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Summary of the report of the National Maternity Review ‘Better Births: Improving outcomes of maternity services in England’

This document is a summary of the National Maternity Review ‘Better Births: Improving outcomes of maternity services in England’. Further analysis and commentary on the Report from the RCM will follow in due course.

Foreword: Baroness Julia Cumberlege

This report begins with a letter to the women of England, and their families, from Baroness Cumberlege, the Chair of the Maternity Review. In the letter she sets out the headline findings of the review and she compares the state of maternity services in 2016 with those at the time, twenty years ago, when she oversaw the production of *Changing Childbirth*.

She begins by acknowledging that the quality and outcomes of maternity care have improved significantly in the last two decades, including a 20% fall in stillbirth and neonatal mortality rates. At the same time maternity services have had to respond to challenges, such as more women giving birth at an older age and the increasing complexity of many women’s health needs. Despite the progress made in recent years, the review identified some instances where maternity services were falling short:

- Women were not always being offered real choice in the services they could access or were told what to do, rather than being given information to make their own decisions.
- Hospital services were frequently operating at 100% capacity while community-based services struggled to survive.
- While women wanted their midwife to be with them from the start, they rarely saw the same professional twice.

• The quality of maternity care varied considerably, there was insufficient collaboration across professional boundaries and staff spent too much time collecting poor-quality data. • Things go wrong too often and fear of litigation inhibits staff from being open about and learning from mistakes.
• Outcomes on some measures are worse in the UK than for comparable services elsewhere in Europe.

For Baroness Cumberlege, a critical element of the review has been to reconcile two principles: that women should be able to make choices about their care and that the safety of mother and baby is paramount. Having listened to what women have said that they want, the review has concluded that women should be in control of their care, in partnership with healthcare professionals, but with that control comes a responsibility to accept that personal health and fitness are integral to safe and fulfilling childbearing.

Baroness Cumberlege describes the review as setting out an ambitious vision that will require greater teamwork, more and better dialogue and the breaking down of professional boundaries, alongside a commitment across the NHS, independent and voluntary sectors to work together in an open and inclusive way.

The Vision

The report sets out the following vision for maternity care in England:

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

And for all staff to be supported to deliver care which is woman centred, working in

high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries."

The vision is underpinned by seven themes, which form the basis for the recommendations set out in the body of the report:

1. Personalised care.
2. Continuity of carer.
3. Safer care.
4. Better postnatal and perinatal mental health care.
5. Multi-professional working.
6. Working across boundaries.
7. A fairer payment system.

Introduction and terms of reference

This section sets out the background to the review and its terms of reference. The review was commissioned in March 2015 by NHS England on behalf of the national organisations that had authored the Five Year Forward View to consider how maternity services needed to change to meet the needs of the population, and to ensure that learning from the Morecambe Bay Investigation could be embedded throughout the NHS.

Baroness Cumberlege was appointed as independent chair, supported by Sir Cyril Chantler as vice-chair, a review team of midwives, doctors, women's representatives and other experts, and a secretariat from NHS England.

The terms of reference were to:

1. Review the UK and international evidence and make recommendations on safe and efficient models of maternity services, including midwife-led units.
2. Ensure that the NHS supports and enables women to make safe and appropriate

choices of maternity care for them and their babies.
3. Support NHS staff including midwives to provide responsive care.
4. Pay particular attention to the challenges of achieving the above objectives in more geographically isolated areas, as highlighted in the Morecambe Bay Investigation report.
5. Ensure that tariff-based NHS funding supports the choices women make, rather than constraining them.
6. Make it easier for groups of midwives to set up their own NHS-funded midwifery services.

The review team agreed that the scope of the review would encompass maternity care from conception through to six weeks after birth, based on shared goals (safe, kind, personalised, professional, family friendly) and the following workstreams:

- Choice
- New models of care
- Professional culture and accountability
- Quality assessment
- Levers and incentives

The themes of improving mental health and public health, and of reducing inequalities, were considered across all the workstreams.

An extensive engagement programme was undertaken, across all regions, to take into account the opinions, expertise and perspectives of as wide a group of people as possible. Engagement activities included drop-in sessions, service visits, 'Birth Tank' events, an online consultation, focussed discussions and international visits.

The case for change

This section summarises the three key sources of evidence that the review team relied on in drawing their conclusions and developing recommendations:

a. Assessment of current quality of care provided by maternity services in England

This assessment, undertaken by a group led by Dr Bill Kirkup, was asked to consider quality across the breadth of the maternity pathway. The assessment found significant variation in safety, effectiveness and outcomes between providers that could not be explained on the basis of differences in demography, deprivation or clinical complexity.

The scope for improving safety were evident from the missed opportunities to save babies lives identified in stillbirth audits to unexplained variations in rates of third or fourth degree perineal tears. The assessment also found evidence that there is widespread under-reporting of safety incidents in maternity services and clear differences in the approach to learning and team working between high and low reporting units.

The group also found considerable variation in the effectiveness of maternity care, particularly in relation to mental health, where 40% of women in England lack access to specialist perinatal mental health services and many women with mental health problems that are detected do not receive evidence-based treatment.

The third element of the assessment – women's experience of maternity care – is reported positively by most women, except that a significant proportion of women reported not being offered choice of place or type of birth and women are less satisfied with the care they receive following birth.

b. Evidence review by the National Perinatal Epidemiology Unit (NPEU)

The NPEU reviewed evidence relating to the safety of place of birth, the effectiveness of 24/7 consultant labour ward presence, the factors which influence women's choice of planned place of birth and international evidence on the delivery of and outcomes from maternity services.

The NPEU's key findings were that:

• For low risk women having a second or subsequent baby, planning a birth at home or in a midwifery unit results in fewer interventions, the chances of transfer are low and there is no evidence that outcomes are worse. For low risk women having their first baby, there is a higher risk of transfer and, for home births, a small increased chance of an adverse outcome for the baby.
• Maternity services need to consider how best to provide care for women with complications who nevertheless want to choose midwife-led care. Flexibility in entry requirements to alongside midwifery units may help to offer such women the type of birth they would like.
• There is insufficient evidence to support a model of 24 hour resident consultant presence on labour ward, compared with other models of consultant cover, and is only viable as a model for large urban hospitals.
• Women need clear unbiased information to help them make decisions about where to give birth and such information needs to be personalised according to their individual circumstances.
• Women almost universally value local services, being seen by the same midwife or group of midwives before the birth and having continuity of carer during labour.

c. The Morecambe Bay Investigation Report

The investigation into the serious failings at Morecambe Bay NHS Trust reported in March 2015. The key lessons that the review has sought to address are:

• A dysfunctional professional culture, as evidence by unchallenged failures in clinical competence, poor relationships between different professionals, or a failure to investigate incidents or learn from them, can directly impact on the quality of services.
• Establishing the right culture requires leadership and commitment from everyone and for individuals to operate as a team across professional disciplines.
• It is harder to establish a positive culture in clinically or geographically isolated

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units, where there can be particular problems recruiting staff. Small units should not therefore operate in isolation.

What the review heard

This section of the review sets out the key themes that the review team heard from women and families, healthcare professionals and from commissioners and providers.

a. Women and families.

Safe and personalised care

Women and families who contacted the review were clear that they wanted to access maternity services that are safe and that keep them as safe as possible.

Women were equally clear that they wanted to be able to choose the care that is right for them, their family and their circumstances, and that they want the care to wrap around them. Women do not always feel that they have a choice and too often felt pressurised by professionals to make choices that fitted the service. They resented the implications of their care being labelled high, medium or low risk. Above all, they wanted to be listened to and to be taken seriously.

Women also placed great importance on knowing and forming a relationship with the professionals caring for them. They preferred to be cared for by one midwife or a small team of midwives throughout their maternity care. It was felt that this would enable midwife to better meet their needs, identify problems and provide a safer service. Continuity was also important for obstetric care, particularly after a traumatic experience.

Women also wanted to know that all the healthcare professionals caring for them are fully trained and competent, to conduct tests, assess them and their baby, recognise

signs of changing risk and escalate care when necessary. Women referred to a lack of awareness of risk and a reluctance to discuss it openly.

Some fathers reported feeling excluded and that their role had not been recognised. Women who relied on their partner for support in pregnancy wanted the NHS to recognise this and help their partners to help them.

The review was also told that services should be designed in a way that put women, their babies and their families at the centre. In this context the review saw evidence of the effectiveness of properly supported and led Maternity Services Liaison Committees as well as a range of voluntary and third sector organisations.

Communication

Women valued good quality and consistent communication and emphasised the importance of professionals communicating with each other. Women want healthcare professionals to have read their notes before they meet them and they thought electronic records would be a means of avoiding having to repeat information to every new health professional they meet.

Women were particularly frustrated by receiving conflicting advice from different healthcare professionals. They want information to be evidence-based, and available in a range of formats, so that they can make genuinely informed decisions. They also wanted time to discuss the information with a healthcare professional.

Most pregnant women expect digital tools to empower them in their decision-making; the more empowered they felt by their digital experience, the more likely they were to ask for help during face to face interactions with healthcare professionals. They attached equal importance to trusting digital information as they did to their care experience but they found it difficult to process and make

decisions based on the vast array of pregnancy related material online.

Women who experienced stillbirth said that they wished they had been better informed about risks and symptoms and, especially during their first pregnancy, found it difficult to know what signs to look out for.

Parents want to be listened to and taken seriously when they expressed concerns about their baby, rather than feeling ignored or patronised.

Care when a baby dies

For bereaved families, kind and compassionate care could make the experience better, whereas insensitive language and dismissive remarks, caused hurt and could pollute memories of the time they had with their baby. Environment mattered, particularly for parents made to share facilities on labour wards with those who had just given birth, this could greatly add to their trauma and distress. Many parents felt rushed through the process and would have liked more time to come to terms with their loss before having to leave the hospital, leave their baby or decide what would happen to their baby.

Care when complications arise

Women and families weren't always confident that complications would be picked up and staff understand the impact on them. They wanted any concerns they had about their or their baby's health to be listened to and taken seriously. Where their baby is harmed, they expect high quality investigations that are factually correct, unbiased and framed in a way that shows sympathy towards them. Women want to be close to their baby if it is in neonatal care and they are still a patient themselves. Care needed to be sensitive and respectful and facilities of a suitable standard.

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Care for women expecting more than one baby

There needs to be greater recognition of high risk groups, such as those who have multiple births and a better understanding of the risks and complications associated with multiple births.

Care for women with different backgrounds

For all women, regardless of their background, it was important for healthcare professionals to understand and respect their cultural and personal circumstances. In terms of how services might be tailored for different groups, this could be about greater engagement between providers and BME communities, providing information in easy to understand formats for those who have difficulty communicating or employing staff with specialist expertise to support drug or alcohol users.

Postnatal care

Women feel that postnatal services aren't sufficiently resourced, that the six week postnatal check is inadequate and that the level of care and support they receive during pregnancy is not continued after birth. Women would like improved support in breastfeeding as well as more support and better access to counselling and therapy for those who have had difficult or traumatic experiences. Additional support was seen as particularly important in preventing the onset of depression and other mental health conditions.

b. Healthcare professionals

Teamwork and respect between professionals

Midwives and obstetricians highlighted the need to improve working relationships between their professions and with other groups but mentioned issues of communication, handovers and disagreements about how to handle specific situations as barriers to achieving this. Everyone has the interests of the woman

and baby as their priority but had different perspectives on how to secure the best possible care for them.

Professionals wanted better investment in education and training, and stressed the importance of multiprofessional education and training throughout pre and post registration careers as well as training to improve skills such as perinatal mental health.

Professional support and work load

Professionals voiced concerns about poor working environments leading to low morale and motivation and wanted to see more creative workforce design and better collaboration between commissioners and providers in workforce planning.

Increased administration was cited as a particular difficulty in that it reduced the amount of time that could be spent with women and thereby increased the risk of mistakes or missed opportunities to spot problems. Other perceived problems included a litigious culture, paper-based systems and data collections not being aligned. Staff would like to see more integrated IT systems and regard digital and accessible maternity records as beneficial.

Whilst some midwives were concerned about the removal of statutory supervision, other midwives and maternity professionals questioned the existence of a separate oversight mechanism for one part of the workforce.

Role of general practice

Most GPs want to be more involved in maternity care; they felt their lack of involvement is to the detriment of women and babies and they recognised the importance of working in partnership with midwives and obstetricians to provide personalised, community-based care. However, some GPs felt that they lacked expertise and had other pressures on their time and so felt it necessary to be less involved.

Litigious and blame culture

Professionals are concerned that the threat of litigation and the high costs associated with it can lead to risk-averse practice, inhibit their support for the choices women may want to make and undermine multiprofessional working. For most bereaved litigation was a last resort after they had failed to obtain answers about their baby's death through other channels. Their main motivation was to ensure the same mistakes weren't repeated but they found the process stressful as it inhibited clinicians from openly discussing what had gone wrong and could take years to resolve.

Continuity

Some midwives welcomed the option of a caseloading model, particularly for vulnerable women, as they felt that having a relationship with the woman could improve both safety and their own job satisfaction. However staff were concerned about the viability of continuity of carer within the current system and the impact on work/life balance. Given the large proportion of midwives who work part time, continuity models would be difficult to implement without additional resources.

A number of elements were identified that could help ensure successful implementation of continuity models:

- Ring-fencing time for midwives working in caseload teams, so they are not diverted to other services.
- Capping caseload numbers to manageable levels, so as to aid planning and avoid over-burdening midwives.
- Midwives to be able to manage their own diary, in conjunction with the rest of the team.
- Rotation of midwives between hospital and community as a means of maintaining skills and promoting a continuity model.

c. Commissioners and providers

Mental health support

There is widespread agreement that mental health care for women is not good enough and that although perinatal mental health is gathering a profile, there is insufficient activity on the ground to improve care. More training and dissemination of best practice is needed to reduce variation and improve standardisation of service provision across England.

Payment systems

The maternity pathway tariffs are not seen as fit for purpose and could inhibit choice. Providers feel the tariffs aren't sufficiently sensitive to the costs of providing different types of care, whilst the risk categorisation was felt to act against the personalisation of care.

Services for rural communities

The review team visited a number of areas where the challenge was to provide services that were local and accessible but also safe and sustainable. In particular, small obstetric units in rural areas see a low number of births and can struggle to employ sufficient numbers of staff as well as ensuring they can maintain and develop their skills.

Shaping the future

Having made the case for change, and summarised the views of women and health professionals in the preceding chapters, the review recommendations for delivering safer, personalised care are set out here. Whilst not wishing to impose a uniform approach to how services are structured, the recommendations are based on all services conforming to the tenets of:

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

- Continuity of carer, to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions.
- Safer care, with professionals working together across boundaries to ensure rapid referral, and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation, honesty and learning when things go wrong.
- Better postnatal and perinatal mental health care, to address the historic underfunding and provision in these two vital areas, which can have a significant impact on the life chances and wellbeing of the woman, baby and family.
- Multi-professional working, breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies.
- Working across boundaries to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care where needed.
- A payment system that fairly and adequately compensates providers for delivering high quality care to all women efficiently, while supporting commissioners to commission for personalisation, safety and choice.

A new deal for women, babies and families

Personalised care

The review calls for a woman's maternity care to be personalised to her needs and those of her baby and family. She should be able to make decisions about her care during pregnancy, birth and after her baby's birth, through an ongoing dialogue with professionals. She should feel supported to make well informed decisions through a relationship of mutual trust and respect with health professionals, and her choices should be acted upon.

Accordingly it is recommended that:

- **Every woman should develop a personalised care plan, with her midwife and other health professionals, which sets out decisions about her care, reflects her wider**

health needs and is kept up to date as her pregnancy progresses and after the birth (recommendation 1.1). The personalised care plan will help the woman to understand her pregnancy and what it might mean for her care and to manage her own health and that of her baby into the long term. Providers and commissioners are both responsible for ensuring that all women have such a personalised care plan by 2020.

- **Unbiased information should be made available to all women to help them to make their decisions and develop their care plan drawing on the latest evidence, and assessment of their individual needs, and what services are available locally. This should be through their digital maternity tool (recommendation 1.2).** Choice should begin as soon as a woman makes contact with maternity services; her midwife should begin the dialogue with the woman and she should expect to have sufficient time and knowledge to discuss options. She may need to make some initial decisions about antenatal care she wants; as her care progresses, and possibly due to changing circumstances, she will need to discuss these options and make further decisions, including about care in labour and in the postnatal period. She should be able to change her mind as her pregnancy progresses. Where appropriate, these discussions will require input from her obstetrician. The National Information Board (NIB) and NHS England will be responsible for ensuring this recommendation is implemented by April 2017.
- **Women should be able to choose the provider of their antenatal, intrapartum and postnatal care and be in control of exercising these choices through their own NHS Personal Maternity Care Budget (recommendation 1.3).** CCGs may need to look to alternative and innovative providers of care such as midwifery practices and social enterprises to provide genuine choice for their community. Personal Budgets should help women to achieve their personalised care plans and women should be enabled to make a choice electronically. It is envisaged that NHS England could support trialling of this scheme in several areas within 2016-17, with a view to moving to widespread availability from autumn 2017. If the trial proves successful, women could use personal budgets to select their chosen provider who is accredited and integrated within the local governance arrangements. Procedures would need to be developed to transfer care to other providers in the event that the woman needs more

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complex care. Further details on this proposal are set out in an appendix to this report (see below).

• **Women should be able to make decisions about the support they need during birth and where they would prefer to give birth, whether this is at home, in a midwifery unit or in an obstetric unit after full discussion of the benefits and risks associated with each option (recommendation 1.4).** CCGs must make available maternity services that offer women the choice of home birth, birth in a midwifery unit and birth in an obstetric unit, and may need to commission collaboratively with others, or work across traditional boundaries.

Coordination and continuity

In response to the many women who said that they saw too many different healthcare professionals and were confused about who they were and what their role was, the review advocates continuity of carer, in order to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions.

The review recommends the following actions to achieve continuity of carer:

• **Every woman should have a midwife, who is part of a small team of 4 to 6 midwives based in the community who know the woman and family, and can provide continuity throughout the pregnancy, birth and postnatally (recommendation 2.1).** Ideally the woman should have her own midwife with her at the birth, but if not then it should be a midwife from the same team.

• **Each team of midwives should have an identified obstetrician who can get to know and understand their service and can advise on issues as appropriate (recommendation 2.2).** Where a woman needs on-going obstetric support, this should be from a single obstetric team and the care should be fully integrated across the midwifery and obstetric services.

• **Community hubs should enable them to access care in the community from their midwife and from a range of other services, particularly for antenatal and postnatal care (recommendation 2.3).**

• **The woman's midwife should liaise closely with obstetric, neonatal and other**

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services ensuring that they get the care they need and that it is joined up with the care they are receiving in the community (recommendation 2.4). A need for hospital based care should not mean a woman has to forego continuity. Where a woman knows from the very start of her pregnancy that she will have to go to hospital most of the time because she needs specialist expertise or to be seen by a multi-professional team, she should be able to have a midwife based at the hospital and get to know the team there.

Evidence shows that continuity models have an impact on improving safety, clinical outcomes, as well as a better experience. In particular, there is evidence that for women who find services hard to access and navigate, they have improved access to care, and there is better coordination of their care between midwifery, specialist and obstetric services. Pre-term births have also been found to be reduced through continuity of care.
Safer care

For most women, the safety of their baby and themselves is their primary concern. They expect the services and staff caring for them to also have their safety as their priority. The review therefore calls for safer care, based on professionals working together across boundaries to ensure rapid referral, and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation, honesty and learning when things go wrong.

Many of the key findings and conclusions from the review are underpinned by considerations of safety:

• **Women should be informed of risks and be supported to make decisions which would keep them as safe as possible.** They must have their needs assessed by their midwife, and obstetrician if appropriate, as part of developing their personalised care plan. They should also be provided with unbiased information to help them make their decisions.

• **Once a woman has made her decisions, she should be respected and the services should wrap around her.**

• **There should be rapid referral protocols in place between professionals**

and across organisations to ensure that the woman and her baby can access more specialist care when they need it (recommendation 3.3). If a woman is concerned about her health or that of her baby, these concerns must be listened to and professionals must act accordingly.

• **Women should have continuity in the person who is caring for them, their midwife and, where appropriate, their obstetrician**. Through a relationship of knowledge and understanding, the woman and her professional will be better equipped to recognise any changes to risk factors or where something might not be quite right, to ensure appropriate referral.

• **Professionals should work together in a multi-professional team in the interests of the woman and her baby, seeking to keep them as safe as possible**. They should learn and train together, and never be reluctant to seek or provide help. Time should be made available for multi-professional training, its uptake should be monitored and impact evaluated.

• **Teams should collect data on the quality and outcomes of their services routinely, to measure their own performance and to benchmark against others to improve the quality and outcomes of their services (recommendation 3.4).**

• **Provider organisation boards should designate a board member as the board level lead for maternity services. The Board should routinely monitor information about quality, including safety and take necessary action to improve quality (recommendation 3.1).** The leadership of all provider organisations must take responsibility for and attach priority to the safety of their maternity services.

• **Boards should promote a culture of learning and continuous improvement to maximise quality and outcomes from their services, including multi-professional training. CQC should consider these issues during inspections (recommendation 3.2).**

• **Providers should work together as part of a Local Maternity System to** ensure that services are provided to meet the woman's choices and ensure that women and their babies are kept as safe as. possible. Specialist care should be accessible when needed, and all providers should operate under shared clinical governance and protocols.

In the context of safer care, the report references two recent initiatives:

- The Government's ambition to reduce rates of stillbirth, neonatal and maternal deaths in England by 50% by 2030. As part of this commitment, maternity services will be asked to come up with initiatives that can be adopted across England, such as appointing maternity safety champions and ensuring all staff have the right training to enable them to identify the risks and symptoms of perinatal mental health.

• Saving Babies' Lives – the care bundle designed to tackle stillbirth and early neonatal death by improving practice in the areas of: smoking in pregnancy; fetal growth restriction; reduced fetal movement and fetal monitoring during labour.

Digital information for improved choice and care

The review considered the role of digital technology and concluded that in order to achieve improvements in care quality, learning and productivity, the NHS must make it easier for professionals to collect and share data with each other and with those they care for. For this to happen, there needs to be greater investment in electronic, interoperable maternity records as well as simple interfaces that minimise data entry time, thereby freeing up more time to care for women. The review therefore recommends that NHS providers should invest in technological solutions that are accessible:

• by women, families and professionals;
• via a mobile device so that they can be used at booking, in community hubs and at home;
• by staff at the community hub and hospital services, and connected with hospital records systems; and
• by all providers of maternity and maternity-related care within the local maternity system.

All women should have access to comprehensive digital sources of information and the development of pregnancy and childcare apps, such as the Baby Buddy App, should be encouraged. To enable the personalisation of information, digital tools must provide an interface with the woman's electronic maternity record. The review calls on NHS England and the National Information Board (NIB) as an urgent priority to support the national roll out of interoperable electronic maternity records for professional use combined with support for a digital tool for women. The review also recommends that:

• Use of electronic maternity records should be rolled out nationally, to support sharing of data and information between professionals, organisations and with

the woman. Commissioners and providers should invest in the right software, equipment and infrastructure to collect data and share information (recommendation 5.3).

Bringing care together in community hubs

In order to ensure that the NHS organises its services around women and families, the review proposes that community hubs should be identified to help every woman access the care she needs and that the hubs work with hospitals and other services to wrap care around each woman.

Community hubs are defined as local centres where women can access various elements of their maternity care, which can be located in sites such as children's centres or freestanding midwifery units. Hubs would enable different providers to work together offering midwifery, obstetrics and other services i.e. ultrasound or smoking cessation services. Women could also meet professionals who would be involved in their care after birth, such as health visitors. Some community hubs would have birthing facilities.

Community hubs would:

• Act as one-stop shops, bringing together different services and different teams operating out of the same facility.
• Provide a fast and effective referral service to the right expert if more specialised care was required.

The review does not seek to prescribe a standard model for the community hub, but recognises that this will depend on what services are already available locally and what is appropriate for a particular community. There should however be close liaison between all community hubs within the local maternity system and between the community hubs and obstetric units to ensure a seamless service for all women.

Rapid referral when needed

With four in ten women developing a complication that

requires some form of more specialist expertise, the review calls for rapid referral to care provided by obstetricians, midwives and other hospital specialists. This should be offered as soon as complications are identified and care should be personalised around the needs of the woman and her baby.
The report goes on to propose that services should be planned to allow for high quality consultation between professionals and referral from one level of care to another as appropriate. High quality consultation can be enhanced if every midwifery team has an identified obstetrician who can get to know and understand their service and advise on issues as appropriate.

Transfers between services should be facilitated by establishing clear referral protocols, whilst recognising that care pathways need to be flexible i.e. women may be suitable for antenatal care in the community but advised to give birth in an obstetric unit or require specialised care during pregnancy but be able to birth in a midwifery unit.

Improving prevention and reducing health inequalities

While most babies and children in England are healthy and well, the report acknowledges that too many children do not have the start in life they need and that this leads to inequalities in later life, high costs for society and multi-generational cycles of disadvantage.

These inequalities are evident in outcomes for babies, for example babies whose mothers live in poverty have a 57% higher risk of perinatal mortality while a child in Tower Hamlets is more than five times more likely to be living in poverty than a child born in Wokingham.

The report calls for maternity services to recognise the unique role they can play in supporting parents of all backgrounds to maximise their own mental and physical health whilst also equipping parents with the skills, information and confidence to maximise their child's emotional, physical and cognitive development. The proposals in the report relating to information and technology to support women in making choices, delivering care

close to home in community hubs, more continuity of care and a systematic upgrade in mental health support and postnatal care are all designed to help maternity services to fulfil this role.

After the birth of a baby, the report emphasises the importance of maternity services working with and ensuring a proper handover to health visitors and how good outcomes come from midwives and health visitors working together on issues like breast feeding and maternal mental health.

Mental health support for all

Whilst recognising that some progress has been made in enabling women and families to access high quality, evidence-based mental health services, the report calls for more to be done to ensure women across England have access to the right care, closer to home, when they need it.

Maternity services have a key role to play both in terms of identification and provision of support. Key improvement measures outlined in the report will improve identification and access to mental health support, particularly:

- Including mental health as part of the personalised care plan and reviewing at every contact.
- Enabling midwives to have sufficient time to have quality conversations with women before and after birth.
- Greater continuity of carer, so that midwives get to know women better and increase mutual trust.
- Community hubs providing opportunities for women to more easily access a range of services and support in one place.

Professionals also need the right training and skills to identify, manage and refer to appropriate specialist support for perinatal mental health conditions.

Accordingly, the review strongly supports the ambition in the Mental Health Taskforce report that at least 30,000 more women each year should have access to evidence-based specialist mental health care by 2020/21.

The review recommends that **there should be significant investment in perinatal mental health services in the community and in specialist care (recommendation 4.1).**

More support after the birth

The report describes current postnatal services as under-resourced, overlooked and, according to the Chief Medical Officer, unfit for purpose. It calls for commissioners and providers to attach sufficient importance to securing high quality neonatal and postnatal care in order to give women and babies the best start in life and recommends that:

• **Postnatal care must be resourced appropriately. Women should have access to their midwife as they require after having had their baby (recommendation 4.2).** Postnatal care should be led by a woman's own midwife, who should help her to develop the element of her postnatal personalised care plan, and provide care alongside others, including as appropriate maternity support workers, to:

o Support her to care for herself and her baby including ensuring she knows when to contact her midwife for support and advice.
o Perform the new-born examination.
. o Facilitate minor common medical examinations without separating her from her baby. o Support her in feeding her baby in accordance with her personalised care plan.
o Involve her partner, family and friends in accordance with her personalised care plan. o Signpost her to voluntary sector and other community support.
o Keep under review the physical and mental health of the mother and provide

rapid referral to more specialised services including when complications or trauma have arisen during labour and mental health services.
o Keep under review the health of the baby, including difficulties in feeding and responsiveness that may indicate underlying problems.
o Include a comprehensive handover to the health visitor for the baby and to the GP or other health professionals involved in care prior to pregnancy for the woman's own ongoing health.

• **Maternity services should ensure a smooth transition between midwife and obstetric and neonatal care, and when appropriate to ongoing care in the community from their GP and health visitor (recommendation 4.3**). Postnatal care has a crucial role to play in identifying complications and ensuring referral to specialist care. Local maternity systems need to be organised to support midwives to identify and respond to these complications, including ongoing hypertension, DVT, sepsis and postnatal mental health problems.

The six week appointment from GPs is a particularly crucial element of postnatal care. Women need to be clear about what the appointment will cover and that a separate time will be available for the baby's check.

Where a woman suffers a pregnancy or birth related trauma, there should be a multi-professional de-brief and handover between labour and postnatal care, and her personalised care plan should be updated in discussion with the woman. This is particularly true of perineal damage where early intervention can make a big difference in long term morbidity.

Despite the strong evidence of the benefits of breastfeeding, women told the review that this element of care was poor and the report calls for much better support for breastfeeding that is focused on practical help that supports and empowers women, rather than pressurises them.

Neonatal care

The report notes that the Report of the Morecambe Bay Investigation recommended that there should be a review of the safety and sustainability of neonatal services. In the time frame in which the National Maternity Review was conducted, it was not possible to review neonatal services concurrently. A report makes a recommendation to take such a review forward:

• A dedicated review of neonatal services should be taken forward in light of the findings of this review (recommendation 4.4).

When things go wrong

The report recognises that maternity related incidents that result in death or severe disability are very rare, but that when they do occur they can have a lasting impact on the woman, her baby and her family. This lasting damage can be exacerbated by poor communication, failure to investigate properly and to learn. In the most serious cases, lengthy legal processes can have an unacceptable toll on families and can also be emotionally damaging for the staff involved.

The report notes that there is currently no standard approach to investigating when something goes wrong, leading to variation in how this is undertaken across different organisations and therefore recommends that:

• There should be a national standardised investigation process when things go wrong, to get to the bottom of what went wrong and why and how future services can be improved as a consequence (recommendation 3.5).

The review supports the underpinning principles of the perinatal mortality review as developed by the Perinatal Mortality Review Task and Finish Group, welcomes the DH's funding of a standardised nationally acceptable tool for perinatal mortality

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review and proposes that the DH consider how this tool could be expanded to cover neonatal mortality, maternal death and serious morbidity.

In order to provide a more rapid, caring response to serious harm and to develop a stronger learning and improvement culture, the report recommends that:

- **There is already an expectation of openness and honesty between professionals and families, which should be supported by a rapid redress and resolution scheme, encouraging rapid learning and to ensure that families receive the help they need quickly (recommendation 3.6).**

For families whose baby has suffered harm or has died, staff can ensure they receive compassionate care that does not further add to their grief. The report recommends that staff consider the principles of good care that have been developed by Sands and the key areas for action contained in the MBRRACE report on term antepartum stillbirths, including:

- Ensuring that care during labour for women following stillbirth is of the same quality and content to that of women having a healthy birth.
- Offering all parents of a stillborn baby a post-mortem, to be clearly documented in the mother's notes.
- Offering all parents a timely follow-up appointment with a consultant obstetrician to discuss their care, the actual or potential cause, chances of recurrence and plans for any future pregnancy.
- Writing a summary of the follow-up appointment, to be sent to the parents and their GP.

A new deal for healthcare professionals

Multi-professional team working

Multi-professional working is a core theme of this review, and the report sets out

an ambition for multiprofessional teams to work effectively and respectfully within and across organisational boundaries to provide seamless, high quality, responsive and kind care to women and their babies. It recommends that:

• Those who work together should train together. The Nursing and Midwifery Council and the Royal College of Obstetricians and Gynaecologists should review education to ensure that it promotes multi-professionalism and that there are shared elements where practical and sensible (recommendation 5.1). Real teams share common rituals and practices, so as well as training together they often socialise together; they are respectful of input from different professions; they communicate well in a variety of different situations; they have clear protocols in place for dealing with emergencies and transfers; they share leadership according to the situation and are not dominated by one individual; they regularly review case data in an open and inquisitive way and they work in partnership with women wherever possible.

The report calls for the NHS to support multi-professional team based learning by:
• Increasing training opportunities for shared learning and reflection.
• Removing unnecessary data burdens to increase the time available for reflection and quality improvement.
• Encouraging teams to proactively ask for outside help i.e. from the Royal Colleges.
• Following a consistent process for serious incident investigation.
• Encouraging greater involvement of women in their decisions.

Education and training

The report views education and training as an opportunity to break down boundaries between professional groups and a way of establishing greater team working, and recommends that:

• Multi-professional training should be a standard part of professionals' CPD,

both in routine situations and in emergencies (recommendation 5.2).** Training undertaken must have proven to have been effective in improving outcomes or other aspects of quality and its impact monitored locally.

Collective leadership for a multi-professional, l earning culture

The report argues that the collective leadership necessary for a multi-professional and learning culture, can only come from midwives and obstetricians, including their management and leadership, working together as part of a single team focussed on the needs of the women and babies in their care.

Since the Boards of provider organisations are ultimately responsible for ensuring that the culture, systems and processes in their organisations ensure the provision of excellent maternity care, the report recommends the appointment of board level champions for maternity services. The review also recommends that:

• Multi-professional peer review of services should be available to support and spread learning. Providers should actively seek out this support to help them improve, and they must release their staff to be part of these reviews. CQC should consider the issue as part of inspections (recommendation 5.5).

A further element of a multi-professional, learning culture is fostering a just culture in which discussion of mistakes can take place and the report views the new approach to investigating incidents and compensating families as helping to promote such a culture.

Data to support and foster a learning culture

The review heard from staff and services that too much time is spent on collecting information that isn't useful, while lacking information that they need in other areas. Time for caring for women and babies is eroded by unnecessary bureaucracy, box

ticking and collecting data that is never used. At the same time the review was inspired by teams and services that actively collect useful data that is used to learn about the quality of their care and to make changes to deliver even better care and outcomes. The review therefore recommends that:

- **A nationally agreed set of indicators should be developed to help local maternity systems to track, benchmark and improve the quality of maternity services. This should include the possible development of PROMS/PREMs measures for maternity (recommendation 5.4).**

New staffing models

Healthcare professionals should, according to the review, be able to work in an environment of empowered professionalism, but are hindered by hierarchical and bureaucratic organisational structures and by care that is broken up into episodes with each one managed by a different professional.

The recommendations for moving to greater continuity of carer would help to resolve this, by allowing midwives to accompany the individual woman, build up a long term relationship with her, support her during labour and see things through to handover to the health visitor and GP. However the report suggests that this cannot happen with current staffing models and requires instead more radical approaches, for example, small groups of midwives taking responsibility for a number of women and planning their workload around them.

The review recognises that improving continuity of carer requires a step change across maternity services that will take two to three years to put into widespread practice. Local solutions will need to be developed and will require support from maternity clinical networks, Royal Colleges and national bodies.

The review references the Buurtzorg model from the Netherlands as a potential model

for such ways of working, which could operate successfully at scale. The Buurtzorg model provides neighbourhood, personcentred care through small self-managing teams. The teams of nurses develop close relationships with their clients and so can offer personalised care and support. Each team handles every aspect of care and business and, as a consequence, the model is able to deliver better outcomes at a lower cost per patient.

The report sets out a series of preconditions for the successful development of new staffing models:

- Staffing levels across the local maternity system have to be adequate, otherwise new models will fail because of the need to ask staff to work in those parts of the system which deal with emergencies.
- High quality leadership that supports innovation.
- Monitoring staff against agreed indicators of quality, rather than day to day processes.
- Staff empowered and supported to establish their own ways of working.
- Educational support for midwives as to how to work successfully in small teams, how to be supportive, how to challenge, how to reach consensus and how to self-manage.
- Consideration of different approaches to staffing, such as using MSWs to assist at home births or integrating midwives in ambulance telephone services teams.

c. A new deal between professionals and organisations

Local maternity systems

The review proposes that providers and commissioners should operate at a local level as local maternity systems, with the aim of ensuring that women, babies and families are able to access services as close as home as possible. The review recommends that:

- **Providers and commissioners should come together in local maternity systems covering populations of 500,000 to 1.5 million, with shared standards and protocols agreed by all (recommendation 6.1).**

Local maternity systems should be responsible for:

• Developing a local vision for improved maternity services and outcomes in order to ensure that there is access to services for women and their babies, regardless of where they live.
• Helping to develop the maternity elements of the local sustainability and transformation plans being developed in each area of England. The plans should describe how providers will work together so that the needs and preferences of women and families are paramount.
• Including all providers involved in the delivery of maternity and neonatal care, as well as relevant senior clinicians, commissioners, operational managers and primary care.
• Ensuring they co-design services with service users and local communities.
• Putting in place necessary infrastructure to support services to work together effectively, including interfacing with services that have a role in supporting women and families before, during and after birth.

Local maternity systems should have as their central principle the concept of 'defaulting to the community' by which women can receive clinically appropriate care as close to home as possible. They will therefore need to promote and support the establishment of community hubs and connect them with obstetric and specialist services. They will also need to develop clinical governance, including standards and protocols to ensure that women and babies get the care they need when they need it.

Local maternity systems will be well placed to address the challenges that are difficult for organisations that work in isolation i.e. the development of ambulance protocols and guidelines for access and referral to specialist services.

Local maternity systems will also:
• enable services to work together to develop interoperable electronic maternity records;
• be key to supporting the development of a learning culture;
• need to foster workforce co-ordination and training;
• ensure there is adequate clinical cover across all providers and that resources can be

shared across the system where necessary.

Maternity clinical networks

At a regional level the report recommends that:

• professionals, providers and commissioners should come together on a larger geographical area through Clinical Networks, coterminous for both maternity and neonatal services, to share information, best practice and learning, to provide support and to advise about the commissioning of specialist services which support local maternity systems (recommendation 6.2)

Making the future

This chapter of the report sets out some of the key actions required to deliver for the future of maternity services outlined in this report over the next five years. Whilst some actions can be implemented centrally, it will largely be down to commissioners, managers and healthcare professionals with an understanding of local opportunities and challenges. National NHS organisations will have a role to play in recognising and supporting the need for local adaptation and leadership.

The chapter outlines broad categories of action relating to people, models of care and resources.

People

Individual responsibility

The report is clear that the review's vision will only be implemented if individual midwives, obstetricians and other professionals act on it. A grassroots movement to improve

maternity care is needed, with individuals taking personal responsibility for supporting improvement. The RCOG and RCM, supported by the national NHS bodies, are encouraged to promote and support such a movement and demonstrate by example that multi-professionalism is the way forward.

The report also encourages women and their families to act as agents for change, by making well-informed choices to ensure safe, personalised care is built around them. Each woman has a responsibility to engage in a relationship with her own midwife and other health professional, acting on advice where she can make a difference i.e. by accepting help to give up smoking, having a healthy diet and being physically active. Some women can choose to get further involved in their local maternity systems by joining a local users group or an MSLC.

Leadership

The report identifies strong local leadership as key to supporting individuals to make a difference; hence the recommendation that boards should designate a board member as the lead for maternity services. Boards should routinely monitor information and take necessary action to improve quality. The report also recommends that CQC should consider the culture of maternity services and the extent to which it is multiprofessional, actively promotes and supports leaders to develop and is fostering a culture of learning and improvement.

Multi-professional education and training

The report advocates embedding the importance of working in multi-professional teams from the outset of a new doctor or midwife's studies. It calls for Health Education England to look into how funds can be made available to roll out training to help teams of midwives, doctors and other health professionals to learn with and from each other. Local provider leadership should ensure there is an ongoing focus on training and ensure

that healthcare professionals are free from clinical duties to use the time for CPD. Such is the importance of this that the report recommends that provider boards and commissioners seek to assure themselves that multi-professional training is happening and the CQC should consider the issue during inspections.

Collecting, sharing and learning from information

To help reduce the burden of data collection and to support learning, the report proposes a number of actions that should take place as a matter of urgency:

• NHS England should make it an urgent priority to roll out use of electronic maternity records nationally, while commissioners and providers should invest in the right software, equipment and infrastructure to collect data and share information.
• NHS England should convene a group to draw up a nationally recommended set of quality indicators which could be used locally and regionally, to review overall data collection and to feed into the ongoing evaluation of the Maternity and Children's Minimum Data Set.
• NHS England should consider commissioning the development of PROMS/PREMs and local services should supplement this with in-depth qualitative discussions with individual women to get into the detail of how they feel about services. Data from staff feedback should also be built into the learning process.
• The RCOG and RCM should offer multi-disciplinary peer support through multi-professional teams on a regional basis offering advice and support when requested from services, local maternity systems or commissioners. Providers should ensure that staff are released to take part in these reviews and CQC should take this into account during inspections.

When things go wrong

The report calls on the DH to give serious consideration to the introduction of a 'rapid resolution and redress' insurance scheme which will pay out for birth injuries caused to

term babies during labour without families needing to go to court and prove negligence in a lengthy and difficult process. At the same time the Health Care Safety Investigation Branch should devise a national standardised investigation process for when things go wrong, to get to the bottom of what went wrong and why and how future services can be improved as a consequence.

Models of care

Early adopters leading the way

In order to harness the enthusiasm of those who already share the review's vision, the report recommends that:

• **NHS England should seek volunteer localities to act as early adopter sites (recommendation 6.4).** This would provide the opportunity to test out different approaches, determine which flexibilities are required and identify the most viable solutions for the long term.

Planning for delivery of this vision over five years

As part of NHS planning guidance for 2016-2021 localities have been asked to produce Sustainability and Transformation Plans, which should include plans for how maternity services will be transformed in line with the vision outlined in this report. In this context, commissioners will need to give particular consideration to:

• Commissioning services from providers that seek to improve outcomes for women and babies, routinely measuring and monitoring providers against these outcomes.
• Commissioning on a footprint of 500,000 to 1,500,000 depending on the nature of the geography.
• Working with providers to bring services together in community hubs and

providing continuity of carer for an increasing proportion of their community. This will require changes to workforce practices and how services are designed and work with each other.

- Ensuring there are services available to support an envisaged increase in births taking place in community settings. This implies a reduction in demand for obstetric services, which must nevertheless remain easily accessible to those who need them. Obstetric units will require appropriate local configuration to satisfy demands for safety as well as access.
- Using the NHS Personal Maternity Care Budget mechanism to support women in their community to take control of their decisions and their maternity care.
- Working with providers to develop shared clinical governance, including standards and protocols which can guide providers and professionals in how they work together across organisational boundaries. These will need to include NHS and other providers, ambulance services, specialist centres, mental health and services in the community.

The report also recommends that:

- **Commissioners should take greater responsibility for improving outcomes, by commissioning against clear outcome measures, empowering providers to make service improvements and monitoring progress regularly (recommendation 6.3).**

For remote and rural areas, commissioners and providers need to take into account the above considerations in thinking innovatively about how to cater for the needs of their communities. They will also need to take into account:

- That whilst an obstetric unit can operate safely in a remote and rural area with a relatively low number of births, if it has sufficient staff and access to 24/7 services, clear pathways and transfer guidelines, there are not currently nor are there likely to be in the future enough obstetricians in the NHS to support a large number of such units. Therefore, there are only likely to be a small handful of such units in the most remote areas of England.

- That the NPEU evidence review finds insufficient evidence to support 24 hour

resident consultant presence, which is only recommended for large urban units.

• How to use the workforce innovatively, including sharing staff across multiple sites, making use of on-call systems instead of 24/7 consultant presence and upskilling generalist medical staff.

• Introducing innovative working practices, such as robust triage, providing transport to women who have to travel to more specialist units and consultations by video link between the centre and smaller unit.

Resources

In this section, the principles for how funding for maternity care should be distributed and flow through the system are set out.

Payment system reform

The report recommends that:

• The payment system for maternity services should be reformed. In particular, it should take into account:

o The different cost structures different services have i.e. a large proportion of the costs of obstetric units are fixed because they need to be available 24 hours a day, seven days a week regardless of the volume of services they provide.

o The need to ensure that the money follows the woman and her baby as far as possible, so as to ensure women's choices drive the flow of money, whilst supporting organisations to work together.

o The need to incentivise the delivery of high quality and efficient care for all women, regardless of where they live or their health needs.

o The challenges of providing sustainable services in certain remote and rural areas (recommendation 7.1).

NHS Personal Maternity Care Budget

The Personal Budget scheme should be demonstrated in a number of pioneer sites and these could be the same areas that are identified as early adopters of the overall vision set out in the report, or different areas.

Flexibilities for remote and rural areas

The review concluded that there is a need to address the difficulties for very remote localities in sustaining obstetric services and has therefore welcomed NHS England's decision to introduce a 'sparsity adjustment' into the funding formula used to allocate CCG budgets.

A portion of the 2016/17 CCG allocations for funding remoteness is in recognition that maternity services in remote areas have unavoidably higher costs because the level of activity is too low for services to operate at an efficient scale.

Continuity incentive

The review recommends that NHS England look at whether a separate incentive, such as a best practice tariff or a CQUIN incentive, is needed in order to encourage greater continuity of carer.

How much will it cost?

The final chapter sets out summary analysis of the cost implications of the report. Of the initiatives proposed in the report, some will add incremental costs to those included in the 5YFV baseline, some would result in savings and some will require a small amount of capital expenditure. The economic modelling has assumed a two phase approach: establishing proof of concept via early adopter sites followed by a national roll-out.

Early adopters
It is expected that up to four sites will trial

the conclusions of the review in order to establish the barriers, work out the potential solutions and share the learning widely. The sites will run from September 2016 to September 2018 and NHS England will make available to them £8m in total.

NHS Personal Maternity Care Budget

It is expected that four CCGs or groups of CCGs will act as pioneer sites to test the Personal Budgets model, with work starting in 2017 and £0.6m allocated. Following successful testing, national roll-out should begin in 2018/19 and will be delivered within existing funding allocations.

Multi-professional training

The NHS should begin rolling out funding for multi-professional training from April 2016 at an estimated cost of £2m per year. This covers the cost of upskilling approximately 5% of all maternity staff in a train the trainer scheme and then for these multi-professional teams to deliver training to all local teams in a multiprofessional setting. It is assumed that staff will use one day from their existing allocation of training days.

Rapid resolution and redress scheme and robust investigation

Costs will fall into two broad areas: a new independent body should be established to administer the rapid resolution and redress scheme at an estimated cost of £1m per year, with effect from 2017/18 (with a small amount of start-up funding available in 2016/17); a new investigatory system is proposed for when avoidable harm has occurred, with funding available in 2016/17 for training and other formation costs, ahead of the system coming into place in 2017/18. It is assumed that the number of investigations will gradually reduce, enabling a reduction in costs over time.

Continuity of care

The NHS will begin testing this new

maternity care model via early adopter sites and it is expected the national changes will take place in 2018/19. The review anticipates changes will be needed to midwifery staffing models:

- Once rollout begins the NHS should achieve an annual increase of 20% of births having continuity of carer each year.
- Midwives should have more time to explain a woman's choices and personalise the advice she receives. It is estimated that this will require on average increasing the length of antenatal appointments by 10 minutes but not the number of appointments.
- Postnatal services need upgrading and it is estimated that this requires increasing the length of postnatal appointments by 10 minutes but not the number of appointments.

Modelling to estimate the size of the midwifery workforce required to deliver these improvements suggests that a significant increase in the midwifery workforce is not required. It also suggests that increasing the number of midwives has only a small impact on the proportion of women who could expect to receive care from a midwife they know in labour. The challenge is likely therefore to be related to moving staff to different models and ensuring that teams have their full complement of staff. This will be supported by non-recurrent funding to manage the change, through project management and clinical resources to support change locally and training for all staff that will be moving to a continuity of carer model.

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

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

Digital information

The NIB

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recommendation on an electronic health record and its work programme will cover the cost of electronic health records for maternity. The cost of developing a platform for a digital tool that offers women information throughout pregnancy and birth is estimated at approximately £0.4m, although further work will be required to link the platform to electronic health records.

Incremental capital costs

It is anticipated that there may be some capital costs in local maternity systems to support the recommendation that women should have access to each of the birth settings recommended in NICE guidelines, depending on what changes may need to be made to the local configuration of services.

Savings

The review has identified a number of savings opportunities that are realisable over the next five years:

- The cumulative effect of the rapid resolution and redress scheme, more consistent investigations and roll-out of multi-professional training should lead to a reduction in avoidable harm, with a 50% reduction in incidences possible.
- The development and roll-out of an electronic care record should reduce the amount of staff time involved in data processing.
- A significant increase in the number of community births will generate savings through more births in less costly settings. furthermore, by increasing the proportion of births supported by midwifery care, the cost of medical interventions will be reduced.
- New ways of working should be done with the aim of improving workforce satisfaction, retention and recruitment of permanent staff and will therefore contribute to delivering maternity services' share of the agency spending reductions announced by DH.
- Substantial savings are also anticipated in a number of areas which are difficult to

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measure, such as lifetime health costs for women and babies if complications are better managed, greater job satisfaction for healthcare staff and reduced staff turnover and increases in breastfeeding rates leading to better health for women and their babies.

Appendix: NHS Personal Maternity Care Budgets

This annex summarises how the Personal Maternity Budgets scheme could work. The review proposes a core set of principles to which CCGs implementing Personal Maternity Budgets would be expected to adhere:

- Clear eligibility criteria. NHS England will work with CCGs to determine whether it should be restricted to women receiving standard care or made more widely available.
- For use only with providers accredited for antenatal, intrapartum and postnatal care.
- Information on locally available providers to be made available on appropriate online platforms.
- Commissioning mechanisms will enable access by accredited midwifery practices to ultrasound and pathology services, and potentially birthing suites.
- In the medium term, accredited providers will be required to participate in interoperable care records, complete national maternity data set returns and provide data to CQC on a set of locally determined outcome measures.
- Agreed and publicised clear local routes of access by women to facilitate choice.

The Personal Budget could work as follows:

- Once a woman has established her pregnancy, she would be told about and offered a Personal Maternity Budget and would be provided with information about local providers of NHS care, their service offer and contact details.
- At this point the woman would receive, either direct from her GP or midwife, or by applying online, the means of making a choice, such as an electronic code to use on a secure website.
- Midwives and GP practices would be expected to encourage and support women

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who may be less confident to access the scheme and help women without internet access.
• The scheme would be voluntary.
• The woman would choose her provider for her antenatal, birth and postnatal care on the basis of the care they were offering. She may choose the same provider for all of her care or separate providers.
• The chosen provider will process the decision and the woman's responsible CCG would be required to honour the woman's choice and reimburse the provider accordingly. Submission of invoices, coding and other normal contracting logistics would occur as now.
• The woman will want an assessment of the type of care she might need and the development of her personalised care plan. She will enter into a commitment to her chosen provider through an agreed process which will also trigger the necessary payments for the provider.
• At the beginning of the pregnancy, the woman would only need to make a decision about antenatal care. She could wait, seeking further advice and considering her needs and preferences before making decisions about who would provide her care at the birth and postnatal stages.
• If the woman's care needs proved to be greater than standard care, her transfer to another provider would be expected, and the payments made pro-rata.

Potential new providers of maternity services would need to pass a system of accreditation based on:
• Baseline quality as addressed by CQC registration followed by ongoing quality assessment on the basis of performance and outcome measures.
• Governance arrangements based on evidence such as the occurrence and handling of significant events, staff feedback, turnover and absence rates and routine management data.

Newly accredited providers would need to be integrated into the local maternity system, meaning that they will:
• Be party to decision making on and will adhere to local clinical guidance arrangements

- Take part in multi-professional training.
- Capture and share data locally to enable benchmarking of both the individual service and the local maternity system.
- Work with the relevant network to ensure that learning takes place when things go wrong.

Midwifery practices should have access to NHS facilities, including the community hub and diagnostics either in the community hub or in hospital. The diagnostic provider may charge a fee and commissioners should use contracting mechanisms to ensure such fees are reasonable.

Royal College of Midwives, February 2016