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Making sense of commissioning Maternity Services in England – some issues for Clinical Commissioning Groups to consider

Why are maternity services important?

Maternity services have often been called the NHS' shop window. Whether or not a new family has a positive experience of pregnancy and childbirth will colour their future use and interaction with health services. Maternity care also has a profound impact on women's physical, emotional and psychological health throughout their life. For example, complications such as pre-eclampsia and gestational diabetes resolve after pregnancy, but can be associated with higher cardiovascular mortality in later life¹. Furthermore, the health and wellbeing of babies is a clear marker of their development and ability to reach their full potential. In current practice most pregnant women will make initial contact with their GP and primary care will have an on-going relationship with women and babies throughout pregnancy and as families grow.

Between 2001 and 2010 the national birth rate has increased by 22% and although it now appears to be levelling off, maternity care cannot be demand managed. Pregnancy is the largest single reason for admission to hospital and for the average clinical commissioning group of 250,000 people, around 3000 women a year will use maternity services, costing around £8.6m. The cost of maternity services is set to rise with increasing numbers of high risk and complex pregnancies requiring careful monitoring and judicious intervention and support. As commissioners can do little to influence the number and health status of local women getting pregnant, they will need to work in close collaboration with their local maternity providers to ensure that services are both clinically and cost effective.

What will work best for commissioning?

The health and social care bill in England sets out special arrangements for the commissioning of maternity services; whilst responsibility will sit with clinical commissioning groups (CCGs), the NHS Commissioning Board will both set a national framework for quality and choice and also expect consortia to work collaboratively to ensure this is delivered. Single commissioning groups of 250,000 populations, generating only around 3000 pregnancies a year will, probably, be too small to commission the full range of maternity, fetal medicine and high risk services effectively, with a risk of local variations in service, as well as unproductive duplication of effort across CCGs. To maximise efficiency and influence, a federated model, with one lead commissioner taking responsibility for local negotiations with the main providers will be the most effective way of maximising the

¹ Royal College of Obstetricians and Gynaecologists (2011) *Why Should we Consider a Life Course Approach to Women's Health Care?* SAC Opinion Paper 27.

opportunity to improve services. Commissioning groups within a federation will need to jointly agree at the outset, the principles underpinning local arrangements, which should include:

- Emphasis on pregnancy and birth as essentially normal physiological processes.
- Commitment to a seamless service for women who require medical/obstetric support.
- Outreach to vulnerable women, encouraging them to engage with services.
- Establishment of a community based multi-profession partnership across antenatal, intrapartum and postnatal care.
- Contributing to the Joint Health and Wellbeing strategy.
- Improvement of the accessibility of maternity services to encourage early booking and ensure women stay in regular contact with services.
- Promotion of continuity of care especially for disadvantaged and high risk women.
- A requirement that clinical services are developed in accordance with best available evidence, and that all providers and professionals offer evidence-based clinical care ensuring that they have informed consent before giving treatment. Practices should be robustly audited.
- Promotion of family based care and locally available access to other services such as parenting skills support, family planning, benefits agencies, baby clinics and children's centres.
- The safeguarding and promotion of the welfare of children through appropriate and timely therapeutic and preventative interventions and adherence to the common assessment framework (CAF) mechanism.
- Recognition that there is likely to be an increase in specialised networks with fewer subspecialist centres. Large hospitals will all provide secondary services but tertiary services may be provided elsewhere.
- Arrangements for procuring smooth transfers to neonatal, special and intensive care which will be nationally commissioned through the NHS Commissioning Board.
- Clarification of the role of general practitioners as professionals involved in providing maternity care and simultaneously as members of commissioning groups with responsibility for commissioning the entire maternity pathway.

Example: Commissioner's Expectation of Maternity Services

Maternity Services will provide the full range of antenatal, intrapartum and postnatal care for women and their families. This includes scheduled and unscheduled care, outpatient, inpatient, community and home based services. All elements of maternity care provision will be flexible, appropriate and accessible to all women. Maternity care will be provided in accordance with the requirements of Royal College and NICE standards, national policy guidelines, evidence and best practice and will also reflect local needs and priorities. Maternity services will support the transition from pregnancy to family life with a quality service that is woman and family centred, that undertakes continuous audit and that seeks and acts on feedback from women and families.

Where will you get clinical advice?

Maternity services have been subject to detailed political and policy scrutiny over the last 15 years and there is now a wealth of evidence-based guidance on clinically and cost effective care produced by independent sources and from the professional bodies for general practice, obstetrics and midwifery. In particular maternity care is well served by NICE and other evidence-based guidance

and this should form the basis of all local commissioning arrangements. Links to all the national NICE guidance is available in appendix 1 and advice from the Royal Colleges at appendix 2.

Locally your main source of advice will come from the providers themselves, particularly the Head of Midwifery, Lead Obstetrician and consultant midwife. Increasingly your local maternity providers will be working in networked arrangements in order to ensure the full range of services is available. This will include any private providers that are able to offer the full range of maternity services to the quality standards required. For example units have long been collaborating in the provision of neonatal care (now to be nationally commissioned) where not all provide the most high level service; not all units should provide fetal medicine (for both clinical and cost effective reasons) and there are other services which could be provided across a larger population, such as home birth services. Commissioners, working with the NHS Commissioning Board and Clinical Senates, will be in a strong place to encourage these collaborations.

Users of maternity services have a long tradition of being involved in the design and delivery of maternity care, from giving feedback to running support groups and antenatal education. All commissioners will be making arrangements to implement the *“no decision about me without me”* philosophy and local Healthwatch will be developing from LINks. The model of a Maternity Services Liaison Committee (MSLC), bringing together health professionals and user representatives should be encouraged to implement this philosophy; for maternity there will already be local groups, coalitions and forums for including the users’ voice in planning and monitoring care. Local voluntary groups, such as the NCT and SANDs, community forums such as Children’s Centres, and groups representing black and minority ethnic communities or disadvantaged groups, such as the BME health forum, are also good starting points for feedback and development of MSLCs.

Questions to ask your maternity provider

1. Are women accessing maternity services early

Why is this important? The evidence is now clear that women who access maternity services early and receive a full health and social care assessment are more likely to receive appropriate care and achieve better health, emotional and psychological outcomes. The latest review of maternal deaths confirms that late presentation to maternity services is very often associated with the worst outcomes. Recent research on women's emotional journey through pregnancy indicates that the first trimester is one of the most anxious times for women. If women are to be able to benefit from early screening, such as nuchal screening and haemoglobinopathies they need to be in the maternity system before the end of the first trimester.

What answer are you looking for? 90% of women should now be receiving a full health and social care risk assessment and booking by a midwife before 12 weeks + 6 days of pregnancy. If your provider is failing to meet this national target you will want to see the action plan for identifying late-bookers, smoothing administrative processes and increasing early access. One key element of early access is increasing the routes through which women can contact the maternity service, including enabling women to contact a midwife as the first point of contact by telephone, web site or in person.

What can you do differently together: GPs can ensure that their own internal processes for informing women about local maternity services and signposting and directing them into the maternity service are as effective as possible, do not introduce any unnecessary delay and are based on an integrated model of care. Commissioners, health and wellbeing boards and maternity services can collaborate to produce local information for surgeries, pharmacies and community locations to encourage early access. Commissioners of preconceptual care services to promote wellbeing with advice on folic acid, diabetes management, weight, alcohol consumption etc. could specify that advice about early access and links to local public health services are included.

2. What percentage of women are socially vulnerable and what arrangements are in place to care for them

Why is this important? There is now clear NICE guidance about the schedule and content of antenatal care for low risk women and many clinical protocols for women at medical risk such as diabetics etc. However, it is women who are socially vulnerable that often either take up a large amount of midwifery and general practice time or fall through the net and miss out care altogether. Statistically these are the women who are often more likely to continue to smoke, to have low birth weight babies and to choose not to breastfeed. These are the babies who do not get the best start in life and will make increasing demands on primary care as they grow.

What answer are you looking for? Every provider should know roughly what percentage of the women it cares for fall into a socially vulnerable category and, depending on the size of the problem, make appropriate arrangements. Many maternity units are working alongside the Family Nurse Partnership initiative to give targeted support to the most vulnerable; other units have dedicated specialist midwife roles to care for teenagers, women experiencing domestic violence or drug and alcohol users. All services should have clear arrangements that link them to local safeguarding

arrangements, including a named safeguarding midwife. Some units have adopted a case loading approach for vulnerable women where a specialist team provides personal 1:1 care throughout antenatal, intrapartum and postnatal care to women at the greatest risk.

What could you do differently together? Maternity services need to be working collaboratively with primary care and social care to ensure vulnerable women receive appropriate, timely and seamless care based on an integrated care model. Many midwives have deliberately moved out of GP surgeries and into Children's Centres so that they can provide coordinated care to vulnerable women, which is directly linked to the services that can support these families. Some GPs have found this a challenge and perceived it as a loss of service. Rather than arguing about where care is delivered, GPs and their local maternity services could be working together to ensure targeted care is available and that through good communications all professionals are kept closely informed.

3. What arrangements are there for women who are unwell, apprehensive or whose pregnancies begin to deviate from the norm?

Why is this important? Almost half of all spending on maternity care is unscheduled antenatal care – that is additional care beyond the routine and planned care women receive from their midwives and doctors. This is where women attend hospital day assessment units, fetal assessment units or antenatal wards; referred by their GP or community midwife or more commonly self referring. The most common reasons that women attend hospital during pregnancy are for reduced fetal movement, vaginal bleeding and abdominal pain. However a large number of women also make contact with maternity services out of hours with queries about travel advice, swollen ankles, 'large for dates' or failure to detect their baby move before 20 weeks. In most cases these women have not sought any other advice before attending. If women with these low level medical conditions can be supported and cared for in primary care (conditions such as swollen ankles and urinary tract infections are common in pregnancy), this will ease the pressure on busy maternity units and save commissioners money.

What answer are you looking for? Your provider should have a clear plan of action for how to reduce the need for unscheduled antenatal care and especially antenatal day or inpatient admissions. This might include dedicated telephone help lines, ensuring community midwives are available out of hours, links with primary care, and written advice on self-management during pregnancy or effective triage arrangements to see and diagnoses women quickly without admitting them to wards.

What could you do differently together? Commissioners will want to be assured that local arrangements provide women with support during pregnancy that is both cost and clinically effective. Community midwives have the knowledge and skills to identify and assist women with many of the conditions they experience during pregnancy, thereby obviating the need for them to present at hospital. However, if women are to be able to access community midwives these services must be sufficiently resourced.

4. How do you make sure women have choices about the place and manner of their birth

Why is this important? Since the 1990s it has been government policy that women should have choice about where and how they give birth, after discussion with their midwife. It is now widely recognised that whilst most women will continue to give birth in a hospital this does not suit everyone. Recent research evidence provides particularly useful information about the comparative benefits and risks of different choices of place of birth for low risk women. The key findings are attached as appendix 3. There is now a good argument to be made for multiparous women being advised to choose a non-obstetric unit birth.

What answer are you looking for: Every provider should be able to offer women at low risk of complications the opportunity to plan for their birth in three settings: an alongside or a freestanding midwife led unit, the hospital labour ward (obstetric unit) and at home. They should be able to tell you what percentage of low risk women plan their care at the end of pregnancy, in each of these settings and the percentage who give birth in each setting. Nationally the rates for place of birth are around 87% (OU), 10% (MLU/FMU) and 3% (home birth). Provider's web sites and literature designed for pregnant women and their partners should make clear that women have a choice about place of birth, and have the opportunity to discuss options and their particular circumstances with a midwife or doctor. You can check with the women in your practice about whether they were offered a meaningful choice and whether midwives discussed all the options with them.

What could you do differently together? There are few GPs today who have a regular involvement in intrapartum care and so many are unaware of the evidence around the safety and quality of home births and midwife led births. GPs have a strong influence over their patients' choices and can help them make good decisions about where and how they want to give birth, if they are informed about local options. Whilst most pregnant women will be clinically eligible to deliver in a midwife-led unit or at home, the majority still end up giving birth in obstetric units. The new commissioning arrangements provide an opportunity to redress this imbalance by making midwifery-led services the default option for pregnant women. Your commissioning group will be seeking advice from clinical senates in designing services and outcome measures. It is worth visiting your local facilities and collaborating with your local provider about how they support home births and midwifery led care. This may mean encouraging providers to collaborate in networks to extend women's choices so that they are not bound by artificial catchment areas for freestanding units for example.

It is also important that commissioners recognise the time that it takes – usually between one and two years - for midwife-led and home birth services to achieve sustainable activity levels and to deliver improved health and wellbeing outcomes for women and babies. It may therefore make sense to adopt a transitional investment strategy of pump priming midwife-led services.

6. What is the normal birth rate?

The consensus statement from the Maternity Care Working Party defines normal birth as “without induction, without the use of instruments, not be caesarean section and without general, spinal or epidural anaesthetic before or during delivery”. It is important to try to increase this rate as well as that of vaginal birth, which includes delivery by forceps and ventouse.

Why is this important: Avoiding unnecessary interventions in pregnancy and childbirth has been shown to lead to better outcomes for women, quicker recovery, improved satisfaction and saves the NHS money. Every potential caesarean section that is enabled to be a normal birth saves £1200 in tariff price alone. Women experiencing a normal birth are more likely to breastfeed and will require less postnatal care and are less likely to visit their GP with postnatal complications.

What answer are you looking for? The national caesarean section rate in England is 24.5%; after years of steadily increasing it has in recent years stabilised and many units are now seeing a decrease. The NHS Institute has reviewed clinical practice and the organisation of services and has concluded that a 20% rate is achievable and sustainable. Every provider unit should have a clear action plan for increasing its normal birth rate, addressing staffing levels and staff deployment, models of care, support and information for women. In terms of staff deployment, consultant midwives have a critical role to play in developing professional practice and improving care standards. Their clinical expertise can prove invaluable in helping to guide and support midwives, while also facilitating and increasing women's choice on where and how they give birth. In terms of models of care, the importance of providing midwifery led care in obstetric units and of changing the environment cannot be understated. There is no reason why a woman giving birth in an obstetric unit cannot have as normal an experience as possible in as natural and comfortable a setting as possible.

What could you do differently together: Women must receive consistent, positive information and advice from their health professionals if they are to have confidence in a normal birth. The first messages they receive will often be from their GP and these will powerfully influence their approach to their pregnancy. If a trusted GP advises a low risk woman that her care pathway will be midwife led, or suggests to a woman after a caesarean section that VBAC is a good option to explore, she is likely to be more confident about achieving a normal birth outcome. Where there are gaps in existing service provision, commissioning groups and their local providers could work together to enhance the support women are offered by, for example, commissioning birth preparation classes from the voluntary sector. Commissioners and providers can also work together to identify measurable outcomes and reduce unwarranted variations.

7. How many hours are consultants present on the labour ward?

Why is this important? There is strong evidence that where experienced consultants are routinely present on the labour ward to support teach and supervise junior staff, better decision making ensues and interventions decrease. Even where consultants are present visible and supportive during the day time only, there are better outcomes at night.

What answer are you looking for: The RCOG and NHS Litigation Authority (CNST) recommendation is that all units (except those with fewer than 2500 births a year) should now have 60 hour consultant obstetric presence on the labour ward, a week whilst larger units (those with more than 5000 births) should have 98 hour presence. Around the country very many units are struggling to reach these levels. Any units of 5000 births that have not yet reached the 60 hour staffing should be challenged about how they ensure safety. You will want to look at their caesarean section and

instrumental delivery rates. All providers should have a clear action plan about how they will improve consultant staffing levels.

What could you do differently together? Where staffing levels are low, for example units with only 40 hour presence, CCGs may wish to use their commissioning influence to require provider units to demonstrate a plan to increase staffing numbers. Where small units struggle commissioners may wish to consider networked arrangements between providers, consolidating obstetric led services on fewer sites but promoting midwifery led care for low risk women.

8. How many women receive 1:1 care in labour

Why is this important? There are nationally recommended ratios of midwives to births that guide maternity staffing levels and these should be used as indicators of resourcing. However these do not tell us a great deal about how midwives are used or what they are doing; more local discussion will therefore be needed to understand the detail of how are deployed. Keeping labour wards safe has got to be a top priority of your providers and 1:1 care in labour – where every woman in established labour is cared for by one midwife has been shown to lead to better outcomes and improved satisfaction.

What answer are you looking for? Not all units are yet routinely recording and reporting their ability to deliver 1:1 care in established labour. As commissioners requiring this information to be reported will of itself raise its priority and focus attention. If providers do not know the answer you may wish to consider asking them to conduct an audit to determine current levels.

What could you do differently together? Keeping labour wards free for only labouring women is a good way of ensuring that midwives spend their time with those women. Many labour wards get busy particularly at weekends and in the evening with pregnant women who are in the very early stages of labour or whose labour is imminent but not yet begun. Local arrangements to assess, advise and then encourage these women to return home mean that the labour ward remains safe. Commissioners may wish to commission triage arrangements, or explore the availability of community midwives to undertake domiciliary visits to women who call to say they think they are in labour. This may appear resource intensive but creating a situation whereby women in labour spend hours travelling back and forth between home and hospital is detrimental to their well-being and more likely to promote anxiety, fatigue, fear, lack of confidence and inability to relax and use personal strategies for pain management. All of these contribute to higher risks of complication and intervention. Commissioning groups will also wish to be assured that midwifery staffing levels are sufficient to provide 1:1 care in labour.

9. What are your breastfeeding rates

Why is this important? Most women want to breastfeed but many still do not receive the support they need to do so. Breastfed babies generally have fewer gastro-intestinal problems, fewer ear infections and bond better with their mothers and this will mean fewer visits to their GP. A significant number of babies that are readmitted to hospital postnatally require only a feed, so

getting breastfeeding right at the outset and ensuring effective domiciliary support saves money whilst also providing better care to women.

What answer are you looking for? The national rate of breastfeeding initiation is 73% and the rate at 6-8 weeks is 48% and the majority of women stop breastfeeding before they wanted to. If your provider's rates are less than this you will want to see their action plan for improvement. This should involve adopting the UNICEF "Baby Friendly" approach and appointing specialist infant feeding coordinators to ensure all staff are fully competent and confident to support women choose and establish good feeding practices.

What could you do differently together? Improving breastfeeding rates requires a coordinated, multi-faceted approach across primary and secondary care, including voluntary providers and the public health input of Health and Wellbeing Boards to provide early clinical interventions and postnatal day case services in the community. Strong positive messages from all health providers, access to support and advice and participation in initiatives such as baby cafes, drop-in centres and peer support have all been shown to work. GPs are well placed to bring together maternity services, primary care, health visiting and other local services to find innovative local solutions to support their local communities.

10. Do you have special arrangements for women with risk factors, for example high BMI?

Why is this important? Women with a BMI over 35 will have fewer choices about their place of birth, those with a BMI over 40 are automatically recommended to have obstetric led care and those with a BMI over 50 have a 50% chance of a caesarean section. As weight increases interventions and PPHs increase, ultrasounds and epidurals become more difficult and women are likely to have larger babies and are less likely to breastfeed. A high BMI therefore has an impact on the quality and safety of maternity services and invariably increases the cost of care.

What answer are you looking for? All providers should have clear protocols and policies for how they will care for women with a high BMI, and particularly their links to diabetic services. Community midwives should continue to support these women through their antenatal period with encouragement regarding diet and exercise.

What could you do differently together? Clearly it is better for women if they can lose weight before they conceive. Preconceptual care fits much more comfortably within primary care than within acute maternity services and consortia could use their commissioning influence to establish new local services to ensure that women are in the best possible health before they embark on pregnancy.

11. How are women with antenatal and postnatal mental health problems supported?

Why is this important? 12% of women experience some form of antenatal and or postnatal depression. Whilst only a small number go on to experience serious mental illness, many more require long term health interventions often consuming a great deal of GP time. These women are more likely to struggle with parenting and there is increasing evidence that their children are more likely to have on-going emotional and behavioural problems. For most women with mid to mild

mental health problems, their GP will be their main carer, so it is crucial that when these women are pregnant there is effective communication and collaboration with maternity providers.

What answer are you looking for? A joined up approach between primary care, mental health services and the maternity services will ensure that women identified at risk of mental health receive appropriate support and that women in crisis are able to access immediate care. Around the country these arrangements are very patchy. Consortia should be asking about local access to perinatal mental health services, referral patterns to CBT and the availability of specialist mother and baby units. Maternity providers should be able to demonstrate that all midwives are trained in assessing women's mental health and are confident in making appropriate and timely referrals.

What could you do differently together? GPs are in a strong position to take a central role in brokering arrangements between services to ensure that mental health services have a better understanding of maternity, whilst maternity services have clearer expectations about mental health services. In commissioning both mental health services and maternity services GPs should ensure that arrangements for early identification, prompt referral and access to appropriate services and included within both service level agreements.

12. What collaborative arrangements are in place for midwives and health visitors to work together

Why is this important? Maternity services provide only one component of the care that new families require in the early years. Ensuring families have appropriate support as they move through the postnatal period to identify and act on medical, emotional or psychological problems relies on a timely and informed handover between maternity and health visiting services. Collaboration between these services and with primary care will ensure there is no duplication of effort or that women slip between different providers.

What answer are you looking for? Your maternity service should be able to demonstrate collaborative working relations and clear data sharing with health visiting, where there are clear and consistent arrangements for communication, handover and parenting support, especially in relation to safeguarding. You might ask whether all women have the opportunity to meet their health visitor during the antenatal period.

What could you do differently together? Local commissioning arrangements could join up maternity and health visiting services, through shared community bases, geographical catchment areas or caseloads. Where local needs for additional support are high, commissioners could commission Family Nurse Partnership schemes to provide enhanced support to the most vulnerable families.

13. How can I be assured of the safety of this service – what story do your SIRIs tell you

Why is this important? The UK's maternity services provide high levels of good quality safe care. Infant mortality rates stand at only 4.6/1000 and maternal mortality at 8.2/100000. Nevertheless every still birth or intrauterine death is a personal tragedy and you need to be assured that your

providers take every opportunity to learn from critical incidents. Serious Incidents Reviews are required for all unexpected or unavoidable deaths or serious harm to patients. Incidents in maternity may be few but their cost to the NHS, and to the families affected, is extremely high. The NHS pooled arrangements for covering negligence claims is split into two elements; all acute care and separately maternity care, with around 50% of all the money paid out related to obstetric litigation. The most recent case of a baby brain damaged during birth was £8m. To mitigate this, the NHS LA Clinical Negligence Scheme for Trusts (CNST) assesses each trust's clinical standards and grades them from 0 to 3 with each level achieved resulting in a discount on the premiums paid. The higher a CNST rating the 'safer' the service is judged to be.

What answer are you looking for: How many SIRIs did your maternity provider report last year and what if any themes or lessons emerged from these? You will want to know:

- whether incidents had a staffing component, highlight training issues or indicate failures of protocols;
- whether the service has commissioned independent scrutiny of the arrangements;
- whether providers are regularly reporting maternity patient safety incidents to the National Reporting and Learning system;
- the number of maternity never events that have occurred and what action has been taken to address these; and
- what level of CNST your local maternity service has achieved and what action plan is in place to move it to the next level.

What could you do differently together? Commissioners should specify in their contracting arrangements that providers routinely report in SIRIS and demonstrate compliance with CNST standards.

14. Are all areas of the maternity pathway adequately resourced?

Why is this important? Care in the immediate postnatal period² is often deemed the 'cinderella' of maternity services and surveys of women and anecdotal reports of midwives indicate that it is currently widely unsatisfactory and poorly resourced (*Left to your own devices*. NCT 2010) and yet this is a critical period in terms of the health and wellbeing of the woman and her family. Women require high quality support for all aspects of becoming a parent including infant feeding but also need regular routine health surveillance to detect possible health complications, some of which can be life threatening e.g. sepsis (CMACE, *Saving Mother's Lives 2006-08: Briefing on genital tract sepsis* 2011).

What answer are you looking for: As a minimum the NICE clinical guidance on postnatal care should be applied - <http://www.nice.org.uk/CG037>. The guideline covers the core care that every healthy woman and healthy baby should be offered during the first 6-8 weeks after the birth.

A minimum number of contacts between women and carers should be agreed. All women, when worried, should be able to contact someone that they trust and ideally know and who can give them appropriate advice.

² In the context of maternity services this is the period up to 28 days after birth.

What could you do differently together? Not all postnatal care has to be given by a midwife nor does it all need to be done at home. Whilst home visits are important for some women and are a vital part of assessing the family/home dynamic, in some parts of the country care is carried out at postnatal clinics, often linked to a children's centre. Some aspects of postnatal care, particularly breastfeeding support and care of the baby, can be undertaken by MSWs.

Note: *Developing the NHS Commissioning Board* (NHS 2011) states it would be inappropriate to give (clinical commissioning groups) authority to commission their own member practices to provide primary care services".

NICE Guidance Maternity Care

Antenatal and postnatal mental health

Antenatal care

Quitting smoking in pregnancy and following childbirth

Caesarean section

Diabetes in pregnancy

Hypertension in pregnancy

Intrapartum care

Postnatal care

Pregnancy and complex social factors

Induction of labour

Fetal cystoscopy for diagnosis and treatment of lower urinary outflow tract obstruction

Fetal vesico-amniotic shunt for lower urinary tract outflow obstruction

Insertion of pleuro-amniotic shunt for fetal pleural effusion

Intrauterine laser ablation of placental vessels for the treatment of twin-to-twin transfusion syndrome

Laparoscopic cerclage for prevention of recurrent pregnancy loss due to cervical incompetence

Maternal and child nutrition

Percutaneous fetal balloon valvuloplasty for aortic stenosis

Percutaneous fetal balloon valvuloplasty for pulmonary atresia with intact ventricular septum

Percutaneous laser therapy for fetal tumours

Therapeutic amnioinfusion

Intraoperative blood cell salvage in obstetrics

Commissioning Support Documents

DH, DHSSPS, Welsh Assembly Government, Scottish Government (2010) Midwifery 2020: Delivering expectations

RCM (2010) One-to-one midwifery care in labour: A briefing paper

RCOG (2011) High Quality Women's Health Care: A proposal for change

RCOG, RCM, RCA, RCPCH (2007) Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour

The Birthplace cohort study: key findings

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.

Giving birth is generally very safe

- For 'low risk' women the incidence of adverse perinatal outcomes (intrapartum stillbirth, early neonatal death, neonatal encephalopathy, meconium aspiration syndrome, and specified birth related injuries including brachial plexus injury) was low (4.3 events per 1000 births).

Midwifery units appear to be safe for the baby and offer benefits for the mother

- For planned births in FMUs and AMUs there were no significant differences in adverse perinatal outcomes compared with planned birth in an obstetric unit.
- 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 obstetric unit.

For women having a second or subsequent baby, home births and midwifery unit births appear to be safe for the baby and offer benefits for the mother

- For multiparous women, there were no significant differences in adverse perinatal outcomes between planned home births or midwifery unit births and planned births in obstetric units.

For women having a first baby, a planned home birth increases the risk for the baby

- For nulliparous women, there were 9.3 adverse perinatal outcome events per 1000 planned home births compared with 5.3 per 1000 births for births planned in obstetric units, and this finding was statistically significant.
- For multiparous women, birth in a non-obstetric unit setting significantly and substantially reduced the odds of having an intrapartum caesarean section, instrumental delivery or episiotomy.

For women having a first baby, there is a fairly high probability of transferring to an obstetric unit during labour or immediately after the birth

- For nulliparous women, the peri-partum transfer rate was 45% for planned home births, 36% for planned FMU births and 40% for planned AMU births

For women having a second or subsequent baby, the transfer rate is around 10%

- For women having a second or subsequent baby, the proportion of women transferred to an obstetric unit during labour or immediately after the birth was 12% for planned home births, 9% for planned FMU births and 13% for planned AMU births.