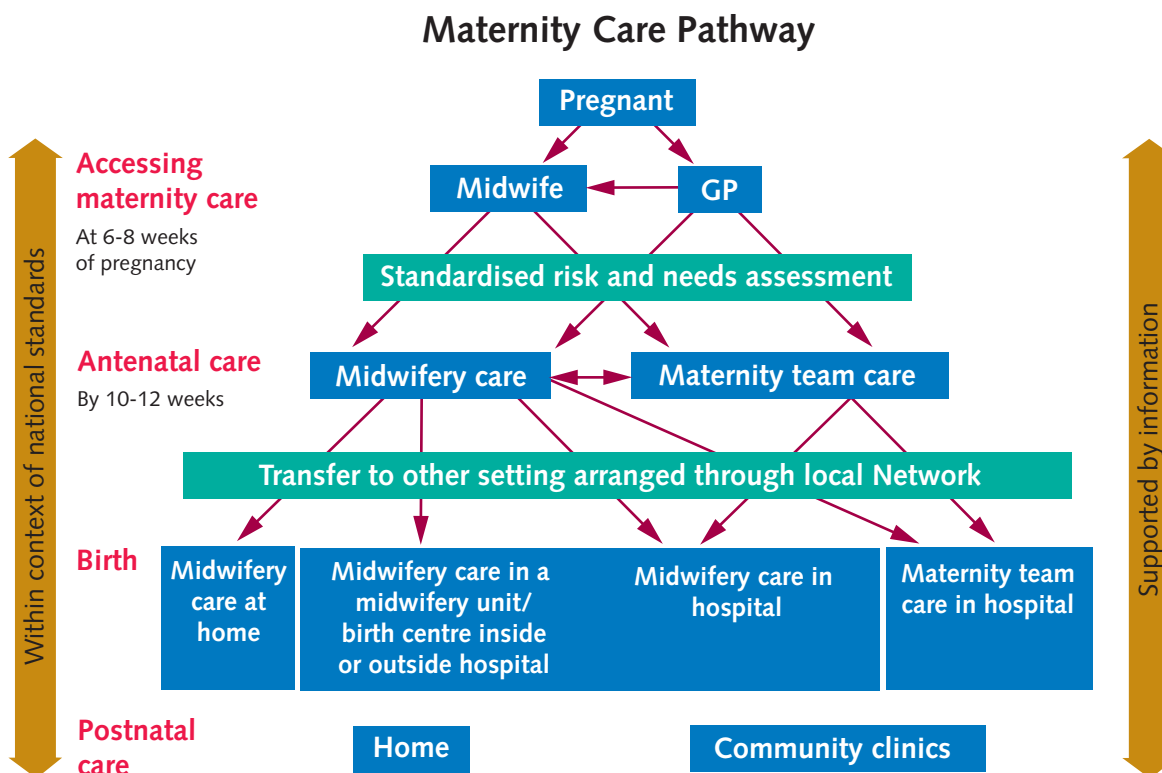


Figure 1: Choice commitments along the maternity pathway

- 2.2 To facilitate choice, comprehensive information in a variety of formats must be accessible and available to help support informed decision making and partnership working between the woman and her partner with their midwife and where appropriate, their obstetrician.
- 2.3 Enabling women and their partners to access midwifery services directly should mean that they enter the maternity care system in places and at times that suit them and at an earlier and more advantageous stage of their pregnancy. At the outset of pregnancy all women will have a discussion with their maternity

professional about their individual needs and preferences. Each woman will undergo a standardised risk and needs assessment to help in her decision making process. A standard framework for this is being developed as part of the forthcoming revised antenatal care guidelines by the National Institute for Health and Clinical Excellence (NICE).

- 2.4 Each woman, in partnership with her midwife or obstetrician, will draw up an individualised and flexible care plan and choice options will be discussed. The woman can then choose the type of care she would like to receive, recognising that her choices may change as the pregnancy progresses.
- 2.5 Women and their partners may choose antenatal care to be provided by midwives in the community or by the maternity team. However, for some women, care from a team of maternity professionals, including midwives, obstetricians and other specialists, will be the safest option. For others, who have complex social needs, maternity care can best be provided in partnership with other agencies. These could include children's services, domestic abuse teams, substance misuse services, drug and alcohol teams, youth and teenage pregnancy support services, learning disability services and mental health services.
- 2.6 Women should receive coordinated postnatal care, delivered according to relevant guidelines and an agreed pathway of care, encompassing both medical and social needs of women and their babies including those requiring perinatal mental health services or neonatal intensive care.
- 2.7 Maternity care must be made as safe as possible and should be provided within the context of any relevant clinical guidance from NICE and other relevant national standards and local protocols.

Accessibility and integration of services in community settings

- 2.8 Antenatal and postnatal care should be personalised and adapted to individual needs. This should include the development of stronger outreach midwifery support and breastfeeding services for vulnerable and disadvantaged families.
- 2.9 Development of maternity, neonatal and perinatal mental health networks* will ensure that all women and their babies have equitable access to the whole range of more specialist services where necessary and can be readily transferred via ambulance should any possible complications or emergencies arise.
- 2.10 Developing maternity services in easily accessible and visible community facilities such as Sure Start Children's Centres is one way to engage with the most

* Maternity, neonatal and perinatal mental health networks will be referred to as networks in the remainder of *Maternity Matters*

vulnerable families especially in disadvantaged areas. There are now over 1,000 Sure Start Children's Centres and the Government plans to have 3,500 by 2010, one for every community. By linking maternity services to the other types of care provided in children's centres, families will be able to access a whole range of other services that provide the valuable support and advice which both parents may need before and after their baby is born. A healthy pregnancy and the first three years of life are vital to a child's development, life chances and future achievement. The birth of a child is an ideal opportunity for maternity care professionals to engage with parents who are likely to be at their most receptive to support. Disadvantaged parents in particular can benefit considerably.

- 2.11 Midwives and health visitors are ideally placed to identify children and families who require additional support. Unfortunately, families with the greatest needs are often the least likely to receive the support they require and services frequently struggle to engage with them. Parenting support programmes delivered through focused home visiting can radically improve outcomes for the mother, child and family. As part of the Social Exclusion Action Plan, a model of intensive health-led home visiting is to be tested in 2007 and 2008 across 10 PCTs in England working in partnership with local authorities. These demonstration sites will evaluate the short term impacts of the parenting programme within the context of existing services in providing intensive support to the most disadvantaged families.

Southampton University Hospitals NHS Trust – Partnership working

The midwifery team in Southampton worked in conjunction with the Sure Start programme to enable women from vulnerable groups and their families to access Sure Start services and easier access to midwifery services in the community. The social model provided by midwives ensures that women have continuity of care throughout pregnancy, birth and afterwards for up to 6 weeks. One of the primary aims was to reduce the incidence of low birth weight babies.

For women cared by these teams, there was a reduction in the quarterly incidence of low birth weight babies from the first quarter in 2003 of 12.6% to 7.9% in the last quarter of 2006. In addition, the midwifery teams attached to Sure Start were able to support 31% of women to give birth in a birth centre or at home, compared to 25% of women cared for by other teams.

Continuity of midwifery care

- 2.12 A guiding principle for the modern maternity services is that "all women will need a midwife and some need doctors too". All women and their partners, however complex the pregnancy, will want to know and trust the midwife who is responsible for providing information, support and on-going care. Midwives are

the experts in normal pregnancy and birth and have the skills to refer to and coordinate between any specialist services that may be required.

2.13 Elements of continuity of midwifery care will include:

- having the time to talk, engage and build a relationship with women and their partners to understand and help meet their needs throughout pregnancy and afterwards
- ensuring that women and their families are aware of the arrangements for on-going midwifery support and coordination, should the known midwife be unavailable
- ensuring continuity of care and handover where a woman chooses to give birth outside her area. The midwives in each area are responsible for this
- providing individual support to women throughout their labour and birth

2.14 If midwives roles encompass these elements, it is likely that they will have a higher level of job satisfaction too.

Considerations to meet the commitment

2.15 The key elements of what commissioners and providers could have in place to enable choice, access and continuity of care in a safe service are identified in appendix A.

3 Achieving the maternity services commitment

3.1 Commissioners and providers will be able to use a number of the elements of the health reform agenda to facilitate improvements and innovation in the maternity services they offer. The challenge for local commissioners is to ensure that each element is sensitive to the specific nature and requirements of their population and provision. This includes implications for the information technology to support the maternity service commitment.

Local commissioning framework

3.2 The commissioning of maternity services must be used together with the national choice guarantees as a way to drive the essential improvements in the quality, safety and accessibility of services. There are four opportunities to do this.

i. The Commissioning Framework for Health and Well-being

The *Commissioning framework for health and well-being*¹³ has a strong focus on addressing inequalities in access to health services and encouraging the increased co-location of appropriate services. Commissioning mechanisms covered within the framework include:

- a requirement to undertake Strategic Needs Assessments
- publication of Primary Care Trust (PCT) prospectuses in Autumn 2007. These should include the PCT proposals for increasing choice and improving maternity services
- an emphasis on the importance of PCTs and local authorities working together to develop practical and deliverable proposals for improving maternity services
- Practice-based Commissioning (PBC): *Health Reform in England: update and commissioning framework*¹ is intended to improve the quality, responsiveness and value for money for services and may lead to the re-design of services to enable improvement

3.3 The DH will work with commissioners to identify the support and tools they require to commission maternity services following publication of the *Commissioning framework for health and well-being*¹³ and *Maternity Matters: Choice, access and continuity of care in a safe service*.

ii. Strategic Needs Assessment

- 3.4 Maternity care should be included within the Strategic Needs Assessments to be undertaken by PCTs and local authorities. Commissioners and partners need to achieve a thorough understanding of the demand for and provision of maternity and associated services in order to commission effectively and include for example perinatal mental health, ambulance and neonatal services, and the part they may play in achieving the commitment by the end of 2009. Some of the key activities in this phase will include:
- Assessing current commissioning processes to support the delivery of effective, high quality maternity services and enable change. The DH has developed, in conjunction with key stakeholders, a strategic self-assessment commissioning tool for PCTs to assess their commissioning capacity and capability for maternity care. The tool covers the aspects of best practice in commissioning maternity services. It includes a scoring system to help PCTs identify any shortfalls in their current commissioning capabilities and a resource section to inform commissioners of relevant policy documents and clinical guidelines. The tool, in CD format, accompanies this document
 - Carrying out a robust local needs assessment that considers a comprehensive range of issues. These include identifying the characteristics of the more vulnerable and excluded local populations and mapping their contact with current maternity services (as well as identifying what arrangements are already in place for reaching out to those who fail to access care). The Race Relations (Amendment) Act 2000, Disability Discrimination Act 2005 and, with effect from April 2007, the Equality Act 2006 also require NHS organisations to conduct race, disability and gender equality impact assessments when developing policy and commissioning services. The DH recommends that assessments should be integrated with other equalities considerations to ensure the effective promotion of equality and delivery of quality services tailored to the needs of local communities¹⁴
 - Assessing the need for and the role of local networks. In order to improve outcomes for the most vulnerable women, networks also need to link with a range of services outside the NHS. Links to commissioning arrangements led by local authorities' children's services should also be strengthened
 - Using the Maternity Services Liaison Committees (MSLC)¹⁵ or similar fora* to agree on a common set of objectives for maternity services, set the service specification for maternity services and to be the local voice in the production of the PCT prospectus

* If such a forum does not exist, then this should be established

- Carrying out a comprehensive review of the current maternity workforce. This is to enable the provision of all models of care including midwifery and team based care. A range of tools is available to local health communities for example Birthrate Plus¹⁶ and the Maternity Decision Support tool developed by the Care Services Improvement Partnership (CSIP)¹⁷
- Developing, where needed, appropriate local quality standards and incentives to improve service quality for inclusion in contracts from 2008/09
- Assessing and planning local information requirements to ensure that women and their partners have the information and advice they need in ways they can use and understand to make informed choices at all stages of their pregnancy and after birth
- Ensuring that robust cost and activity data are available for all maternity services

iii. Focus on Reorganisation

- 3.5 Maternity services need to be safe and flexible – designed around the needs and choices of women and their partners. Any reorganisation of services should reflect this. An overview of the drivers of change for the reorganisation of maternity services can be found in appendix B.
- 3.6 Section 11 of the *Health and Social Care Act 2001*¹⁸ places a duty on NHS organisations, including NHS Foundation Trusts, to make arrangements to involve and consult patients and the public in service planning, in the development of proposals for changes in services, and in decisions affecting the operation of services. NHS organisations, including NHS Foundation Trusts, are also required to consult relevant overview and scrutiny committees on proposals to substantially vary or develop services. Where NHS Foundation Trusts are planning and taking forward major service change, they should take into account the commissioning strategy of the PCT(s) as well as meeting their own regulatory requirements¹⁹. Commissioners want to secure improvements in services that are both flexible and responsive to the needs of the local population, including the particular needs of more vulnerable and disadvantaged women and their families. Safety of mothers and babies is paramount in all settings. Reorganisations will be guided by the principle that there needs to be absolute clarity around responsibilities and clear protocols governing transfers before, during and after labour and that these should be on a network basis, so that women can transfer flexibly and in a timely manner between different levels of care²⁰.

Mayday Healthcare NHS Trust – Effective Skills Mix

Mayday Healthcare NHS Trust has successfully reorganised its maternity services in a way that promotes normality and enhances the choices available to women regarding the location for giving birth and choice of analgesia in labour.

The main element of the reorganisation has been the development of the midwifery Mayday Birth Centre on the main hospital site. The centre was developed with user involvement and consultation. This centre gives women with uncomplicated pregnancies the option of a birth in a home-like and non-clinical environment, with the security of robust transfer procedures in the event that complications arise. The innovative environment, which has three birth pools and mood lighting, has led to an increase in the number of normal births where women are giving birth with minimal pharmacological analgesia and no medical intervention.

In addition, the Mayday has introduced both caseload and integrated midwifery teams and developed a triage system, which together has relieved the pressure on the labour ward. In the first four months since opening, 194 births took place in the birth centre away from the labour ward.

iv. Implementation planning

- 3.7 The planning for maternity services should be undertaken in partnership with other organisations including local authorities. Local commissioners, providers, staff and service users are best placed to determine the most effective method of ensuring improved access to care for the most vulnerable in their communities.
- 3.8 Local health communities are responsible for identifying the priorities as part of their commissioning and contracting processes and publication of their prospectus. Furthermore, all changes to local service provision will need to be reflected in the *Your Guide to Local Health Services*²¹.
- 3.9 During this planning phase, commissioners will be able to draw on the experience gained by NHS North West, who have committed to work jointly across the DH and the NHS to feedback all learning and provide expert advice drawing on their experience, as commissioners work to shape the future of maternity services to meet the needs of their local population. This will include piloting work around areas such as payment by results (PbR), choice and workforce capacity. Further learning from a social enterprise pathfinder, which is being established in the North West, will be shared. It's focus is on providing antenatal, postnatal and community midwifery services at home or in birth centres in the Trafford area of Greater Manchester and will contribute to the further extension of choice of maternity care.

Tariffs for commissioning high quality and innovative services

- 3.10 *Our health, our care, our say*⁷ stated that PbR will support the choices women make during their pregnancy and the scope of PbR will, over time, increase in order to take choice into account. The scope of PbR for 2007/08 will not change but there is flexibility to introduce locally agreed prices for activity such as home births and this has already happened in some areas. Such local innovation is encouraged but providers and commissioners should satisfy themselves that their costing is robust, for example by correctly apportioning Clinical Negligence Scheme for Trusts (CNST) contributions. This will enable the true cost of maternity activity to be recorded.
- 3.11 Commissioners and providers can also encourage normality in birth without any changes to PbR. Commissioners can set their providers challenging targets to reduce interventions as part of the contracting process. Providers can apply lessons from the NHS Institute for Innovation and Improvement's *Focus on: Caesarean Section*²² to help reduce intervention. High rates of interventions, such as large numbers of caesarean sections, could lead to worse outcomes for mothers and their babies, as well as being less cost effective for the NHS.
- 3.12 Further detail on the strategy for PbR in 2008/09 was set out in the consultation document *Options for the Future of Payment by Results 2008/09 to 2010/11*²³. It considers how to develop PbR to support DH policy including pricing to reward quality care, strengthening PbR's building blocks (including improving Health Reference Groups) and extending its scope. The future policy on PbR will take into account that:
- PbR does not cover all birth settings, as home births are excluded
 - PbR does not cover clinics for which a midwife is clinically responsible or community visits by midwives and health visitors. This excluded activity is being paid for out of existing "block" contracts. Providers may currently have an incentive to do more maternity team care as they know extra activity in this area will be rewarded
 - In common with other services, PbR does not include the cost of any emergency ambulance transfers, for example, transfer for women from home, from a stand alone midwifery unit to a hospital or for a baby to a neonatal intensive care unit
 - Past reference costs for obstetrics submitted by the NHS have not always recognised the higher proportion of the CNST cost that falls on maternity services
- 3.13 Concerns have been expressed that current tariffs are not designed to promote normality as caesarean sections attract more funding than normal births,

however, this is because they cost more than normal births to provide. There is no evidence to suggest that PbR is leading to more caesarean sections.

- 3.14 Any changes to the scope of PbR may be tested in PbR development sites before national roll out. Subject to successful testing, national tariffs may be set for all clinics conducted by a midwife and for home births. Consideration is being given to whether home births should receive the standard tariff for normal birth without complications or if a separate tariff is needed because the cost and resources used for birth at home are significantly different. The options for setting a tariff for community antenatal and postnatal visits by midwives will be investigated.

South Devon Healthcare Trust – Developing innovative local tariffs

South Devon Healthcare Trust's major hospital site in Torbay provides services for an area of mostly rural communities spread over 300 square miles. To help meet the needs of these communities, the Trust's midwives sought to offer midwifery services to women and their families more locally. To support this, the Trust established a local tariff price with their commissioners for home birth – ensuring that the Trust is paid for each additional home birth supported by their midwives.

The price has been set at a competitive level that is good for the commissioner, but which is still profitable for the Trust because of the efficient way the maternity services operate. This gives the Trust a clear incentive to encourage home births where they meet women's needs and when women want them. This may be related to the fact that the Trust has a home birth rate of over 11%, against the national average of 2%.

High quality and safe services

- 3.15 Maternity care providers are responsible for clinical care at the point of contact and must ensure safe, high quality and effective maternity services, appropriate for the needs of the local women and their families. Providers are also responsible for the environment and facilities, which are essential for woman-focused, family-centred care.
- 3.16 The patient pathway approach used in the NSF provides a tool to ensure a comprehensive service, which emphasises the need for multi-agency health and social care especially in reducing inequalities in access and uptake of care. Importantly it also specifies the supporting elements to enable evidence-based clinical care and the organisational, training, education and governance issues that must accompany a safe service that continually strives to improve.
- 3.17 In developing networks and pathways for clinical care, the importance of clinical leadership and multidisciplinary working must be recognised. All clinicians

providing care need to recognise each other's responsibilities within the team to improve safety. Within the network, at all stages of pregnancy and postnatally, women require access to the appropriate professional to give information, advice, care and support, however simple or complex the need.

- 3.18 There is a particular need to provide more senior cover on labour wards. Increasing the presence of consultant obstetricians on the delivery suite has been shown to reduce both caesarean section rates and complications of operative vaginal delivery, a major contribution to improving safety for women and their babies. The experience at Northwick Park has illustrated an appropriate increase in the hours of consultant obstetrician presence is one factor that can contribute to the reduction in maternal mortality.

Northwick Park Hospital NHS Trust – Safe services

Special measures were imposed by the Secretary of State at Northwick Park Hospitals NHS Trust in April 2005 following the Healthcare Commission's investigation into maternity services. This was triggered by unexpectedly high maternal mortality figures (there were ten maternal deaths in a three year period). As a result, the structure of the unit was strengthened through leadership – clinical leaders became visible and were supported by senior trust staff. Safety standards were improved by increasing midwifery staffing levels to be on par with other London hospitals and by increasing the consultant obstetrician presence on the delivery suite from 40 to 60 hours per week. The clinical governance structure was strengthened by revised protocols and guidelines, better risk management processes, audits and multidisciplinary learning.

Special measures were lifted in September 2006. Near miss audits indicate a trend in reduction of morbidity such as admissions to intensive care unit, postpartum hysterectomies and massive blood transfusion. The continued performance and governance issues are monitored by a performance and governance scorecard, which shows marked improvement in safety parameters.

- 3.19 Ultimately, the experience and perception of maternity services by a woman and her partner often depends on the attitude and manner of the health professionals they meet. Consistent quality of care throughout the continuum of pregnancy, birth and the postnatal period is vital. Aspects of care that women rate as less satisfactory e.g. postnatal care in a hospital setting, should be addressed as a matter of priority when commissioners plan their services. Effective commissioning will help improve the quality of the services provided and lead to improvements in perceptions of the service received.

Skilled workforce

- 3.20 Local planning will determine the workforce capacity required to support the national choice guarantees. It is essential that local organisations begin to plan now, in line with *The NHS in England: the operating framework for 2007/08*⁸ which requires local organisations to undertake a comprehensive review of their workforce capacity.
- 3.21 The maternity workforce has increased in recent years²⁴. There are over 2,400 more midwives working in the NHS compared to 1997, providing the equivalent of almost 900 more full time midwives. There are around 950 extra doctors working within Obstetrics and Gynaecology compared to 1997, and the whole time equivalent medical workforce has increased by over 970 during this period.
- 3.22 There is more growth in the system to come through, with over 1,000 additional midwifery students due to qualify leading up to 2009. It is vital that opportunities are made available to ensure that they secure employment on qualification.
- 3.23 As part of the development of a local workforce strategy, there are other aspects to be considered in parallel with the size of the maternity workforce. These influences include:
- **Good leadership and an open, supportive culture** It is imperative that organisations have good leadership, within an open and supportive culture which will provide the foundation for good maternity services that can fulfil the needs and expectations of women and their families. Organisations will need to consider the level of investment required to build and enhance leadership, that will also support job satisfaction and staff morale
 - **Geographical variations** Different areas have different staffing profiles and there are variations in vacancy rates amongst employers operating in similar labour market areas. Local organisations are required to assess both their current position and their future requirements in line with the changes to maternity services outlined in this framework
 - **Increasing workforce capacity** In order to enhance services, some areas may identify a need to invest in services and increase their workforce capacity. There are a range of strategies which can be used locally to achieve this, including running return to practice and adaptation programmes or changing skill mix in the workforce
 - **Working Time Directive** The requirements of the WTD will affect the way that hospital maternity services are provided as it impacts on doctors hours and midwifery time. Local workforce plans will need to consider the impact on their maternity services and take appropriate steps to ensure full compliance

- **Safe staffing levels** Assessments of future workforce requirements should be made locally to identify the number and experience of staff required to provide appropriate and safe cover on labour wards. CNST standards for staffing are derived from the recommendations of a joint RCOG/RCM working party which agreed that an obstetrician who has completed a minimum of two years training in obstetrics should be available on the labour ward within 5 minutes. Where this doctor requires supervision or help, the consultant obstetrician must be available within 30 minutes. CNST also requires dedicated consultant obstetrician presence on labour ward for 40 hours per week and recognises that over time there will be greater consultant obstetrician involvement in care through the 24 hour period
- **Staff development** It is vital that attention be given locally to evaluating the skills within the maternity team. These skills will need to continue to be developed and enhanced in line with the changes made to services. An audit of skills would help local organisations identify any gaps where they need to channel their investment
- **Skill mix** It is important to ensure that services have staff at appropriate levels, with appropriate skill sets, undertaking appropriate tasks. Changing skill mix has the potential to release clinical time and improve outcomes for babies, in particular through maternity support workers and the employment of consultant midwives

3.24 These and other factors which may impact on the development of a maternity workforce suitable to meet the needs of women and their families, are highlighted in detail in appendix C.

Derby Hospitals NHS Foundation Trust – Mixing skills to develop an effective workforce

Derby Hospitals NHS Foundation Trust's involvement in the Maternity Support Workers (MSW) programme has enabled the maternity service to improve quality of care provided to women and their families. The types of activities carried out by the MSWs included: breastfeeding support and advice, general health promotion, blood tests and appointment booking. Midwives reduced their non-midwifery tasks by 30% and there has been a reduction of 20% in waiting times in community antenatal clinics. 18% of the home visits are undertaken by MSWs.

The programme has enabled staff to modernise and redesign their services with measurable outcomes and benefits for both women and midwives. The service is able to demonstrate both quality of care and efficient use of resources for the benefit of the local population.

Monitoring framework

- 3.25 Performance management within the NHS is evolving. Work is still underway on creating the regulatory framework within which the new, reformed NHS will operate. *Health Reform in England: update and commissioning framework*¹ signalled a shift from the existing DH target driven system. Post 2008, a metrics based system will be in place within a context of quality and safety requirements. Foundation Trusts will continue to be regulated by Monitor which authorises, monitors and regulates NHS Foundation Trusts and can intervene if they are deemed to be failing in their healthcare standards or breaching their terms of authorisation.
- 3.26 When developing local indicators for *Maternity Matters* the focus should be on women's perception of choice, early access to maternity services and continuity of care. It is also anticipated that some baseline indicators for choice and continuity of care will be reported through the local patient experience survey being coordinated by the Healthcare Commission in Summer 2007.
- 3.27 A maternity dataset is currently being developed to support the implementation of the NSF. It is being designed for secondary use purposes e.g. planning and commissioning of services rather than direct care of the patient and will be derived from information already, or anticipated to be, captured in the electronic care record (a primary source of data). The plan is to implement the dataset towards the end of 2009.
- 3.28 The national understanding of progress will be supplemented by the Healthcare Commission, which has a key role in providing independent assessment of performance of NHS organisations. Elements of Healthcare Commission work in progress include:
- A national survey of maternity experience jointly funded with the DH and conducted by the National Perinatal Epidemiology Unit²⁵. A separate Trust level survey of women using maternity services will be conducted during summer 2007 and will feed into the Annual Health Check
 - Working with stakeholders such as the Royal Colleges to ensure that evidence based clinical guidance and standards are being developed
 - Developing a range of indicators for the Maternity Services Review, which will enable users, trusts and commissioners to compare performance against others. This work will be shared with Trusts in Autumn 2007 and this will complement the new DH performance regime for commissioners.

4 Roles and responsibilities

4.1 Successful provision and delivery of the best possible maternity services, including choice, will require full engagement of all service providers, commissioners and organisations that facilitate regulation, systems management and support. The diagram features the women and their families at the centre of the provision of woman-focused, family-centred maternity services and below that are likely roles and responsibilities for each type of organisation.

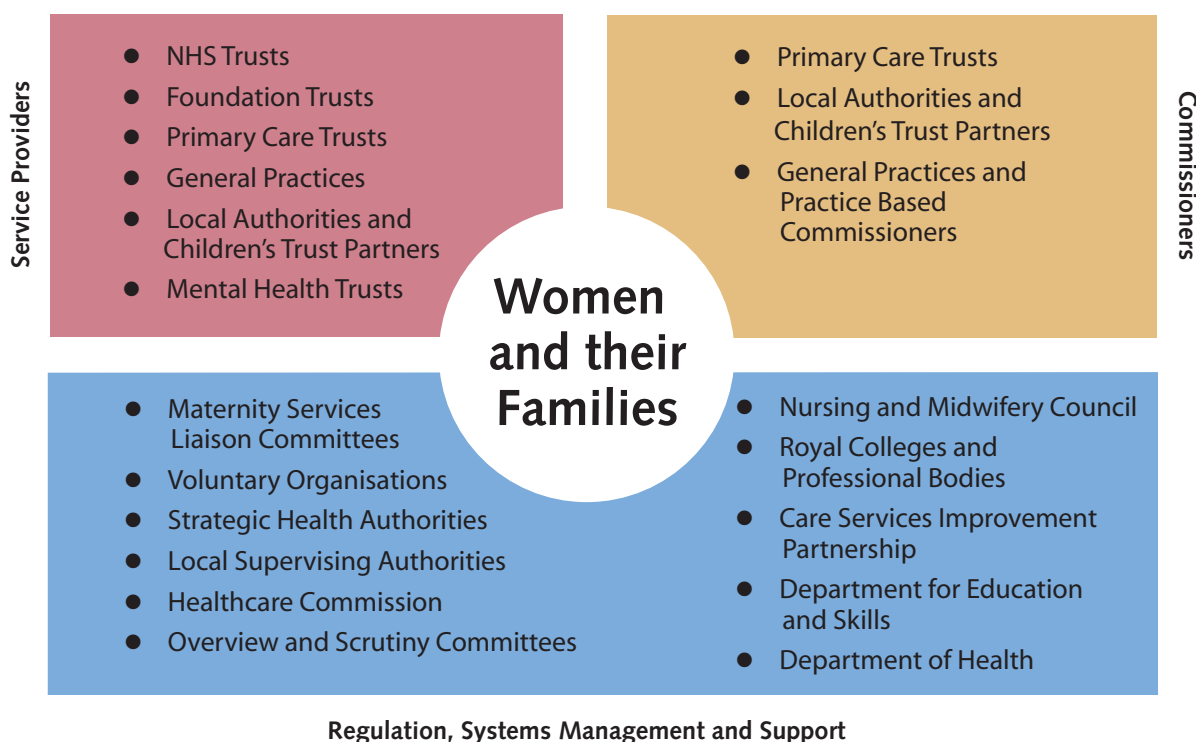


Figure 2: Organisations involved in the provision of maternity services

4.2 NHS Foundation Trusts, NHS Trusts, Ambulance Trusts and other maternity service providers

- Deliver high quality, safe and responsive maternity care with appropriate levels of trained staff in compliance with national guidance e.g. NICE. Clinical care should be regularly audited and poor outcomes must be subject to detailed review. The findings of audits and reviews must be acted upon

- Be responsible for the environment, facilities and timeliness of services, including transfers, that are essential for women-focused, family-centred care
- Support PCTs in planning and monitoring maternity care
- Gather and report routine data including specific maternity activity as required through the monitoring framework
- Be responsible for developing their workforce for maternity services, ensuring that they have sufficient appropriately trained staff who undertake continuous professional development
- Ensure board regularly reviews the performance and function of maternity services

4.3 Primary Care Trusts

- Develop the local vision for maternity services in consultation with key stakeholders and local authorities and publish in the annual PCT prospectus
- Assess current services, identify gaps and the barriers to service development then set out the local strategy for meeting the maternity commitment by the end of 2009
- Assess the current baseline of their maternity workforce, use appropriate workforce planning tools, such as the CSIP Maternity Tool and Birthrate Plus, to identify future workforce needs and take action to address any gaps in workforce provision including the development of new skills and roles
- Commission high quality, equitable, integrated maternity services as part of local networks according to local need. Critically this will include developing and agreeing clinical protocols and maternity service pathways in line with the NSF and the national choice guarantees
- Engage with the local population to ensure that maternity services are developed in line with local needs and priorities
- Ensure all maternity service professionals receive regular continuing professional development and understand how the local network functions
- Monitor the performance, quality and safety of maternity service providers
- Ensure the provision of high quality information to enable informed choice

4.4 General Practices

- Work with PCTs to commission a comprehensive and equitable range of high quality, responsive and efficient maternity services that reflect local need
- Ensure that high quality, responsive maternity services are provided, including general medical services for pregnant and postnatal women

- Work with PCTs and providers to agree clinical protocols and pathways within local networks and assist women and their partners in considering their options for antenatal, birth and postnatal care
- Refer all pregnant women to maternity services as soon as possible
- Provide the relevant medical and social history to the midwife responsible for the care of the pregnant woman regardless of which referral route has been chosen

4.5 **Local Authorities and Children's Trust Partners**

- Support the development of local networks
- Work in partnership with PCTs to develop Children's Centres which include maternity services
- Meet duties under Childcare Act 2006 and work with NHS partners to improve the outcomes of all children up to 5 and reduce inequalities between them, by ensuring early childhood services are integrated to enable easy access. This will involve informing Local Area Agreements and Children's and Young Peoples Plans

4.6 **Mental Health Trusts**

- Work with PCTs to agree clinical protocols and pathways for seamless care for pregnant or recently delivered women with mental health problems
- Ensure the provision of the specialist perinatal psychiatric services for women with serious mental health disorders and provide services to inpatient mother and baby units for those women who require admission

4.7 **Maternity Services Liaison Committees**

- Advise PCTs and maternity service providers on all aspects of maternity services
- Monitor progress of service development against an annual plan

4.8 **Voluntary Organisations**

- Provide patient and parent representatives
- Provide a range of services including support and information
- Contribute to local consultations

4.9 **Strategic Health Authorities**

- Provide strategic leadership to assist PCTs in the development of the local vision for local maternity services, the development of networks and of user involvement

- Oversee and contribute to the development of the workforce strategy, workforce modernisation and workforce development
- Ensure that opportunities exist for three year and 18 month pre-registration programmes and flexible return to practice midwifery programmes
- Hold PCTs to account for commissioning comprehensive maternity services
- Ensure that Local Supervisory Authority standards and activities promote safe, high quality care for women and their babies and monitor standards of midwifery practice
- Ensure that the local community has representation on a local MLSC or equivalent and other user involvements groups e.g. LINKs

4.10 **Local Supervising Authorities (Midwifery)**

- Monitor maternity service interface with clinical governance structures and mechanisms across the SHA, to identify trends and provide a framework for continuous improvement in both individual services and across networks
- Monitor service developments and reconfigurations to ensure that safety and quality is assured
- Monitor staffing levels, workforce planning and professional development to ensure that women are able to access services which are fit for purpose
- Contribute to educational fora to ensure that curriculum development reflects the needs of a modern maternity service

4.11 **Healthcare Commission**

- Undertake and report on the Maternity Services Review and woman's experience survey in 2007
- Maintain oversight of organisations' approach to care through the Annual Healthcheck, local presence and investigations activity

4.12 **Overview and Scrutiny Committees**

- Provide scrutiny and challenge around the role and integration of maternity services with local authority provided services

4.13 **Royal Colleges and Professional Bodies**

- Define measurable standards for the skills, competencies and regular continuing professional development needed for the provision of maternity services
- Support the development of the curriculum requirements for postgraduate education and training in maternity services

- Facilitate multidisciplinary learning so that all clinicians train in a way that recognises each others responsibilities within the team to improve care and safety

4.14 **Nursing and Midwifery Council**

- Set the curriculum requirement for pre and post registration education and quality assure nursing and midwifery education including regular continuing professional development
- Set standards and provide guidance for LSAs for the supervision of midwives and provide midwifery guidance and advice
- Ensure midwives and nurses are on the relevant professional register, are compliant with continuing professional development and have processes in place to address allegations of professional misconduct

4.15 **Care Services Improvement Partnership**

- Provide regional and local support to enable implementation and support the development of networks
- Enable use of tools and improvement methodologies to support change in local maternity services and facilitate sharing and spread of good practice

4.16 **Department for Education and Skills**

- Ensure that the programme for the development of Sure Start Children's Centres takes into account the requirements of maternity services

4.17 **Department of Health**

- Develop national policy and guidance to support and enable local implementation

5 Conclusion

- 5.1 The future belongs to our children, with their mothers and fathers as custodians. Nothing can therefore be more important than cherishing and providing the best possible care for all our pregnant mothers, expectant fathers and babies, and equipping new parents with the skills and support they may need to enable every child to have an equal, confident and healthy start to family life.
- 5.2 A comprehensive programme for improving choice, access and continuity of care in maternity services is being developed. *Maternity Matters* sets out a strategy that will put women and their partners at the centre of their local maternity service provision. It highlights how commissioners, providers, maternity professionals and user representatives will be able to use the health reform agenda to shape provision to meet the needs of women and their families.

Appendix A: Considerations for commissioners and local providers

The following tables identify the key elements of what could be in place to support the provision of choice, access and continuity of care. They summarise what commissioners and providers will want to have in place to deliver woman-focused, family-centred maternity care.

CHOICE	Key Elements
<p>Women and their partners will have the choice between self referral to the local midwifery service or accessing this service via their GP</p>	<ul style="list-style-type: none"> • Visible, self-referral midwifery services available in easily accessible settings including Sure Start Children’s Centres • Publicly available information e.g. in local pharmacies, community centres and in pregnancy testing kits, about the need to seek care as early as possible including self referral to a midwife • Contact details of midwifery services published in local PCT prospectuses and <i>Your Guide to Local Health Services</i> • GP receptionists, NHS Direct and pharmacists knowledgeable about the availability of direct access midwifery services and how to direct women to this service
<p>For all antenatal care, women and their partners will have the choice between midwifery care or maternity team based care and be able to choose convenient antenatal appointments</p>	<ul style="list-style-type: none"> • Robust information about the types of antenatal care available to help decision making • Antenatal care plans developed in conjunction with the woman, her partner and their maternity provider to reflect their needs and choices. It should be reviewed regularly and updated as required • Antenatal care services, including antenatal classes, provided in easily accessible community settings such as Sure Start Children’s Centres • Sufficient staff providing different models of care using a range of skills • Appropriate services to respond to the full range of choice options. This may require more services to be available in the community e.g. ultrasound services, blood tests • Early contact with women by midwives or obstetricians to ensure they offer a convenient first pregnancy appointment to conduct the standardised risk and needs assessment before the 12th week of pregnancy

CHOICE	Key Elements
<p>For all antenatal care, women and their partners will have the choice between midwifery care or maternity team based care and be able to choose convenient antenatal appointments</p>	<ul style="list-style-type: none"> • Well understood, functioning protocols for when, how and where to refer women for more specialist opinion or care. This includes women with socially complex needs • The ability to book appointments at times and in places that are convenient to women and their partners
<p>Women and their partners will have a choice of the type of care and place of birth</p> <p>Women will have a choice of pain relief methods appropriate to the type and place of care chosen</p>	<ul style="list-style-type: none"> • Appropriate services and capacity to respond to the full range of choice options • Robust information on the types and places for childbirth should be available to women and their partners together with the opportunity to discuss these options throughout the antenatal period including where appropriate during the early stages of labour • All birth environments designed to offer a home-like comfortable environment with en-suite facilities, including equipment such as comfortable chairs, beanbags, mats, balls, baths and birth pools • Epidural anaesthesia in hospitals where there is a 24 hour obstetric anaesthetic service available • Well understood, functioning protocols for emergency transfers required in labour, birth or after birth within the local network • Paediatric support for neonatal problems, including arrangements for transfer to neonatal special care and intensive care when necessary • Sufficient staff, working flexibly across community and hospital settings, to provide high quality maternity care • Training and mentoring for midwives to develop their skills and confidence in natural and normal birth

CHOICE	Key Elements
<p>Women and their partners will have a choice in how and where to access postnatal care either at home or in community settings, such as Sure Start Children's Centres at convenient times</p>	<ul style="list-style-type: none"> • Robust information to ensure women and their partners know about the range of choices available to them for postnatal care • Sufficient staff, working flexibly across hospital and community settings, to provide high quality maternity care • Appropriate services and capacity to respond to the full range of choice options • A process to book appointments at times and in places that are convenient to women and their partners

ACCESS	Key Elements
<p>Antenatal care: midwives will be visible, readily identifiable and easily accessible in community settings</p>	<ul style="list-style-type: none"> • Midwifery services, including antenatal classes, based in community settings such as Sure Start Children's Centres accessible at convenient times • Provision of effective outreach services for socially excluded groups
<p>Postnatal care: midwives and health visitor services will be visible, readily identifiable and easily accessible in community settings</p>	<ul style="list-style-type: none"> • Midwifery services to provide care in the home or in community settings such as Sure Start Children's Centres • Health visiting services based in Sure Start Children's Centres and other community settings, accessible at convenient times

CONTINUITY OF CARE	Key Elements
<p>Women and their partners will be supported by a midwife they know and trust before and after birth</p> <p>Women will be individually supported throughout their birth</p>	<ul style="list-style-type: none"> • Sufficient numbers of midwives and support staff working flexibly across community and hospital settings • Women and their partners should know about all members of the maternity team supporting them throughout the maternity pathway and how to make contact with them or their midwife at any time

Appendix B: Reorganising maternity services

B.1 The overarching aim for reorganising services is to improve the quality of service, concentrating on safety and working towards better outcomes and satisfaction, for all women and their babies. Services need to be delivered in an appropriate setting by skilled maternity professionals with the required level of experience and training. Women should have an appropriate choice of place and type of birth according to their individual needs and wishes. The development of local networks must ensure easy access to, and transfer between, all levels of care in a responsive and timely manner.

Specific drivers for change:

- Maternity services must be appropriate for the 21st century and meet the needs of women and families
- Women and their partners want services that reflect their views and expectations
- Implementation of choice may increase the demand for homebirth and midwifery care
- There is a need to empower midwives to promote normal birth
- The changing profile of women who become pregnant has increased the number of women who may be considered high risk
- There is evidence that women with risk factors or complications may need expert care at any time of the day or night and that that care may be highly specialised
- Recognition of the need for an increase in the presence of consultant obstetricians on labour wards to provide direct care for women in labour and to increase direct supervision of trainees
- Shorter working hours imposed by the WTD which significantly affect maternity services because there can be no cross-cover from another medical specialty
- Shorter working weeks can also make it more difficult for trainees and consultant obstetricians to obtain and maintain their skills to an appropriately high standard

- Ensuring financial affordability and value for money for the taxpayer
- The PSA target to reduce infant mortality and childhood obesity
- Increasing demand for capacity as a result of the increasing birth rate
- Choice gives providers the opportunity to increase capacity to provide maternity services to women from outside their area

- B.2 Reorganisation gives local managers the chance to develop local services that are fit to deliver 21st century care, and in different locations. Antenatal and postnatal care may be provided in community settings such as Sure Start Children's Centres but care that is more complex may be provided in a hospital within the local network. Reorganisation need not mean closure. It does however offer the option, using the existing infrastructure, to redesign services, which are responsive, flexible and meet the needs of the population, both as a whole and as individuals.
- B.3 There is also the potential for acute and community services to be more integrated and for resources to be deployed in a more efficient and equitable way. Reorganisation can help to reduce inequalities in service provision and focus on those families that have the potential to be socially excluded e.g. teenage mothers. Sustainability of services and affordability are key to reorganisation issues.
- B.4 Reorganisation gives the opportunity to address local staffing issues and look at innovative ways to resolve recruitment and retention issues. The impact of skill mix, for example the introduction of MSWs, has the potential to release midwifery time and improve outcomes for women and babies e.g. improved breastfeeding rates. Promoting effective skill mix within the maternity team will be key to delivering the Government commitment, improving the working lives of midwives and other staff delivering maternity services and improving continuity of care to women.
- B.5 All organisations involved in commissioning maternity services should work within a fully functioning network to ensure that they have sufficient staff, with appropriate skills, to deliver high quality and safe services. From the outset a full range of stakeholders, including staff and service users, should be involved in discussions around reorganisation issues.

Appendix C: Building your local workforce

- C.1 The NHS must have sufficient skilled and motivated staff working within maternity services to meet the needs of the population and the Government commitment by the end of 2009. It will be vital to have good leadership and an open, supportive culture, together with locally developed workforce plans that enable the development of high quality, safe and accessible maternity services.
- C.2 This annex sets out the factors that PCTs will need to consider when planning the local maternity workforce to support the framework outlined in *Maternity Matters*. Local workforce planning will determine the workforce capacity required to support service development and local organisations should begin to plan now for the required changes to their local workforce.
- C.3 *The NHS in England: the operating framework for 2007/08*⁸ set out the local action required now to prepare for 2008/09 onwards. PCTs should work with providers to undertake preparatory work for the implementation of the commitment outlined in *Our health, our care, our say*⁷ to improve choice, access and continuity of care in maternity services. PCTs should assess current services, identify gaps and barriers to service development and set out their local strategy for meeting the maternity commitment by the end of 2009. This process should include an assessment of workforce capacity.

National workforce capacity and investment

- C.4 The maternity workforce has grown since 1997. There are over 2,400 more midwives working in the NHS compared to 1997, providing the equivalent of almost 900 more whole time equivalent (WTE) midwives. There are around 950 extra doctors working within Obstetrics and Gynaecology compared to 1997, and the WTE has increased by over 970 during this period. This growth has been supported by extra training capacity.
- C.5 Between 1996/97 and 2004/05 the total number of midwifery training places increased by over 40%. There are over 1,000 midwifery students currently in training, who are due to qualify leading up to 2009. Table 1 shows the number of midwifery training places available each year*.

* Taken from SHA Quarterly Returns to the Department of Health (2007)

	1996/ 1997	1999/ 2000	2001/ 2002	2002/ 2003	2003/ 2004	2004/ 2005	2005/ 2006	2006/ 2007*
Degree	161	395	621	709	753	895	1,042	890
Diploma	498	620	525	724	716	744	517	602
Other	993	757	732	677	757	735	661	579
Total	1,652	1,772	1,878	2,110	2,226	2,374	2,220	2,071

Table 1: Number of midwifery training places available per year

- C.6 There was a reduction in the overall midwifery training numbers in 2006/07, although the decrease in the number of degree programmes has been offset by the increase in diploma programmes.
- C.7 The number of consultants in obstetrics and gynaecology has increased by over 40% since 1997. The number of specialist registrars in training in Obstetrics and Gynaecology has also increased by more than 40% during this period. Increasing consultant numbers improves direct care of women and their babies and allows for more intense supervision and assessment of specialist trainees.
- C.8 Growth in the maternity workforce is a positive step towards reorganising maternity services to offer all women and their partners improved choice, access and continuity of care. However, there are other aspects which should be considered in parallel with the size of the maternity workforce as part of the development of a local workforce strategy.

Key influences on a local workforce strategy

Leadership and organisational culture

- C.9 Innovation and service development is strongly associated with positive leadership and an organisational culture supportive of people in developing their ideas for improvement. Successful development of maternity services that can meet the expectations of women and their families requires such leadership, together with management and clinical engagement, and user involvement. Positive leadership can contribute to engagement of staff and support job satisfaction and morale²⁶.
- C.10 At Trust and PCT board level there should be strong engagement around maternity issues in order to secure high level support for the development of maternity services and to ensure that the board is aware of the strengths and risks associated with the service.

* 2006/07 are indicative commissions. Final statistics are due on Q4 returns.

- C.11 PCTs and local providers should take account of the investment required to build leadership, undertake succession planning and support multi-disciplinary team working.
- C.12 Tools and programmes are available, or in development, for organisations to use to improve and support leadership across maternity services. Two examples are:
- The Royal College of Midwives (RCM) have a leadership programme, which provides midwifery managers with learning support to enable them to develop the critical midwifery leadership competencies including: developing a vision, thinking strategically and systematically, driving change, influencing others and communicating effectively
 - The DH is producing a new strategic framework to support NHS leadership

Geographical variations

- C.13 There is marked geographical variation in vacancy rates with higher rates in some areas and between employers operating in similar labour markets²⁷.
- C.14 There is also wide variation in the relative number of maternity staff who are employed²⁴. This includes medical, midwifery and management staff, though it is particularly noticeable in midwifery where in some areas there may be 25 births for each WTE midwife and in others 35 births or more^{24, 28}. The factors affecting these variations include complexity of casemix, geographical constraints as well as the local staffing structure and skill mix.
- C.15 The variation in vacancy and midwifery to birth rates should be considered locally. Any existing shortfalls within workforce capacity should be identified and factored into the development of local workforce plans.

Working Time Directive

- C.16 The requirements of the WTD affect the way that hospital services are provided and should be taken into account in workforce planning:
- **Medical** The working hours of doctors in training are being reduced from 56 to 48 by 2009 and this will impact on middle grade rotas and the types of care available. Shorter working hours imposed by the WTD will significantly impact on maternity services because there can be no cross-cover from another speciality
 - **Midwifery** Through Agenda for Change, NHS staff are already required to work less than the 48 hours limit imposed by WTD. The main impact on midwifery teams arises from the WTD requirement for appropriate rest periods. This needs to be factored in to both the service and workforce plans when considering how to organise midwifery care.

Safe staffing levels

- C.17 Appropriate staffing levels and skill mix across all professional groups are essential for providing a safe service. Assessment of the future workforce requirements needs to acknowledge that midwives are involved in the care of all women. Women with more complex needs may require senior medical staff involvement at any stage of a woman's journey from pre-pregnancy through antenatal, labour and postnatal care.
- C.18 CNST concentrates on consultant obstetrician presence on the delivery suite and requires a minimum of 40 hours consultant obstetrician presence each week in hospital units. There is a strong possibility the CNST will increase the standard to 60 hours, with longer cover, up to 168 hours, in larger (>6000 deliveries) units. Local assessments will need to factor this into their future plans. Redesign of services and reallocation of resources may provide an opportunity to increase consultant availability for direct patient care through all stages of the woman's journey through maternity services.
- C.19 Training and continuing professional development for all maternity professionals are integral to the development of safe services within local networks.

Developing services to ensure choice, access and continuity of care

- C.20 The choice of birth setting could result in an increase in women seeking to give birth away from a hospital e.g. in the home or a birth centre. Services will need to be developed, and have sufficient suitably trained staff available to provide such options according to local changes in demand.
- C.21 There should be improved access to services e.g. by providing more outreach services in alternative locations such as Sure Start Children's Centres and offering services in the home. This should help reduce the percentage of pregnant women who delay seeking maternity care and make services more accessible to all women and their families.
- C.22 Appropriate staffing levels will need to be considered to ensure that all women and their families will have continuity of care with a midwife that they know and trust and with arrangements in place for coordination of on-going midwifery support should the known midwife not be available.

Local population and social factors

- C.23 Additional resources and skills may be needed to support challenged communities. Comprehensive and on-going assessments of the needs of the local population will be essential. Social factors, such as deprivation, high rates of teenage pregnancies, migration and changes in birth rates should be factored into workforce plans

Local reorganisation

C.24 Organisations should factor in any plans for reorganisation when planning workforce. Staff should be involved in developing workforce plans so that their needs and concerns are assessed and addressed throughout.

Workforce planning for the future

Assessment

C.25 National workforce planning together with the influences noted above demonstrate that new skills and extra capacity may be needed in some areas, as part of the local workforce strategy. There will be variation across the country and it will be local planning that drives the actual growth and investment required.

C.26 Commissioners and service providers should also consider and assess their long term workforce capacity requirements beyond 2009, and take steps to ensure that they commission appropriate training places to meet the projected need, taking account of factors such as the current age profile of the maternity workforce.

C.27 Tools are available to support this including Birthrate Plus¹⁶, the recognised strategic maternity workforce planning tool and the Maternity Decision Support tool, developed by the Care Services Improvement Partnership (CSIP)¹⁷. These workforce planning tools allow local health communities to compare alternative approaches to service redesign, and their associated impact on the local workforce.

Increasing workforce capacity where required

C.28 There are a range of options that can be used to increase workforce capacity where required, including:

- **Newly qualified midwives** More midwives are coming out of training each year leading up to 2009. Local organisations should be planning for and taking appropriate action to secure employment opportunities are created for these midwives
- **Return to Practice Programmes** These have proved to be a timely and cost-effective way of drawing back trained staff to the NHS. Targeted campaigns could identify potential returners, who could be incentivised to return to the NHS. Both the RCM and the NHS Employers web-site contains details about running successful return to practice programmes, including the RCM open learning package
- **Adaptation programmes** When assessing their local population, some NHS organisations may identify people in the community who trained overseas and have appropriate skills, so that they could become NHS midwives through adaptive programmes

- **18 month pre-registration midwifery education programmes** These programmes would enable registered nurses with an adult qualification to become midwives
- **Optimising skill mix** The appropriate use of skill mix can target extra capacity to overcome workforce gaps and barriers

C.29 Immediate action would be required to ensure that people completing some of the above programmes would do so in time to help meet the Government commitment to maternity services by the end of 2009.

Investing in skills and development

C.30 Maternity services should ensure optimum skill mix is in place and staff at suitable levels, with relevant skill sets, undertake appropriate tasks. Organisations should consider the development of new and existing roles, including:

- **Consultant midwives** provide senior clinical leadership within maternity services and complement the role of the Head of Midwifery. Consultant midwives contribute to effective leadership, training and mentoring, as well as having specific responsibilities such as promoting normal birth or reducing inequalities. Consultant midwives are able to drive services improvement through working with colleagues in health and other agencies to develop effective care pathways or services for specific client groups
- **Heads of Midwifery (HoMs)** provide strategic and organisational leadership and are accountable for the quality of midwifery services within their organisation. Local investment in HoMs, and their ongoing development, will contribute to improved services and staff development
- **Maternity Support Workers** who are appropriately trained and supervised can carry out a range of duties including: clerical work, supporting women with breastfeeding, helping to run parent craft classes and supporting postnatal care. An increase in MSWs could make an important contribution to the workforce in organisations* where the roles and responsibilities of midwives and support staff have been clearly defined and where midwives have been trained to support and delegate to MSWs
- **Specialist midwives** including practice development midwives, lecturer practitioners and antenatal screening coordinators, effectively contribute to the maternity team and can drive forward enhancements to services

* The Large Scale Workforce Change Team Maternity Support Worker Report (2006) concluded some midwifery time could be saved by handing over simple duties to appropriately trained and supervised support workers. Additional research undertaken in December 2006 showed that managers are enthusiastic about the contribution that existing MSWs were making.

- **Consultants in obstetrics and gynaecology** are increasingly appointed with a special interest to complement the skills and experience of the existing team. Maternity Units may benefit from having a consultant lead in areas such as labour ward management, early pregnancy assessment, diabetes and prenatal diagnosis
- **Subspecialists in feto-maternal medicine** work in tertiary centres and have the expertise to provide specialised care for more complex problems and ensure comprehensive care within a network

National support available

C.31 The DH and its partners will continue to support local workforce planning. Examples of this include:

- **National Workforce Projects**
 - providing support, guidance and tools to help local workforce planners
 - undertaking a 12 month study to improve information about staffing and service provision within paediatric and maternity services, including neonatal services
 - developing a support package, including the provision of workforce planning masterclasses for both strategic and operational staff during Spring/Summer 2007
- **NHS Employers**
 - providing advice and support for NHS organisations to improve productivity and develop new roles and new ways of working.
 - advising on temporary staffing solutions and flexible working arrangements which will help towards offering more choice around appointment times and dates
 - having a range of materials and guidance to help employers improve recruitment and retention and to run return to practice programmes
 - helping to find the right person with the right skills for maternity service roles and help organisations access international skills where needed
 - providing employers and staff with support through organisational change e.g. reorganisation of services

- **Skills for Health**
 - continuing to work with employers and other stakeholders to ensure that those working in the health sector are equipped with the right skills to support the development and delivery of healthcare services
 - having a framework of 25 competences for maternity and neonatal care, which offers the opportunity for staff to map a career in the NHS
- **Widening Participation in Learning Strategy Unit**
 - supporting NHS organisations and working with the RCM to identify the development needs of maternity support workers

Appendix D: Impact assessment statement

- D.1 The promotion of equality has been one of the drivers in developing the policy contained within this document. In giving women the national choice guarantees over the place of birth, increasing the places where they can access maternity services and ensuring continuity of midwifery care the specific needs of all members of society can be catered for. In addition this policy encourages providers and commissioners to meet the needs of individual women, particularly those from disadvantaged and vulnerable backgrounds.
- D.2 Equality and human rights legislation places specific obligations on organisations, including a legal duty to ensure the delivery of services that do not discriminate on the grounds of race, disability, gender, age, sexual orientation and religion or belief. The Race Relations (Amendment) Act, Disability Discrimination Act and (with effect from April 2007) the Equality Act also require organisations to conduct race, disability and gender equality impact assessments when developing policy and commissioning services, to ensure the effective promotion of equality.
- D.3 An Equality Impact Screening and Equality Impact Assessment have been completed to ensure that the policy contained within *Maternity Matters* complies with the above legislation. A copy of the full assessment is available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073312
- D.4 Research such as the UK Confidential Enquiries into Maternal Deaths¹⁰, the National Survey of women's views⁹, as well as internal Department of Health analysis has been used in developing this policy. Stakeholders have been involved in developing the policy and we will continue to monitor whether this policy has the desired effect of reducing inequality in maternity services, and improving the outcomes for those women and babies who currently have poorer outcomes.

Appendix E: Glossary

Antenatal care Professional care provided to a woman and her partner to support them and their baby through the pathway of pregnancy and to help achieve the best possible health, psychological and social outcomes for the mother, baby and family

Home birth This is usually a planned event where the woman gives birth at home, with care provided by a midwife. Should complications arise, all NHS home birth services are provided within a functioning, swiftly responsive, and well understood local network of emergency services and transfer arrangements

Individual care plan A woman's written record of her planned and actual care, including her preferences for her care during pregnancy, labour and childbirth which is updated at regular intervals

Integrated service Coordinated service provision across professions and organisations according to people's needs

Known midwife A named, registered midwife who is responsible for providing all, or most, of a woman's antenatal and/or postnatal care and co-ordinating care should they not be available

Local health communities A range of medical, mental health and social care services in a particular area that meets the needs of a local population

Maternity, neonatal and perinatal mental health networks These networks support the effective planning and delivery of a full range of maternity services thereby ensuring access to high quality, safe and appropriate services which meet the needs of women and their families

Maternity team care Although every woman has care by a midwife, for women with complex pregnancies, care is provided by a maternity team comprising midwives, obstetricians, anaesthetists, neonatologists and other specialists working in partnership

Midwifery care Care where the midwife is the lead professional. Midwifery care is suitable for women assessed to be low risk

Midwifery units/birth centres A facility (free standing or within a maternity hospital) managed and run by midwives which provides a comfortable home-like environment for women and partners who anticipate a straightforward birth. As with home births, all midwifery services must be provided within the safety net of a functioning local network providing prompt emergency transfer when required

Neonatal care Medical care for newborn babies

Payment by Results (PbR) Remuneration of a service provider for the number of patients treated based on the type of care and treatments received

Perinatal mental health Refers to maternal mental health problems that are already present or develop during pregnancy and for up to one year after the birth of their baby

Postnatal care Professional care provided to meet the needs of women and their babies up to 6-8 weeks after birth, in the context of their families

Practice Based Commissioning (PBC) Engaging GP practices and other primary care professionals in the commissioning of services through resources and support, to become more involved in commissioning decisions improving access and quality of care

Public Service Agreement (PSA) Sets out what organisations agree to deliver in return for funding. PSAs set out the key improvements that the public can expect from Government expenditure. They are three year agreements, negotiated between the Department and HM Treasury during the Spending Review process. Each PSA sets out the department's high level aim, priority objectives and key outcome-based performance targets

Sure Start Children's Centres These are situated in easily accessible areas, often a pram's push away from home and bring together a range of integrated services for children and their families through pregnancy and then birth to five years of age. Services include; child and family health, education and support e.g. for parents of children with special needs

System management and regulation An independent inspection regime, through regulators such as the Healthcare Commission and Monitor, which, together with national standards and targets, will provide assurance of service quality and continuous improvement

Tariff As part of Payment by Results, the tariff is the mandatory national price that is paid to all NHS providers for providing services

Woman-focused, family-centred The needs of the individual woman provide the main focus for the planning, organising and delivery of maternity services. The needs of her partner and her family in relation to caring for the baby and for supporting positive health outcomes for the mother are kept in focus at all times

Working Time Directive (WTD) Health and safety legislation that provides for minimum daily and weekly rest periods, annual paid holidays, a limit on the working week of 48 hours and restrictions on night work

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278867 1p 3k Apr 07 (CWP)

Produced by COI for the Department of Health

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