

## NHS Policy Salon: Discussion summary

### Why has the NHS not delivered on maternity care? 30 June 2009

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The NHS is unlikely to deliver the government's commitments in *Maternity Matters* by the end of this year to deliver choice, access, and continuity of care for women. Despite the huge costs of litigation and a rising birth rate, the NHS has failed to invest energy and resources in delivering a women-centred, safe and efficient service. Why is this and how does the policy environment need to change if maternity care is to deliver for women and their families? How will the challenges of the credit crunch apply in this care area?

This NHS Policy Salon seminar was led by the Department of Health Strategy Unit who are conducting a rapid review of maternity delivery to ensure current commitments are met. Anna Dixon, Director of Policy at The King's Fund, responded. Anna led the work of an independent Inquiry into the Safety of Maternity Services in England and has been responsible for the recently launched Safer Births initiative, a service improvement partnership led by The King's Fund.

This note represents a non-attributed summary of key themes from a discussion held at the King's Fund and organised by the NHS Confederation.

#### **Context**

Whilst England's maternity services policy is delivering improvements – and is seen as a good strategy internationally – the focus should be on what enhanced action is required to meet deliverables by the end of 2009, including delivering on patient choice.

It is not necessarily clear in the NHS what 'maternity services' include, namely the complete journey from antenatal care through to deliveries and then postnatal care. Keeping this broad focus, the evidence was presented on the achievements in effectiveness, experience and efficiency.

Themes for the DH Strategy Unit will include addressing inequalities (often the most deprived access care later, have a worse experience and have the worst outcomes); considering how the service can be more innovative and spread good practice; and finding solutions to the need for improved support and information for mothers.

#### **Safety**

It was suggested that NHS maternity services were generally safe when measured at high levels, for example mortality. Outcome variations were generally determined by public health rather than clinical services.

From a quality perspective the key is to provide a level of care appropriate to risk. Even if a mother cannot give birth at home, the environment should be home-like. Whilst headline mortality figures are comparable internationally there are many near misses and very high litigation costs so a focus on safety is important.

## **Experience and choice**

However through the lens of experience, quality is poorer with less self-determination (e.g. low take-up of home births), increasing c-sections (with higher risks to mothers), and poor and varied experiences surveys. Experience correlates with the provision of one-to-one care, and the provision of support does not match the moments of greatest need in the care pathway, for instance in early pregnancy and post-birth. Post natal care currently has the lowest patient satisfaction results.

Provision of information and support, including to inform choices, is patchy with a lack of awareness and utilisation of the NHS Choices care planner, for example.

In response to these issues, it was suggested that a more substantial offer of choice was needed to encompass involvement in decisions about how and by whom care is provided, rather than just where. Information and communication skills and support aids were important to this agenda.

Choice is made more difficult by the need for some decisions to be made on a clinical basis.

There needs to be a greater focus on quality outcomes as well as quantitative outcomes. There is currently confusion around what to expect from the current patient pathway.

Maternity services are seen as a good learning experience for Board members who want to understand patient experience.

## **Reconfiguration**

*Maternity Matters* set an agenda for concentrating maternity services. However this would require both capital investment (see the NHS Policy Salon on PFI for discussion on this), and public/ political support. Public opinion is usually conservative about changes to maternity services and can raise very emotive claims. For example, changes in Greater Manchester were criticised for being the end of 'Bury babies'. However it was argued that there is a need to test the case for reconfiguration and ask whether changes are based on consultant rotas or women's choices.

## **Workforce**

Although there has been a steady increase in maternity workforce since 2004, as per the Policy Framework, these are simply matching the rise in birth rates and so are allowing the service to stand still rather than improve (as measured by inputs, at least).

It was argued that the workforce challenge needs more specific definition. There is a shortage of funded posts. But there is also a need to improve the use of existing staff. The specialist skills of experienced midwives are often not well used, whilst the implementation of maternity support assistants is not consistent. Midwives are often doing work that is time consuming and not appropriate, there needs to be a better understanding of what their role should be and an introduction of a set of standards.

Rising birth rates and increased complexity should not be too difficult for the NHS to deal with. The problem was more a case that they were not predicted or planned for – why was this? Increasing complexity may need new skills and more experienced midwives rather than a new cohort of newly qualified staff.

It was argued that increasing the number of midwives not necessarily the only (or main) answer to improving the service. The policy aim to reduce the number of births per

midwives was, it was argued, counter-intuitive in the financial situation where the aim was to increase productivity. Suggestions for improving midwifery included:

- clarifying the role of midwives and what is expected of them (managing continued care not just delivery)
- agreeing what they are accountable for
- increasing their skill mix and level of experience

To solve workforce issues there needs to be a better understanding of what is happening on the frontline, there appears to be a disconnect between policy and what is happening in reality.

### **Local leadership**

An important aim for policy should be to establish better mechanisms for self-improvement rather than central government targets. Local leadership will be important but currently front line organisations are not allocating resources to maternity in line with tariff increases.

In discussion it was reiterated that board engagement was as being key. Given the costs of clinical negligence in this area there should be a good incentive to give greater priority to improving maternity service; from a reputational perspective the experience of parents is also an important driver of overall hospital perception. Overall there needs to be more focus on the experience of women and families.

Maternity services are not a priority for PCTs and there is a perceived lack of buy in from the Board. 'Red flags' on the Quality Dashboard are not a high enough concern for Trust chief executives as they are not acting on them with urgency or discussing them at Board level.

It was argued that PCTs should reward/ incentivise trusts with regard to quality targets as well as financial ones.

### **Finances and tariff**

It is important to align incentives for outcomes and include postnatal care. Hospitals are losing money on maternity services, generally only breaking even on more complicated cases such as Caesarean Sections.

Litigation arising from the service is costly to both the NHS and families. There is a real opportunity to improve services, reduce litigation and make substantial savings. However, even if savings are made it is important to note that they very rarely get invested back into maternity services as service line reporting is not effective everywhere.

Could potentially see maternity services rise up the agenda with the economic downturn, coding and tariffs are likely to be looked at more closely.

### **Commissioning focus**

There is a lot of evidence and documented guidance on maternity services to support commissioners but believe it is not being widely consulted. Suggested this could be due to there being information overload on the subject, therefore making it less manageable. Commissioners also appear to have other focuses at the moment. Suggested perhaps the benefits of a standard contract approach should be investigated.

Dashboard is focussed on Acute care, there is no real commitment or focus on the community care aspect.

### **Financial and organisational innovations**

Moving beyond third party commissioning there is scope for exploring risk-capitation payments. This could open up potential opportunities of introducing independent midwife cooperatives and personal budgets for women.

Payment system – could look at a new system whereby women have a personal budget for maternity care, could operate as a voucher system and offer women more choice with regard to prenatal and postnatal care.

### **Different models (UK and abroad)**

Although the statistics are not directly comparable, figures presented suggested that midwives in the UK are delivering one birth every ten days (including ante- and post-natal care. Other organisational models might be able to improve productivity.

For example, New Zealand operates a different model to the UK, with midwives working in cooperatives and managing over 100 births per year (and earning more). Italy and Germany have less specialist maternity doctors, with payment per case. In Canada, midwives are completely independent and community based, women only go into hospital if necessary.

It was suggested that a hybrid solution for England/ UK could be investigated, where midwives could remain part of the NHS but manage their own budget under strong semi-independent leadership. This could also take the onus off hospital boards having to run maternity services as part of an otherwise 'sickness'-oriented institution.

Taking these ideas further, it was suggested that more autonomous maternity providers could potentially merge midwifery services of smaller hospitals rather than closing units down and centralising. This would give more scope for consultant support to float free of one particular unit.

Maternity networks could enable a sharing of values and best practice across services. It was suggested that acute care could then be accessed when necessary rather than being the organisational focus of maternity services.