



Commissioning Board
A special health authority

Commissioning Maternity Services

A Resource Pack to support Clinical Commissioning Groups

July 2012

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Key Messages

- **Maternity Services are used by over 700,000 women a year and the birth rate continues to rise at around 2% per year**
- **Maternity care costs the NHS on average £2800 per woman for antenatal, intrapartum and postnatal care**
- **Effective maternity services are interdependent on primary care, specialist services and the range of early years services provided in community settings**
- **The average CCG with a population of 300,000 will be responsible for commissioning maternity services for around 4000 women a year at a cost of around £9m**
- **Outcomes in maternity care are generally good but there is a large amount of regional variation, sometimes but not always linked to demographic factors**
- **Commissioning effective maternity care requires attention paid to both the safety of services but also the experience women and families have**
- **Maternity is well served by an evidence base about what works and by standards that facilitate high quality**
- **Identifying trends and causes in maternity outcomes requires large populations, CCGs may find it effective to collaborate in the sharing of data, analysis and specifying commissioning intentions**

Introduction

This Maternity Resource Pack sets out a framework for the commissioning of the discrete set of maternity services provided by acute trusts – essentially obstetric and midwifery care across the antenatal, intrapartum and immediate postnatal periods. However, it is clear that the pathway for women, babies and new families from pre-conception to early years is a complex one with many interdependencies. One of the key messages in this pack is to think in a holistic way about women's health, maternity services and early years.

The Pack has been co-produced by the DH and the clinical commissioning community¹ taking into account national priorities with the flexibility to reflect local needs. It is intended as a point of reference and a resource and might be used to:

- Revisit and review local existing arrangements for commissioning and priorities for service improvement
- Enhance an integrated approach to maternity as part of a wider early years agenda that spans primary, acute, community and social care

Maternity is often called the NHS's 'shop window', with services used by over 700,000 families in England every year. Having a baby is the single largest reason for admission to hospital and the experience families have during pregnancy and postnatally often colours their long-term health and wellbeing and their use of health services. Like every other part of the NHS, maternity services face enormous challenges, in terms of rising demand and increased expectations set against the need to demonstrate productivity. However, maternity is unique: it cannot be demand managed and activity cannot be controlled through referrals. Like A&E, it is a core NHS service but one that whilst delivered by acute trusts happens mainly in the community with interdependencies with primary and community services.

By focusing on outcomes, this Resource Pack aims to make it easier to commission even better maternity services. Much of the hard work in the commissioning process has already been done, and by bringing together existing service specifications, benchmarking templates and other resources, the intention is that CCGs will be able to spend more time having informed discussions with providers about service delivery and redesign and focusing on matters that will make the most difference to women and families, rather than process or bureaucracy.

The pack provides

- Section 1: An introduction to the scope for doing things differently
- Section 2: An overview of current maternity services including outcomes and performance
- Section 3: Five big challenges for improving maternity care
- Section 4: A summary of the opportunities for improving maternity outcomes
- Section 5: A briefing on current national priorities and requirements
- Section 6: An outline of the changes proposed for maternity payment systems
- Section 7: A reference to 'what good looks like' in maternity
- Section 8: A collection of already published resources, guidance and information sources

¹ Huge thanks go to Dorset, Portsmouth, Southend, Leeds, Basingstoke, Coventry, Wirral and Surrey CCGs, to SHA and PCT maternity leads, to RCM, BMJ, RCOG and NCT representatives and to James Kingsland and Jane Povey for introductions to all the other organisations and individuals who contributed to this Pack.

Section 1: The Opportunity to do things differently

The Commissioning Challenge: Dame Barbara Hakin October 2011

“The system we are developing gives us a real opportunity to do things differently. I would encourage everyone who is involved with or has an interest in commissioning to really think about how we can be different, how can we use commissioning to give patients much more voice and choice”

Current Position

In many PCTs a maternity commissioner (usually a general manager sometimes with little clinical experience of maternity) has formed relationships with their local providers (most commonly the Head of Midwifery) and together agreed plans for service development and improvement, looked at quality indicators and ensured services respond to local need. At the same time, the PCT acute contracts team have managed spend and activity, although in the main the inability to demand manage maternity means these contracts have not received much attention and existing patterns of referral and use have not been challenged in many organisations. Payment for maternity services has been through a combination of tariffs for deliveries, outpatient activity (eg obstetric antenatal clinics) and unscheduled attendances; with block contracts/payments for midwifery delivered antenatal and postnatal care in the community (including in GP surgeries, children’s centres and women’s homes). It is the wide variation in the levels of these block payments that accounts for the variation across the country in spend per birth. The inability of this payment system to act as a sufficient lever for quality improvement has led to a review and the introduction, in shadow form in 2012, of a pathway payment system for maternity. More details follow later in this guide.

Potential to change

The authorisation process for CCGs includes demonstration of the added value clinicians bring to commissioning, including:

- Strengthened knowledge of local health needs and the quality of local services
- Engaging local communities to adopt improved services
- Improving the quality of referrals into care pathways, driving service integration around patients’ needs
- Improving the quality of primary care

What that means in maternity, is an opportunity to harness the perspective of clinical commissioners, firmly linked into the needs of local communities to:

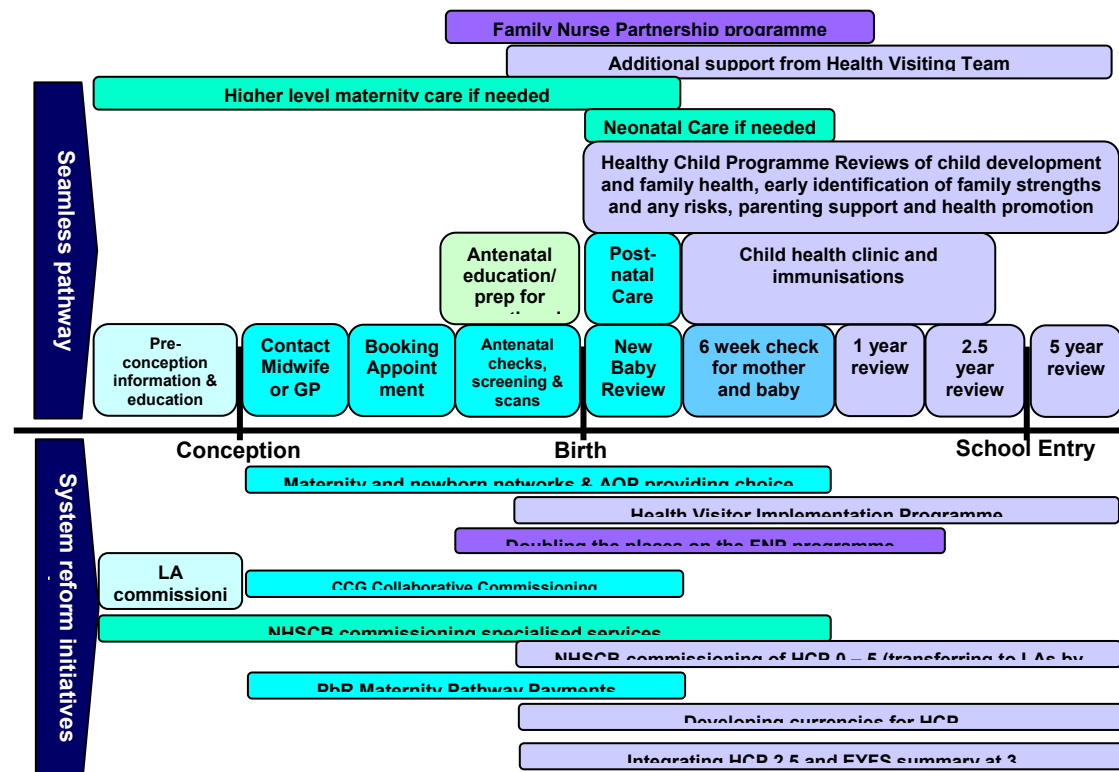
- Redesign the whole -9months to 5 years early years pathway through better integration of primary, acute based, community based and social care that supports new families
- A clinical perspective to challenge existing provider behaviour where outcomes vary from neighbouring, regional or benchmarked norms
- A clinical perspective into provider network discussions about configuration that ensures patients’ needs are at the heart of decision making
- Development of new primary care led services such as preconceptual care, perinatal mental health services

Challenges for CCGs

Collaborative commissioning

Many CCGs may find themselves commissioning too few births to be able to give this area great attention, or to be able to commission the full range of both routine (high volume/low cost) and specialist (low volume/high cost) maternity services. There may therefore be benefit in collaborative commissioning between CCGs with one leading and negotiating on behalf of neighbours.

Maternity care is only one element of a pathway that spans from contraception services, preconception care through pregnancy and birth to early years and mainstream and specialist children's services. Whilst CCGs will be responsible for much of this pathway it will be local authorities through Health and Wellbeing Boards that will lead on important public health initiatives such as teenage pregnancy, breastfeeding, weight management and smoking cessation; whilst the NHS Commissioning Board has responsibility for the related services of neonatal care and health visiting. Co-ordinating these interdependencies to ensure women receive a seamless service will be crucial and it is through primary care that CCGs are in a powerful position to monitor the extent of local joined up working.

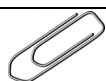


Given the limited scope for changing referral patterns and activity levels, CCGs might conclude that maternity is not an early priority area for developing new ways of working. In which case, CCGs may prefer to share responsibility with neighbours and use already existing national or regional specifications and templates as the basis for local arrangements. This resource pack includes a number of templates.

Improving Relationships

In recent years, primary care involvement in maternity care has been limited. This means there has been some confusion between CCGs and clinicians in acute trusts about their relative roles in providing and commissioning. Clarifying the relationship and the contribution that general practice can make to maternity care will underpin healthy discussions about service improvement. Both the [Kings Fund](#) and the joint Royal Colleges (RCGP, RCM and RCOG) have published useful guidance to support strong relations between primary care and maternity services.

CCGs could commission and contract on the basis that acute maternity providers and general practitioners will agree to local guidance setting out where each antenatal and postnatal contact (including its content) will take place, based on the NICE guidance. If this was made a requirement for all parties then expectations would be clear. This would also help clarify avenues of redress, both for dissatisfaction with care, incomplete care (e.g. tests not done) and overall contribution to care.



Consensus statement by RCGP, RCM, RCOG - The role of the General Practitioner in Maternity Care

The three Colleges recognise that GPs have an important role in maternity care, and those who wish to provide the care must maintain competence. In all other circumstances collaboration and communication between all members of the maternity team is crucial in delivering woman-centred care

Strategic policy should ... reinforce the value of retaining relationships with GPs during pregnancy, and the crucial role of GPs in continuing care for women with underlying medical conditions. Policy should reiterate the importance of GPs and midwives sharing information as partners in care, in order to facilitate optimum specialist maternity care provision for women. In remote and rural areas, the GPs role in maternity care may be enhanced to ensure appropriate medical input, through GPs retaining a range of obstetric skills, which facilitate safe provision of antenatal, intrapartum and postnatal care for women.

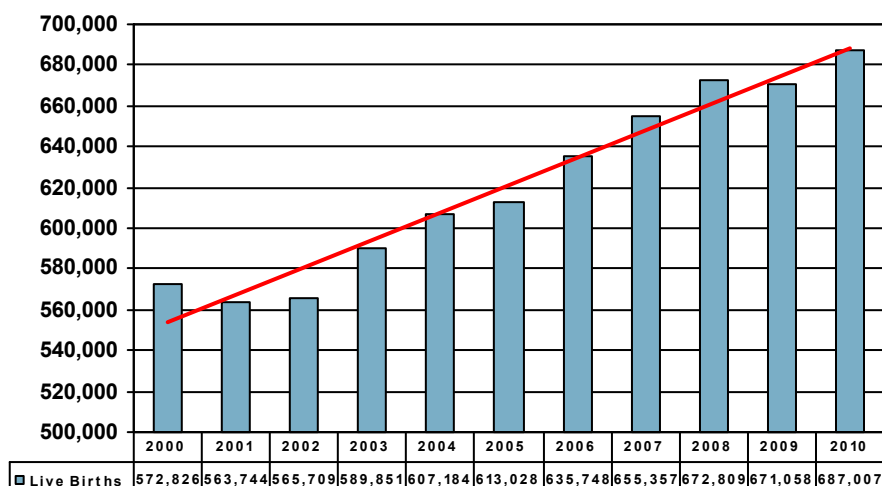
<http://www.rcog.org.uk/news/colleges-join-forces-improve-maternal-care>

Engaging users

CCGs will want to be assured that their commissioning plans reflect the needs and preferences of local maternity users and that the views of individual women are reflected in shared decision making and commissioning decisions, including supporting women to exercise choice. The existing method for involving maternity service users has been through Maternity Services Liaison Committees (MSLCs), currently serviced by PCTs. Where these work well CCGs may want to continue and extend their involvement in providing feedback and involvement in decision making. Where MSLCs do not exist or do not work well, clinical commissioning offers the opportunity to find new and innovative ways to include a user perspective as part of their overall patient and public involvement strategies. There is a strong history of user involvement in maternity services, from the [National Childbirth Trust](#) to specialist self-help groups such as the [Stillbirth and Neonatal Death Society](#) as well as national charities such as [Best Beginnings](#) and local Children's Centres and families groups that will be eager to work with CCGs.

Section Two: Maternity Today

The birth rate in England has risen by 22% in the last decade and whilst the rate of increase may be slowing, it continues. At the same time the proportion of high risk and complex pregnancies continues to grow due to increased BMI, increased maternal age and a host of long-term conditions that impact onto pregnancy.



Whilst outcomes and performance in maternity are generally good, there is a high degree of unexplained variability around the country and consequently room for improvement. Of these key indicators

- Perinatal mortality rates range from 6/1000 in South East Coast to 9.1/1000 in West Midlands
- Caesarean section rates range from 15% in Shrewsbury, Mid Staffordshire and parts of Nottinghamshire to 36% in parts of London
- Home birth rates range from 1.2% in the North East to 3.8% in the South West
- Stillbirth rates are unchanged since the 1990s and are amongst the highest in Europe

Maternity services will be a key element of the commissioning portfolio for which CCGs are responsible. In the main maternity services are provided by acute trusts. Whilst there are variations in the models of care, the most common is:

- Midwives employed by the trust working in the community (based in GP practices, health centres and children's centres and sometimes in women's homes) to provide routine antenatal and postnatal care and home births. The active role of GPs in antenatal care has reduced significantly and many now report lack of skills or confidence to take on routine pregnancy care.
- Midwives and obstetricians (supported by Maternity Support Workers and nurses and specialist acute services) working in hospitals provide specialist antenatal care for high risk women, inpatient and outpatient monitoring and observation for women whose pregnancy starts to deviate from normal, as well as intrapartum care and postnatal recovery
- Hospital based ultrasound scanning and other diagnostic services such as screening as well as an interface with specialist services including neonatal care, diabetes, CHD etc.

CCG Population	Est births per year²	Est maternity spend³	Est births to women over 35⁴	Est perinatal mortality⁵	Est Number of C-Sections⁶
100,000	1400	£3m	250-300	9	336
200,000	2800	£6m	550-600	18	672
300,000	4000	£9m	800-900	25	960
500,000	7000	£15.5m	1400-1500	44	1680
700,000	9800	£21.5m	1950-2000	62	2352

A national survey of users of maternity services conducted by the CQC in 2010 confirmed that not only are outcomes generally good but that on the whole women are satisfied with the care they receive:

- Most participants (83%) had a choice about where to have their baby.
- Almost three-quarters (74%) said they were 'always' involved in decisions about their care and 63% said they were 'always' treated with kindness and understanding in hospital after the birth.
- The majority (86%) were given support, encouragement and advice on how to feed their baby.

The survey also highlighted areas where support for women could be improved, particularly during the postnatal period when the mother and baby start to settle into family life.

- 8% of participants said they didn't receive the pain relief they want
- Almost one in five (18%) did not feel that they got enough information about their own recovery and 21% felt they were not given enough information about emotional changes they might experience following the birth.
- Seventeen per cent said that infant feeding was not discussed with them during their pregnancy and 13% said they didn't receive advice about feeding their baby in the six weeks that followed the birth.

In addition to hospital delivery, suites providing obstetric led births, many acute units now also provide along side or co-located midwifery led birth environments and/or freestanding midwife led birth centres for women anticipating a straightforward delivery. A small proportion of women choose to deliver their babies at home and will be supported by community midwives. Recently published research into the outcomes for just under 65,000 women supports the policy of offering healthy women with low risk pregnancies a choice of birth setting. Women planning birth in a midwifery led unit and multiparous women planning birth at home experience fewer interventions than those planning birth in an obstetric unit with no impact on perinatal outcomes.

² Based on ONS reported live birth rate December 2010

³ Based on HES data reported in CHiMat 2009

⁴ Estimated as 20% of birth +/- 2%

⁵ Data Source: ONS

⁶ Based on 2010 national average LCSC rate 24%



The Birthplace cohort study: key findings

The evidence provided by this national cohort study supports the policy of offering 'low risk' women a choice of birth setting:

Freestanding midwifery units and alongside midwifery units appear to be safe for babies and offer benefits to both the mother (fewer interventions) and baby (more frequent initiation of breast feeding). Women having their first baby should be informed of the relatively high probability of intrapartum transfer in these settings when choosing their planned place of birth.

For multiparous women, home births appear to be safe for babies and offer benefits to both the mother (fewer interventions) and baby (more frequent initiation of breastfeeding).

The substantially lower incidence of major interventions, including intrapartum caesarean section, in all three non-obstetric unit settings has potential future benefits to both the woman and NHS in terms of avoiding surgical complications and reducing the need to address the higher frequency of major interventions and the relatively low proportion of "normal births" in "low risk" women in obstetric units.

The continued provision of a home birth service is important so that multiparous women, and some nulliparous women who are aware of the additional risks to the baby and the high likelihood of transfer, can plan to have their baby at home.

Expansion of the provision of midwife led units would provide a choice of birth setting for 'low risk' nulliparous women who do not wish to opt for an obstetric unit birth.

<https://www.npeu.ox.ac.uk/birthplace>

Section Three: Five big challenges for maternity

- With the understanding of the impact of maternal health before pregnancy on outcomes, it is perhaps surprising that **pre-conceptual care** in the UK is so patchy. Maternity services only tend to engage with women when their pregnancy is confirmed, whilst primary care has an on-going relationship with women and is well placed to engage with women to prevent unplanned pregnancies and support women in becoming fit for pregnancy. Acute based maternity services are not always best placed to maximise preventative care. However, CCGs working with Health and Wellbeing Boards will be well placed to co-ordinate funding and organisation of so-called 'up stream' services such as smoking cessation.



Luton Diabetes Preconception Care Project

A joint initiative between GPs, the PCT and hospital in Luton has seen the development of clinical pathways and protocols for supporting women in general practice, reporting data on incidence and transferring information between professionals. The focus of the project was to create a means by which general practices could ensure that all women with diabetes of childbearing age are given regular advice, support and education (pre-conception counselling/care) prior to their decision to cease contraception and actively seek to become pregnant, with those not wishing to become pregnant counselled to ensure that effective contraception is in place.

- A greater understanding of the impact of maternal mental health on outcomes (pre-existing mental health conditions are a leading indirect cause of maternal deaths whilst chronic enduring postnatal depression has a significant impact on mother and child bonding) has not been matched by the development of **perinatal mental health** services. Mental Health Trusts do provide variable levels of support for women with acute mental illness and maternity services have become much better at identifying women at risk. However, the provision of support for women with chronic low-level mental health problems remains patchy and there is often confused responsibility between primary care, mental health and maternity services.
- The **rising birth rate** is challenging many organisations, as they seek to maintain safe services in terms of both appropriate staffing levels and the physical capacity to care for more women. With many units now delivering more babies than they were designed for the recent BirthPlace study offers the opportunity to rethink birth location and increase midwifery led birth environments. At the same time changes in expectations for obstetric, paediatric and neonatal cover is driving discussions about the future configuration of maternity services. It will be important for each CCG to understand its local labour market so that it can assure itself that providers' plans are affordable, achievable as well as delivering high quality safe services.



Is there a safe and affordable integrated workforce plan for maternity to deliver future services?

Questions CCGs may wish to ask:

“Will the services provided deliver the patient care required in my locality in line with our strategic commissioning intentions and will employers reflect the clinical models we would like to see?”

“Do we understand any potential workforce risks and how these will be managed?”

What can CCGs to be assured?

Ensure contracts reflect safe sustainable workforce

Influence local strategies through clinical networks

Review areas of risk/concern through patient and staff surveys, quality and morbidity data etc

Invite providers to complete the 9 key workforce lines of enquiry

- In addition to more women having babies, the **complexity and acuity** of pregnancy is increasing. Higher numbers of older women, women with high BMIs, and pre-existing medical conditions means that the number of women who do not experience pregnancy as ‘normal’ is increasing. These women require coordinated care between primary and secondary care and often specialist acute services. Almost 1 in 4 women now deliver by caesarean section with a further 10-12% delivered with the aid of forceps or ventouse. The quality of intrapartum care has a significant impact on women’s chances of achieving a normal birth and the variation in cesarean section rates (from 15-36%) is a good indicator that there is much that can be done to reduce unnecessary interventions.
- Maternity services provide only one part of the support to new families and have often been physically and organisationally separate to primary care, community based services such as Health Visiting and social care. **Integration with the early year’s** agenda and in particular a seamless approach to safeguarding means working across Health & Wellbeing Boards. There remains enormous scope to both streamline the maternity/early year’s pathway and to reduce duplication between midwives, health visitors and GPs. The DH has recently published resources to support multi-disciplinary working with new families called Preparation for Birth and Beyond. <http://www.dh.gov.uk/health/2011/10/preparation-for-birth-and-beyond-resource-pack-to-help-parenthood-groups/>

Section 4: The Health Gain in Maternity

The objective of maternity care is to maximise the health and wellbeing of mothers and babies. The evidence base for what is important in maternity care and the opportunities for improving health and wellbeing are well documented, most recently in the Marmot Review, [click here for summary](#). For example, we know that the health of mothers is critical to the development of their children both before and after birth. Their nutritional status before and during pregnancy, as well as their mental health is important, as is their lifestyle choices.

Pregnancy and early life can help lay the foundations for individual health, well-being, cognitive development and emotional security not just in later childhood but also in adult life.

Important antenatal influences on developing brain architecture

Mother's health and nutritional status (e.g. adequate folic acid to prevent spina bifida)
Potentially serious damage from:
certain **antenatal infections** (such as rubella)
environmental toxic exposures (such as mercury, lead, and organophosphates)
legal and illegal drugs (such as alcohol, nicotine, and cocaine)

Adverse ante- and postnatal experiences

can have a profound effect on the course of health and development over a lifetime
The premise underlying *developmental programming*, is that biological events occurring during fetal and antenatal life predispose a child to an elevated risk of subsequent physical and mental health problems. (e.g. low birth weight babies have an increased lifetime risk for cardiovascular disease, diabetes, and learning difficulties)

The period between birth and three years

is a time of rapid cognitive, linguistic, social, emotional, and motor development
Explosive growth in vocabulary, for example, starts at around 15-18 months and continues into the preschool years.
The ability to identify and regulate emotions in oneself and others is also well underway by the second year.

Between three and five years of age

There is an emergence of increasingly complex social behaviours, emotional capacities, problem-solving abilities, and pre-literacy skills that build on earlier developmental achievements and are essential building blocks for a successful life.

The key outcome indicators for babies including infant mortality and prevalence of low birth weight remain high in the UK when compared internationally and show considerable regional variation.

So our challenges include:

- Preventing unplanned pregnancies
- Preventing infant mortality (which, although improving, is high when compared internationally);
- Encouraging and enabling the good health of mothers, both before and during pregnancy and after birth; and
- Maximising early child development.

Joint Strategic Needs Assessments are the local mechanism for capturing evidence of local health needs and assessing the suitability of existing services to meet these. In addition to the information contained in their local JSNA, CCGs will wish to be familiar with local rates of and interventions to address issues of:

- maternal obesity
- maternal age (both teenagers and older mothers)

- smoking during pregnancy
- breastfeeding
- low birth weight
- maternal mental health
- screening for infectious diseases



Birmingham & Solihull Maternity Strategic Needs Assessment 2012

Prevalence by ward, metropolitan area and NHS Cluster:

Birth trends and demographics
 Maternal age and BMI
 Predicted infant problems
 Congenital abnormalities
 Perinatal mortality and substandard care
 Stillbirth, infant deaths and causes
 Detection of intrauterine growth restriction
 Early booking, smoking and breastfeeding
 Community midwifery workforce and cross boundary flows
 Standardised Healthcare Resource Groups
 Assessment of Population risk

<http://www.perinatal.nhs.uk/commissioningsupport/index.htm>



Example: Leeds Maternity Health Needs Assessment 2007-2009

Prevalence by population, ward and maternity population

Deprivation
 Ethnicity
 Migration
 Population projections
 Fertility rate
 Live births
 Perinatal mortality
 Stillbirth
 Maternal mortality
 Births by age
 Country of origin
 Smoking
 Breastfeeding
 Obesity
 Postnatal deprivation
 Substance abuse
 Domestic violence
 Vulnerable groups



The Stillbirth Challenge

In the last 20 years, the decline in stillbirth rates has slowed and halted. UK rates of stillbirth today are the same as in the late 1990s. More than 30% of stillbirths happen at term (after 37 weeks gestation), the age when a baby is preparing to start life outside the womb. The number of babies who die in the neonatal period - within the first 28 days of birth – has fallen by 20% over the last decade largely due to progress in caring for premature infants. However, it remains the case that one in 300 babies dies in the first four weeks of life and around a quarter of these babies are born at term.

The parent's support and campaigning organisation Stillbirth and Neonatal Death Society has set out a number of practical organisational steps as well as policy changes to help prevent Stillbirths

http://www.uk-sands.org/fileadmin/content/Media/PREVENTING_BABIES_DEATHS_REPORT_2012LR02.pdf

Section 5: National Context and Requirements 2012-13

In December 2010 in its response to the consultation “Liberating the NHS”, the Government clarified that clinical commissioning would include maternity services. Prior to and since then, Ministers and Officials have made a number of statements about the future of maternity services commissioning, these can be summarised as:

- Confirmation that whilst CCGs will commission maternity services, the NHS Commissioning Board will have a role to play in supporting collaborative working (the nature and form of this support has not yet been defined)
- Expectation that commissioning of maternity services should focus on **quality** and **choice**
- Expectation that maternity provider networks will be established and they should have a role in informing commissioners (a national review is underway of the future form, function and resourcing of all existing and proposed networks, including maternity networks)

Maternity services are specifically highlighted within the [2012/13 Operating Plan for the NHS](#), with expectations that services will deliver improved continuity of care, choice, access and productivity:

“Continuity in all aspects of maternity care is vital, from antenatal care through to support at home. Mothers and their families should feel supported and experience well coordinated and integrated care.” (para 2.39)

Assurances commissioners should be seeking to deliver this:

- Adequate staffing and a skill mix and deployment that ensures midwives are able to deliver continuity of antenatal and postnatal care
- Adherence to all relevant NICE standards
- Achievement of 1:1 care in labour measured either through PROMS or using agreed tools such as the NPSA score card.
- Collaboration between primary and secondary care to promote early access to services demonstrated through compliance with the 12 week booking indicator.

“Choice is critical to giving patients more power in our systems. PCT clusters should drive forward improvements in patient choice so there is a presumption of choice for most services from 2013/14. During 2012/13 this means continuing the implementation of choice about maternity care.” (para 3.22)

Assurances commissioners should be seeking to deliver this:

- Evidence of access to all types of intrapartum care: homebirth, midwife led environments (freestanding or along side units) obstetric led environments.
- Evidence of a range of models of antenatal and postnatal care including individual and group sessions, in and out of hours availability
- Promotion of normal birth through reduced caesarean section rates
- Adoption of best practice in preparation for parenthood, such as DH Preparation for Parenthood & Beyond Framework
- Cooperation through maternity networks to ensure local patterns of services meet women’s needs and expectations

“In 2012/13 DH will expand the scope of (PbR) tariff to introduce national pathway tariffs for services such as maternity care.” (para 4.20)

Assurances commissioners should be seeking to deliver this:

- Engagement with the process of calculating local case mix proportions using the national templates

In addition, the [Outcomes Framework for the NHS 2012/13](#) sets the high-level nationally required outcome measures that commissioners should use to judge the quality and effectiveness of their services, including maternity services

Domain 1	Preventing people from dying prematurely	Perinatal Mortality Rates
Domain 4	Ensuring that people have a positive experience of care	<p>Patient Reported Outcome Measures using nationally determined survey questions to users</p> <p>Did you get enough information from a midwife or doctor to help you decide where to have your baby?</p> <p>Thinking about your antenatal care, were you involved enough in decisions about your care?</p> <p>Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you?</p> <p>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</p> <p>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</p> <p>Did you feel that midwives and other carers gave you active support and encouragement?</p>
Domain 5	Treating and caring for people in a safe environment and protecting them from harm	% of term babies admitted to Neonatal Intensive Care

Assurances commissioners should be seeking to deliver these:

- A contractual requirement (through the quality schedule) to report on these Outcomes on a regular basis
- Benchmark local providers against national, regional and comparator populations

The new [Public Health Outcomes Framework](#) introduces the overarching vision for public health, the outcomes government wants to achieve and the indicators that help CCGs understand how well they are improving and protecting health. The focus is on the wider determinants of health combined with proposals for improving it. The overarching objectives are:

1. Increased healthy life expectancy.
2. Reduced differences in life expectancy and healthy life expectancy between communities.

For maternity and the related pathway, there are specific indicators

Domain 2: Health Improvement	Domain 4: Preventing Premature Mortality
<ul style="list-style-type: none"> • Low Birth Weight • Breastfeeding Rates • Smoking at delivery • Under 18s conceptions 	<ul style="list-style-type: none"> • Infant Mortality

Assurances commissioners should be seeking to deliver these:

- A contractual requirement (through the quality schedule) to report on these Outcomes on a monthly basis
- Benchmark local providers against national, regional and comparator populations

Section Six: Funding of maternity services

The current payment arrangements for maternity services are set to change in 2013. CCGs will have little opportunity to control maternity spend through referral mechanisms so will need to be confident that providers are providing appropriate levels of care.

Current Arrangements: In most instances, maternity services are funded through two distinct mechanisms, firstly local contracts between PCTs and acute units for community antenatal care and postnatal care usually based on block contracts; whilst the national PbR system provides a series of tariffs for inpatient and some clinic activity and for intrapartum care. These tariffs have failed to capture in a coherent way the work that is undertaken in maternity care and have introduced an incentive for providers to intervene more often during pregnancy.

Proposed Pathway system for introduction 2013/14: A new system which brings all maternity care into PbR is now being tested. It will pay for maternity services as a pathway bundles upfront. The aim is to create incentives for providers to deliver the best, proactive care to prevent avoidable complications and interventions. The rationale is that the more proactive services are, the less interventions will be necessary and the fewer expensive interventions services undertake, the more money providers will save. Neonatal care will continue to be excluded from the pathway payment and will be commissioned and funded separate from maternity through the NHS Commissioning Board.

How it will work: Maternity payments will be split into three modules (antenatal care; birth spell to discharge; postnatal care, including the care of well babies). Each module will be split into pathway levels by intensity of care needed; based on a woman's characteristics and factors that can be objectively identified and quantified at the point of booking. Estimating the frequency of the onset of particular conditions during pregnancy has been factored in and enhances prices.

	<i>Intermediate</i>	<i>Intensive</i>
Current factors	Complex social factors Obesity BMI >35 Physical Disabilities Underweight BMI <18 Substance/Alcohol Misuse	Twins or more
Medical factors	Mental Health Hepatitis B or C Generic/Inherited Disorder Epilepsy requiring convulsants Hypertension Previous uterine surgery (exc LSCS)	Cardio vascular disease HIV Malignant Disease Diabetes/other endocrine Rhesus isoimmunisation Renal disease Severe (brittle) asthma Autoimmune disease Venous thromboembolic disease Sickle cell/ thalassaemia Thrombophilia/clotting disorder
Previous Obstetric History	Pre-eclampsia, HELLP Puerperal psychosis Term baby ,21/2kg or 41/2kg Intrauterine growth restriction	Previous fetal congenital anomaly that required specialist fetal medicine

Placenta accrete Fetal loss (2 nd or 3 rd trimester) Neonatal death/stillbirth 3 or more consecutive miscarriages early pre-term birth <34 weeks fetal congenital abnormality	
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Impact on Commissioners: Commissioners will pay a pathway tariff for each module of the pregnancy to their preferred pathway provider (i.e., 3 payments per pregnancy). Where women's choice or transfer of care mean a woman receives some elements of care from a different provider, the different provider will need paying by the pathway provider. Business rules have been published to ensure providers receive the right funding and ensure choice is not restricted.

Preparation: Shadow Year 2012/13: During 2012/13 all providers should be preparing for the new system by ensuring their information systems are sufficiently robust to collect the data required to allocate women to appropriate pathways and demonstrate this to commissioners. Providers will need to be able to estimate the proportions of women falling into each of the case mix categories and commissioners will compare this against national benchmarks and local data on needs and demographics.

More information is available on the DH web site:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132685



Wirral CCGs/PCT: Contracting for Alternative Providers.

Wirral PCT devolved leadership to GPs ahead of the move to CCGs and is already using the opportunities to commission differently. Long standing frustrations that maternity services, particularly antenatal and postnatal care were not meeting local needs had not been resolved despite an external review and PCT investment. In particular, levels of antenatal admissions for minor conditions of pregnancy were deemed unacceptable. Commissioners working with a GP with interest in maternity care identified a local private provider willing to extend early access, deliver continuity of care and tailor services to women's needs. The company 'One-to-One Midwifery' are commissioned to provide the entire pathway of antenatal, intrapartum and postnatal care for low risk women, within the existing tariff structure. There are no guarantees of volume and GPs are able to offer women choice at the point of referral. The new service is in its early days and the proportion of women using it is still quite small, but GPs are reporting better communication and collaboration with the midwives and GP practices are sharing midwifery resource on the understanding that not every practice can sustain a dedicated midwife. The aim of the new service is to: increase choice of providers for women; provide tailored flexible care particularly for deprived women and to focus on promoting normality in care. CCGs will now be monitoring outcomes and referrals, with more work to do to provide a seamless transition from maternity to health visiting services.

For more information, please contact Abhimantgani@btinternet.com

Section Seven: So what does good look like

Maternity is one key element along the continuum of a woman's life course and the beginning of the pathway of childhood development. The Government's aim is for a coherent framework of services for families, from pregnancy through to age five which focus on promoting children's development and help with all aspects of family life. The aim is to offer choice for all families, while also providing more targeted help for those in greatest need.

There is a growing body of evidence that supports what clinicians know from experience – the early years of a child's life are critical to their future chances, and what parents and families do makes a big difference.

The aim of maternity services should be to support the transition from pregnancy to family life with a safe high quality service that is woman and family centred and that enables mothers and baby's to achieve the best possible outcomes. CCGs can establish the principles upon which local services are delivered:

- Emphasising pregnancy and birth as essentially normal physiological processes
- Providing a seamless service to women who require additional care including medical/obstetric/psychological support during their pregnancy
- Outreaching to frequently excluded groups, encouraging them to engage with services
- Establishing a community based multi-professional partnership approach to care that ensures seamless links between primary, secondary and community services
- Improving accessibility of maternity services to encourage early booking and ensures women stay in regular contact with midwifery services throughout pregnancy and the postpartum period
- Promoting continuity of care especially for disadvantaged women or those with special needs
- Ensuring safe clinical care is based on best available evidence and is robustly audited
- Promoting family based care and locally available access to other services such as parenting skills, family planning, benefits agencies, baby clinics
- Safeguarding and promoting the welfare of children through appropriate and timely therapeutic and preventative interventions by staff able to identify risk factors and contribute to reviews, enquiries and child protection plans, through the CAF mechanism

Nationally these principles have been expressed in terms of **CONTINUITY** and **CHOICE**.

Locally they provide the starting point for a conversation between CCGs and provider units about current services, inputs, outcomes and the opportunities and challenges to doing things differently.

Good maternity provision is flexible, appropriate and accessible to all women. It emphasises pregnancy and birth as essentially normal psycho/social life events and provides seamless care for women who may need additional medical support.

Good health and wellbeing in pregnancy increases the chance of having a healthy baby and the best opportunity for improving the health of mother and baby is to improve the health of parents before conception. Although up to 40% of pregnancies

may be unplanned, primary care can support all women who may become pregnant, but in particular provide:

- Advice and counselling for women with long term medical conditions, including mental health problems and diabetes
- Counselling of women with known genetic conditions or at genetic risk, such as consanguinity
- Fit for life counselling including exercise, weight management, smoking cessation alcohol consumption and drug use

When a woman thinks she [is pregnant](#), she can contact her maternity service direct or her GP can refer her to the local [midwifery team](#).



Early Access Leaflets

Many PCTs have produced simple leaflets that are freely available in GP surgeries, pharmacies, libraries, children's centres and other community venues encouraging pregnant women to make early contact with local services, helping them get in touch with local maternity units and offering practical advice about staying healthy in pregnancy.

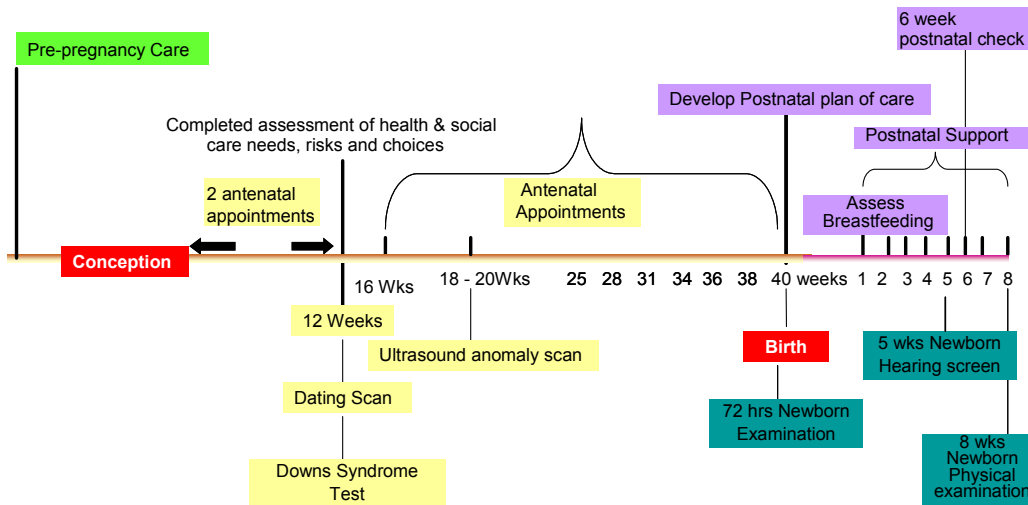
For an example of NHs Derbyshire's happy to be Pregnant leaflet, [click here](#)

Her midwife will help her develop a personalised plan of care for pregnancy including undertaking a full medical and social risk assessment before the end of the 12th week of pregnancy. In some cases this may require sharing information between the woman's GP, other specialist services and her midwife. All women need a midwife and some will need a doctor too and depending on her needs a woman may see an obstetrician and other specialists. Throughout pregnancy midwives will continue to assess the level of risk and the appropriate care required. GPs, midwives and health visitors will work together to care for the mother and support the baby's development.

During pregnancy all women will be offered the opportunity to form a trusting relationship with a small team of midwives who will monitor her pregnancy, coordinate care and provide consistent advice and information about things like [nutrition and medication, drinking alcohol and stopping smoking](#). They can also introduce parents to other local services, including children's centres and for those needing extra help the Family Nurse Partnership. The maternity pathway will be non-medicalised wherever appropriate, bringing care into the community and closer to home. Local one-stop settings will be available with appropriate communication systems in place to ensure referrals between primary and secondary care are timely and coherent.

Maternity Services will provide the full range of antenatal, intrapartum and postnatal care for women and their families including scheduled and unscheduled care, outpatient, inpatient, community and home based services. Maternity care will be provided in accordance with the requirements of national policy guidelines, evidence and best practice and will also reflect local needs and priorities. There will be a shared explicit philosophy that supports, protects and maintains normality, with the midwife as the lead professional for healthy women with uncomplicated pregnancies and the obstetrician as lead carer for medically high risk women. Continuity of care within the pathway shall not be disrupted because specialist input is required.

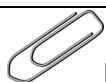
The Maternity Pathway in England



Women will be supported to take a central active role in their own care during pregnancy, labour and the postnatal period, including [choosing antenatal groups](#) to help them learn and feel ready for the arrival of their child. Women will be offered a choice about where to give birth appropriate to their level of risk, including [at home](#), in a midwifery unit or birth centre, or in a hospital; with information and advice from their midwife or doctor to assist them decide what may be best for their own and their baby's health. Women in labour will receive personalised supportive and continuous midwifery care (1:1 Care) reflecting their needs and preferences. Decision making about if and when to intervene in the birth will be made in collaboration between the woman and their maternity team.

Whether they are in hospital or at home, the maternity team and GP will guide and support parents in the [first few days](#) as well as check that the mother is recovering from the birth.

Referral mechanisms will be in place to ensure the successful and safe movement and/or transfer of women between local, secondary and tertiary services. Appropriate communication systems will be put in place to ensure the woman's care remains midwife co-ordinated, regardless of complexity. Wherever possible the midwife should always transfer with the woman. Consistent high quality communication will ensure women are provided with relevant information at appropriate times regardless of first language.



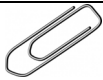
How good is your local service?

To help you assess your own local service the RCM, RCOG and NCT suggest you ask 13 key questions. For each of these they will tell you why you should be asking it, what answers you might expect and what potentially you could do differently by working with your maternity provider:

1. Are women accessing maternity services early?

2. What percentage of women are socially vulnerable and what arrangements are in place to care for them?
3. What arrangements are there for women who are unwell, apprehensive or whose pregnancies begin to deviate from the norm?
4. How do you make sure women have choices about the place and manner of their birth?
5. What is the normal birth rate?
6. How many hours are consultants present on the labour ward?
7. How many women receive 1:1 care in labour?
8. What are your breastfeeding rates?
9. Do you have special arrangements for women with risk factors, for example high BMI?
10. How are women with antenatal and postnatal mental health problems supported?
11. What collaborative arrangements are in place for midwives and health visitors to work together?
12. How can you be assured of the safety of the service?
13. Are all areas of the maternity pathway adequately resourced?

<http://www.rcm.org.uk/college/policy-practice/government-policy/commissioning/>



Dorset CCG: A strategic Approach to Maternity

The Dorset CCG has established a Maternity Reproductive and Family Health Clinical Commissioning Programme which is supported by a Maternity Commissioning Delivery Group to provide a focus for strategic decision making taking a population based approach to priorities, pathways and services within localities. The objectives of the Delivery Group, which is chaired by a GP, include:

Over see the development and monitoring of the maternity programme on behalf of the Clinical Commissioning Programme (CCP);

Provide expert public health and clinical advice, providing recommendations for best practice to support and inform the CCP on all matters relating to the maternity strategic programme;

To systematically prioritise the maternity programmes according to identified need and provide recommendations for CCP ratification.

Both groups have terms of reference and a work programme, including

Development of health needs assessments

Service reviews;

Development and implementation of clinical pathways;

Implementation of national programmes such as screening and health awareness campaigns;

Development and implementation of service specifications including key performance indicators, quality indicators, PPI involvement.

For more information, please contact Karen.kirkham@gp-J81073.nhs.net

Section Eight: Resources to Support You

Understanding local need

Individual practices will have a good idea about the needs and preferences of their local populations, but CCGs will need to aggregate these into a picture of the health and wellbeing of the population in relation to the provision of maternity services; such as the prevalence and distribution of teenage parents or women over 35 having babies, the extent of obesity and other risk factors such as alcohol and drug misuse, smoking, diabetes and other long term conditions. Many maternity services have had under-developed pre-conceptual services and the opportunities for a stronger connection between primary care 'fit for pregnancy – fit for life'-type initiatives

Maternity Needs Assessments

Local Maternity Needs Assessments offer a deep-dive into JSNAs focussing specifically on the demographic and other factors that are important to understanding local maternity demands.

Dorset's Health Needs Assessment forms the basis for determining local maternity priorities, [click here](#)

Listening to users – NHS Institute

This resource is for people with designated responsibility for improving patient experience – both as providers of services and as commissioners. It is intended to provide the evidence needed to focus on improving patient experience.

http://www.institute.nhs.uk/patient_experience/guide/home_page.html

Accessing your local resources

All maternity providers will produce their own '**dashboards**' to monitor activity, outcomes and performance. This 'real time data' will help you identify the challenges and opportunities in your own area

If a local maternity Services Liaison Committee is working, it will have a good overview of what **women and their families** say about local services – the good the bad and the ugly!

Your local **Public Health Department** collects and analyses population, demographic and trend data in maternal and infant outcomes, often at ward level

Benchmarking performance

Comparing local services, both their outcomes and the way they are organised will help CCGs identify areas that require improvement through commissioning and the scope for collaboration and development. There are nationally available summaries of maternity inputs and outputs, activity and key performance indicators, as well as local insights into how services compare with their neighbours.

Using the CHiMat data source

ChiMat is the national Child and Maternal Health Observatory (ChiMat) provides information and intelligence to improve decision-making for high quality, cost effective services. It brings together Hospital Episode Statistics (HES) data with other nationally verified information to provide insight into quality, performance safety and productivity

<http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=10&geoTypeId=1>

LSA MO Reports

Midwifery is subject to a statutory process of supervision undertaken by Local Supervising Authorities which are impartial organisations. Each LSA appoints a Midwifery Officer who annually undertakes an audit and review of all local maternity units. These reports give an insight into the quality and safety of local units

<http://www.nmc-uk.org/Nurses-and-midwives/Midwifery/Supervisor-of-midwives/England-LSA-reports/>

CQC Surveys of Provider Units

In 2008 the CQC undertook an assessment of all maternity units in the country. In 2010 they surveyed over 25,000 women about their experiences of maternity care. Results show how individual trusts performed on key questions.

<http://www.cqc.org.uk/surveys/maternity>

Outcomes & Standards

Outcomes in maternity are generally very good. Maternal and perinatal mortality rates are low, but do show regional and local variations and are often linked to standards of care. The NHS Outcomes Framework has set some high level indicators and maternity is well served by NICE guidance setting out best clinical practice.

National Standards & Requirements	National Guidance	Professional Recommendations
<p>CNST The Clinical Negligence Scheme for Trusts (CNST) is a pay-as-you-go non profit pooled fund to cover negligence claims. Organisations receive a discount on the maternity element of their CNST contributions where they can demonstrate compliance with the CNST Maternity Clinical Risk Management Standards.</p> <p>www.nhs.uk/NR/rdonlyres/61B58996-CD88-4840-8203-53E886981CD3/0/CNSTMaternityStandards201213.doc</p>	<p>NICE Maternity has been well served by NICE with 9 guidelines relating to birth and 29 relating to pregnancy, including caesarean section, antenatal care, perinatal mental health, diet, smoking and exercise.</p> <p>http://www.nice.org.uk/guidance/index.jsp?action=byTopic&o=7252</p>	<p>RCOG Standards of Maternity Care In 2008, the joint Royal Colleges published national standards for maternity care. Their purpose is to provide guidance for the development of equitable, high quality Services across the UK. They provide a valuable tool and resource for commissioners and providers to plan and quality assure maternity services</p> <p>http://www.rcog.org.uk/catalog/book/standards-maternity-care-report-working-party</p>
<p>National Screening Committee The UK National Screening Committee the NHS about all aspects of screening and supports implementation of screening programmes. The six NHS antenatal and newborn screening programmes all contain a series of mandatory quality standards and KPIs covering</p> <ul style="list-style-type: none"> • Fetal abnormality screening • Infectious diseases in pregnancy • Antenatal sickle cell and thalassaemia • Newborn and infant physical examination • Newborn blood spot • Newborn hearing screening <p>http://www.screening.nhs.uk/england</p>	<p>Confidential Enquiries Since the 1950s, three yearly reviews of all maternal and infant deaths have been undertaken to identify direct and indirect causes, regional trends and variations and to highlight service improvements to raise standards.</p> <p>http://www.rcog.org.uk/news/cmace-release-saving-mothers%E2%80%99-lives-report-%E2%80%93-reviewing-maternal-deaths-2006-2008</p>	<p>RCOG: High Quality Women's Healthcare Against a backdrop of NHS reform, financial and workforce pressures, increasing complexity of women's health care, many of the current structures cannot be sustained. This report looks at how NHS women's health services could be configured to provide high quality, safe and timely care</p> <p>http://www.rcog.org.uk/high-quality-womens-health-care</p>
<p>Toolkit for Neonatal services In 2009 the DH published guidance improve the care provided for premature and sick babies and their families It includes a set of eight principles for high quality neonatal services and a framework to assist commissioners.</p> <p>http://www.dh.gov.uk/en/Publicationsandstatistics</p>	<p>Institute for Innovation and Improvement: Focus on Normal Birth and Reducing Caesarean Section Rates Aims to help local health communities and organisations improve the quality and value of care for promoting normal outcomes</p>	

<p>ics/Publications/PublicationsPolicyAndGuidance/DH_107845</p>	<p>and reducing caesarean sections to a safe minimum</p> <p>http://www.institute.nhs.uk/index.php?option=com_joomcart&main_page=document_product_info&products_id=185&cPath=100</p>	
<p>Preparation for Pregnancy & Beyond</p> <p>This is a practical tool that aims to improve outcomes for babies and parents through a refreshed approach to antenatal education that moves beyond traditional models. It covers the physiological aspects of pregnancy and birth, but also addresses the emotional transition to parenthood in greater depth and recognises the need to include fathers and other partners in groups and activities.</p> <p>http://www.dh.gov.uk/health/2011/10/preparation-for-birth-and-beyond-resource-pack-to-help-parenthood-groups/</p>	<p>Promoting & Supporting Breastfeeding</p> <p>The Baby Friendly Initiative is a World Health Organization and UNICEF programme. It encourages maternity hospitals to implement the Ten Steps to Successful Breastfeeding and to practise in accordance with the International Code of Marketing of Breastmilk Substitutes. In the UK, it also works to implement the Seven Point Plan for Sustaining Breastfeeding in the Community and run a University Standards programme for midwifery and health visiting courses.</p> <p>The Baby Friendly Initiative works with the health-care system to ensure a high standard of care in relation to infant feeding for pregnant women and mothers and babies.</p>	

Service specifications

The service specification is the formal expression of commissioner's expectations and should form the basis of an on-going dialogue with providers. It should:

- Describe at a high level the requirements for effective, efficient and reliable maternity services
- Identify specific local areas for development and improvement in line with the needs assessment
- Develop an action plan for the achievement of specific goals or targets
- Provide a structure for monitoring and measuring performance against national and local objectives
- Facilitate the planning, implementation and evaluation of changes



South Central SHA Standard Maternity Service Specification

Aim

To commission safe quality maternity services, responding to both national policy initiatives and local priorities whilst at the same time ensuring the most effective use of resources maximising productivity

Coverage

Scheduled and unscheduled antenatal care, outpatient, inpatient community and home based care

Antenatal, intrapartum and postnatal care

Principles

Localised and normalised care

Choice of birth setting

Dynamic assessment

Seamless care

Communication, referral and transfer between providers and professionals

Objectives – Defined by Women

I will have access to appropriate support and advice as soon as I know I am pregnant

I will have a named midwife whom I know and trust

I will choose where to have my baby

I will feel safe and supported during my birth experience

I will feel confident to care for my baby

My views will be taken into account

Strategy

Maternity services are important to the public and a priority for the government. Over recent years, there have been numerous official reviews and policy initiatives focusing on flexible, appropriate and accessible services that are of high quality and offer women choice. The challenge for CCGs is to prioritise investment decisions and specify expectations in order to deliver the most effective local service

The Birthplace in England: National Prospective Cohort Study.

The Birthplace cohort study compared the safety of births planned in four settings: home, freestanding midwifery units (FMUs), alongside midwifery units (AMUs) and obstetric units (OUs). The main findings relate to healthy women with straightforward pregnancies who meet the NICE Intrapartum care guideline criteria for a 'low risk' birth. It demonstrates that giving birth is generally very safe and that for planned births in FMUs and AMUs there were no significant differences in adverse perinatal outcomes compared with planned birth in an obstetric unit, but that Women who planned birth in a midwifery unit (AMU or FMU) had significantly fewer interventions, including substantially fewer intrapartum caesarean sections, and more 'normal births' than women who planned birth in an OU

<https://www.npeu.ox.ac.uk/birthplace>

Families in the Foundation Years

As part of a cross-Government approach, a new document, Families in the Foundation Years, has been produced which outlines how services for children and families are changing in order to help and support them through every stage - from pregnancy until their child turns five.

<http://www.education.gov.uk/childrenandyoungpeople/earlylearningandchildcare/early/b0077836/introduction>

Healthy Lives Healthy People

This White Paper sets out the Government's long-term vision for the future of public health in England. The aim is to create a 'wellness' service (Public Health England) and to strengthen both national and local leadership. It sets out the vision for the preventative aspects of maternity care.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121941

Kings Fund: Safer Birth Programme

The Safer Births programme aims to enable front-line professionals working in maternity units to improve the safety of the services they deliver to women and their babies. The programme includes a thorough exploration of the role and contribution of general practice to maternity care.

http://www.kingsfund.org.uk/current_projects/improving_safety_in_maternity_services/index.html

Teenage Pregnancy

Around one in 15 of all births are to young women under 20 and we know these young women and their babies have poorer access to maternity services and experience poorer outcomes than older women. This guide produced by the DH sets out the actions commissioners can use to drive improvements in their local services to support better care for this vulnerable group.

<http://media.education.gov.uk/assets/files/pdf/t/teenage%20parents%20who%20care%20s.pdf>

Maternity Matters

Maternity matters: choice, access and continuity of care in a safe service is for commissioners, service providers and other organisations involved in the provision of maternity services. It builds on the maternity services commitment outlined in Our Health, Our Care, Our Say and is an important step towards meeting the maternity standard set out in the Children's NSF.

Maternity matters highlights the Government commitment to developing a high quality, safe and accessible maternity service through the introduction of a new national choice guarantee for women. This will ensure that by the end of 2009, all women will have choice around the type of care that they receive, together with improved access to services and continuity of midwifery care and support.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073312

Assurance

Providers should regularly report key performance measures on activity and outcomes to their commissioners. A minimum set will be specified contractually. However, for their own purposes, providers will use more detailed reporting and commissioners will want assurance that these are reported regularly to the Trust Board

Midwifery Workforce: Birthrate plus

Birthrate Plus standards for midwife work are based upon NICE Guidelines for antenatal and intrapartum care and are regularly updated to reflect changes in care practices and policies

http://www.birthrateplus.co.uk/index.php?option=com_content&task=view&id=15&Itemid=19

RCOG Maternity Dashboard

The Maternity Dashboard is a tool for individual units to use in planning and improving their maternity services. It serves as a clinical performance and governance score card to monitor the implementation of the principles of clinical governance on the ground. This may help to identify patient safety issues in advance so that timely and appropriate action can be instituted to ensure a woman centred, high-quality, safe maternity care.

<http://www.rcog.org.uk/womens-health/clinical-guidance/maternity-dashboard-clinical-performance-and-governance-score-card>

National Patient Safety Agency Intrapartum Scorecard

The dashboard is a tool for gathering retrospective maternity data on a monthly basis to report to the Board. It serves as a clinical performance and governance Scorecard to monitor the implementation of the principles of clinical governance on the ground. This may help to identify patient safety issues in advance so that timely and appropriate action can be instituted to ensure woman centred, high-quality, safe maternity care.

<http://www.nrls.npsa.nhs.uk/resources/collections/intrapartum-toolkit/?entryid45=66358>