



Royal College of
Obstetricians and Gynaecologists

Bringing to life the best in women's health care

Introduction to new digital resource
July 2013

Commissioning Women's Health Services

**Advice for Clinical Commissioning Groups
and NHS England**



Royal College of
Obstetricians and Gynaecologists

Bringing to life the best in women's health care

Commissioning Women's Health Services

**Advice for Clinical Commissioning Groups
and NHS England**

Introduction to new digital resource
July 2013

tomorrowsspecialist@rcog.org.uk

© 2013 The Royal College of Obstetricians and Gynaecologists

First published 2013

All rights reserved. No part of this publication may be reproduced, stored or transmitted in any form or by any means, without the prior written permission of the publisher or, in the case of reprographic reproduction, in accordance with the terms of licences issued by the Copyright Licensing Agency in the UK [www.cla.co.uk]. Enquiries concerning reproduction outside the terms stated here should be sent to the publisher at the UK address printed on this page.

Published by the Royal College of Obstetricians and Gynaecologists

27 Sussex Place

Regent's Park

London NW1 4RG

Registered Charity No. 213280

Edited and typeset by Andrew Welsh (www.andrew-welsh.com)

Contents

Abbreviations	iv
Introduction	1
Scope	1
Background	1
Obstetrics and gynaecology	3
Workforce	3
Training	3
Work settings	3
Obstetrics	3
Gynaecology	4
Multidisciplinary input	4
Out-of-hours care: the need for specialist presence	4
Obstetrics	4
Community sexual and reproductive health	6
Workforce	6
Training	6
Work settings	6
Multidisciplinary input	6
Out-of-hours care: the need for specialist presence	7
Case studies	8
Obstetric and gynaecological physiotherapy services at The Ipswich Hospital NHS Trust	8
Seven-day working at the Leicester Fertility Centre Assisted Conception Unit	9
Community gynaecology within an integrated sexual and reproductive health (SRH) service at the Chalmers Sexual Health Centre	10
Northumbria Healthcare NHS Foundation Trust	11
A seven-day consultant-led and -delivered acute care service across a geographically challenged trust	11
Delivering sexual health services to a vast rural county with diverse population needs	11
References	13

Abbreviations

ACU	Assisted Conception Unit
CCG	Clinical Commissioning Group
CCT	certificate of completion of training
CfWI	Centre for Workforce Intelligence
cSRH	community sexual and reproductive health
FSRH	Faculty of Sexual & Reproductive Healthcare
GP	general practitioner
GUM	genitourinary medicine
IUD	intrauterine device
IUS	intrauterine system
IVF	in vitro fertilisation
LARC	long-acting reversible contraception
NICE	National Institute for Health and Care Excellence
RCOG	Royal College of Obstetricians and Gynaecologists
SASGs	staff, associate specialists and specialty grade doctors
SRH	sexual and reproductive health
STI	sexually transmitted infection

Introduction

Scope

The Royal College of Obstetricians and Gynaecologists (RCOG) and the Faculty of Sexual & Reproductive Healthcare (FSRH) are committed to raising standards in women's health care and support the National Institute for Health and Care Excellence (NICE) in the production of guidelines and quality standards related to women's health. The aim of this guidance and the [digital resource](#) is to support commissioners and health service managers with commissioning and providing high quality women's health care. It brings together all standards for hospital-based obstetric and gynaecological care, and community-based sexual and reproductive health careⁱ produced by the RCOG, FSRH, royal colleges and professional societies, with standards derived from policy documents such as joint consensus statements and reports, *High Quality Women's Health Care*¹ and the more recent *Tomorrow's Specialist* working party report.² It is designed to be a 'live', fully interactive tool and easily navigable. It provides a user-friendly interface for commissioners who may not have in-depth clinical knowledge and expertise in women's health.

We have deliberately excluded specific, condition-based standards, as these are likely to be less relevant to commissioners. We have also excluded generic standards, for example risk management and governance standards, as these will vary according to local structures. Where recent NICE guidance and standards have incorporated and/or superseded the RCOG's guidance and standards, we have referred to them. Similarly, reference has been made to NHS specialised commissioning resources.ⁱⁱ

Background

The concept of women's health networks, championed in the RCOG report *High Quality Women's Health Care: A Proposal for Change*,¹ is now a realistic prospect with the appointment of a National Clinical Director for Maternity and Women's Health. A women's health network would cover all aspects of women's reproductive health care from the cradle to the grave (in practice, from puberty to old age); we call this the 'life course'.

A life-course approach is essential in enhancing health throughout the life of a woman rather than through the episodic nature of disease prevention and treatment subscribed to in the past.³ Women deserve a service that focuses on their individual needs, is safe and effective, and, as a minimum, meets their expectations. In addition, it must be efficient and local, and one in which the woman's informed choice is respected. Women also deserve to be cared for by doctors who are compassionate and able to empathise and who establish a culture of shared decision making. The proposed network approach would provide more consistent, 24-hour care, reduce variation, and use existing standards and guidelines set by the RCOG, FSRH, NICE and other organisations. Targets, incentives

-
- i. The medical specialty of community sexual and reproductive health (cSRH) was formally established in 2010 to ensure specialist leadership in this field, which includes community gynaecology and some aspects of men's sexual health within the community.
 - ii. NHS England. Specialised commissioning resources [www.england.nhs.uk/resources/spec-comm-resources/].

and measurable clinical outcomes may need to be considered to drive the model, with women's involvement at its core.

Configuration of services must be tailored to the specific needs of the local population and geographical area. A 'one size fits all' approach is not feasible or constructive; we must rely on the commissioners' and service managers' ability, working with their local health and wellbeing boards and Healthwatch, to adapt the model to their population's particular needs.

In England, the commissioning of sexual and reproductive health care is split between local authorities, Public Health England, NHS England and Clinical Commissioning Groups (CCGs). This raises significant challenges in ensuring that cohesive, comprehensive services are commissioned around the woman and her family, and that they deliver both for the individual and on the public health agenda.ⁱⁱⁱ

A combination of NHS reforms and workforce and financial pressures, against a backdrop of rising demand, increasing complexity and demographic changes, makes the delivery of women's health care in its current configuration unsustainable. However, these challenges create an opportunity to develop more efficient, sustainable health services, providing better care for women. We hope that this resource will help commissioners and service managers to meet these challenges.



Dr Anthony D Falconer FRCOG
President, RCOG



Dr David H Richmond FRCOG
President-elect, RCOG



Dr Chris Wilkinson FFSRH
President, FSRH

July 2013

iii. As these services are mandated open-access services, some areas of the country may choose to commission collaboratively at a supra-local and sub-national level.

Obstetrics and gynaecology

Workforce

There are approximately 2000 specialist registrars^{iv} and a similar number of specialists in the UK, with an additional 700 staff, associate specialists and specialty grade doctors (SASGs) providing NHS obstetrics and gynaecological services.⁴ The majority of specialists are in joint obstetrics *and* gynaecology posts, although approximately 20–30% practise in only one field, usually with a tertiary, regional or subspecialty focus.

The implications of the *Working Time Directive*⁵ and the likely reduction in the numbers of specialist registrars in obstetrics, gynaecology and neonatology effectively mean that the current number and configuration of maternity services need to be reviewed if patient safety is to be assured. The Centre for Workforce Intelligence (CfWI) anticipates a 20% reduction in the number of specialist registrar posts over the next 5 years (i.e., 40 of approximately 200 obstetrics and gynaecology posts in England will disappear).⁶ Change is urgently required as additional funding for an expansion in specialist numbers is unlikely in the near future. The RCOG believes that developing women's health networks is the key to successful change, although it recognises that the formation of maternity and children's services *strategic clinical networks*⁷ is likely to result in some repositioning of obstetric and gynaecological care. A flexible multiprofessional workforce free from traditional acute healthcare boundaries should be considered.

Training

At the end of their foundation training, specialist registrars in obstetrics and gynaecology are appointed to a national run-through specialty training programme comprising seven levels (ST1, ST2, etc). The MRCOG Part 1 examination^v is taken before they can progress from ST2 to ST3, and the MRCOG Part 2 examination^{vi} is taken before they can progress from ST5 to ST6. On successful completion of the Part 2 examination, specialist registrars are awarded the MRCOG qualification and can become members of the RCOG. The certificate of completion of training (CCT) is awarded at the end of ST7. Doctors who have achieved a CCT can then apply for a consultant post or other specialist work.

Work settings

Obstetrics

The majority of maternity care is currently provided in traditional hospital settings, with midwives and doctors working together, although there are an increasing number of midwife-led units located within or next to traditional maternity units (alongside midwifery-led units) or some distance away from the traditional hospital setting (freestanding midwifery-led units). These units provide care for low-risk women with uncomplicated pregnancies. Home births are still uncommon (fewer than 1.5%). The

iv. Doctors undertaking specialist training in obstetrics and gynaecology.

v. [www.rcog.org.uk/education-and-exams/examinations/exam-part-one].

vi. [www.rcog.org.uk/education-and-exams/examinations/exam-part-two].

present configuration and distribution may vary according to local facilities, patient choice and the configuration of hospital services.⁸

Gynaecology

Despite national recommendations, many of the investigations and much of the management of gynaecological problems that could be dealt with in an outpatient environment (such as contraception advice and provision, and minor surgical procedures) still take place in hospitals. The RCOG believes that pathways need to be strengthened to encourage the initial assessment and management of women with benign gynaecological problems to be undertaken in community or primary care settings. This should be through networks of care with appropriate expertise. A successful system will rely on the right person being in the right place at the right time; this *person* could be a consultant in obstetrics and gynaecology or in sexual and reproductive health in a community clinic, an SASG, a general practitioner (GP) with a special interest, or a specialist nurse.

Multidisciplinary input

Interdependencies in obstetrics must be recognised. Midwifery, neonatal and anaesthetic capabilities affect the comprehensive nature and feasible workload of a maternity service; for example, the level of neonatal facilities (special care units, local neonatal units or neonatal intensive care units) will dictate the type of obstetric service that can be safely provided. Moreover, the availability of high dependency or intensive care facilities for women will determine to some extent the type of service that can be safely provided and the medical complications that can be dealt with. Interventional radiology and haematology are among a range of specialties that also need consideration when planning a maternity service.

Out-of-hours care: the need for specialist presence

Out-of-hours services are still predominantly provided by SASGs and specialist registrars, with a focus on obstetrics. Out-of-hours gynaecology, particularly after 10 pm, is related to early pregnancy complications and very occasionally to emergency surgery for acute haemorrhage or ectopic pregnancy.

Obstetrics

Obstetrics is an emergency specialty and, owing to demographic and medical changes,⁹⁻¹¹ the need for 24-hour specialist presence has never been more pressing. The RCOG has produced standards for specialist presence on the delivery suite, according to the number of births that take place there.¹² The RCOG also recommends the use of the *Maternity Dashboard*,¹³ which has demonstrated improvements in the safety of maternity services where it has been used.¹⁴⁻¹⁶ The *Dashboard* is available on the RCOG website. Local adaptation and implementation will provide evidence for the monitoring of clinical outcomes and activity. This will allow more accurate trend analysis, and assessment of projected capacity and variability in clinical outcomes.

The current NHS tariffs¹⁷ do not support the development of specialist-delivered, 24-hour maternity care. Even the largest units struggle to achieve more than 98-hour-per-week

specialist presence on the delivery suite; where this has been achieved, it does not cover planned annual and study leave and tends to be irregular in its pattern. The only way to achieve a 24-hour standard, without additional funding, involves a rationalisation of the number of obstetric units. This should be possible, through the establishment of strategic clinical networks and a reduction in the number of smaller units (i.e. those with fewer than 3000 deliveries per year), particularly in urban conurbations.

Community sexual and reproductive health

Workforce

The specialty of community sexual and reproductive health (cSRH) was established in 2010 in response to the identified need to develop community-based specialists trained in leadership, public health, medical gynaecology and sexual health. As a relatively new specialty, the workforce is less developed than in other areas.

Training

The new cSRH programme remains a specialty under the RCOG umbrella. For new entrants, it has replaced the previous 3-year subspecialty training in sexual and reproductive health that followed obstetrics and gynaecology specialty training. It is a 6-year run-through programme commencing at ST1. The programme is designed to allow trainees to develop the skills to lead and manage the community-based sexual and reproductive health services of the future, and to lead large multidisciplinary teams. Successful completion of the MFSRH examinations (Part 1^{vii} and Part 2^{viii}) marks the achievement of the membership of the Faculty of Sexual & Reproductive Healthcare of the RCOG, a recognised qualification in reproductive health care.

Work settings

Specialists in cSRH usually work in community-based services and are ideally positioned at the clinical crossroads between hospital-based gynaecological care, general practice and genitourinary medicine (GUM). In recent years, there has been a move towards the integration of sexual and reproductive health (SRH) and GUM services, which are both designated open-access services with considerable areas of overlap in the levels of the care provided. Specialists working in SRH will frequently lead services based in multiple community clinics, often with a hub-and-spoke structure comprising outreach (for example, to young people, vulnerable adults and those seldom heard), core open-access and specialist SRH services, and other specialist services (such as psychosexual medicine, abortion care, medical gynaecology and prison health care).

Multidisciplinary input

In recent years, much routine activity has transferred from doctors to nurses. At the same time, the need for highly specialised doctors working in these services has risen. Increasingly, cSRH specialists work as part of complex multidisciplinary teams that include nurses, healthcare support workers, health advisers and psychologists and often also specialists in GUM.

vii. [www.fsrh.org/pages/MFSRH_Part_1_Examination.asp].

viii. [www.fsrh.org/pages/MFSRH_Part_2_Examination.asp].

Out-of-hours care: the need for specialist presence

cSRH services traditionally operate in the evenings and at weekends as well as during the working day.¹⁸ The structure and workload of individual services dictate the demand for an out-of-hours presence. As cSRH services often operate nurse-led services from multiple sites, ready access to a specialist by phone is required.

Case studies

Obstetric and gynaecological physiotherapy services at The Ipswich Hospital NHS Trust¹⁹

After careful analysis of referral patterns and patient outcomes, the obstetrics and gynaecology team at The Ipswich Hospital NHS Trust concluded that women were not receiving the same level of care throughout the week. It was established that physiotherapy services should be improved for the care of:

- women incurring perineal tears after delivering their babies (particularly on Saturdays and Sundays)
- women requiring gynaecological surgery on a Thursday or Friday (resulting in a protracted length of stay)
- women with back or pelvic pain resulting from childbirth (even years after the delivery)
- women requiring outpatient care (particularly on Mondays and Tuesdays, when the backlog of inpatients could be up to 60 women).

A 7-day physiotherapy service was established, where:

- women with perineal trauma are offered electrotherapy to promote and improve the quality of healing; this can be commenced 24 hours after delivery
- women are given exercises and advice to prevent postoperative complications and advice on returning to daily activities once discharged from hospital
- women are assessed for back pain and given physiotherapy/exercises to do at home
- women with, or at risk of, urinary retention and bladder distension are identified and their treatment is immediately instigated
- antenatal women are able to self-refer directly if they have a problem
- self-referrals are also accepted up to 6 weeks post-delivery.

The service improvement resulted in:

- reduced length of stay for women incurring perineal tears – from 3 or 4 days in 1998 to less than 24 hours in 2011
- reduced length of stay for women undergoing gynaecological surgery – from 4 or 5 days in 1997 to 1 or 2 days in 2010; the team is now aiming for surgery to be day case only.

Although the team acknowledges that physiotherapy may have contributed to the reduced length of stay in some instances, most of the reduction is more likely to be due to a change in clinical practice. Midwives were originally opposed to the 7-day physiotherapy service, as they could not see the full potential of it. Now the physiotherapists' contribution is recognised and they are considered integral to the team.

The physiotherapists agreed locally that petrol and travel time would not be paid as they would have 2 days off the following week – so they would only complete the same number of car journeys per week. Since the payment for 'on call' physiotherapists was eliminated, the establishment of this service was entirely cost neutral. Initial recruitment concerns about covering weekend working proved unwarranted.

This change to working practice has ensured that an effective plan for every patient is attained with no delays incurred in beginning therapy or discharging patients. A reduced length of stay for postnatal and continence surgical patients ensures that there is less risk of acquiring a hospital infection.

Read the full case study [here](#) and a summary [here](#).

Seven-day working at the Leicester Fertility Centre Assisted Conception Unit²⁰

The Assisted Conception Unit (ACU) at the Leicester Fertility Centre (University Hospitals of Leicester NHS Trust) provides fertility treatment to patients within the age range 18–45. These treatments, particularly in vitro fertilisation (IVF), require patients to attend for daily scans and blood tests, to monitor follicular development. Egg retrieval must be undertaken when the follicular development is optimal, and it must happen in a surgical theatre. The ACU had two fixed operating days per week: Monday and Tuesday.

However, since it is not possible to predict the exact day when a woman will be ready to be taken to theatre for egg retrieval, the outcome of the treatment could be compromised if she missed the ACU allocated days.

The ACU staff felt that this arrangement, together with a 5-day working week, severely restricted the quality and effectiveness of the service offered. In addition, they were aware that in order to survive in the current competitive market it was vital to modify their services and the way they were delivered.

In view of the above, the ACU introduced 7-day working from 1 January 2010. In October 2010, the ACU added a third theatre list on a Friday morning and this was enabled by the fact that other services (such as laboratories) were available over the weekend.

By increasing the working days to 7 days, the ACU staff were able to:

- improve the quality of care and clinical outcomes
- offer greater patient choice
- reduce cancelled treatment cycles
- reduce risk
- reduce complaints
- ensure service expansion and development
- increase success rates
- increase business
- increase service profile
- generate additional income.

The introduction of 7-day working involved a multidisciplinary team approach with various grades of staff. The staff were driven by the commitment to patient care, and the fact they wanted to be in the top-five best ACUs in the country.

Read the full case study [here](#) and a summary [here](#).

Community gynaecology within an integrated sexual and reproductive health (SRH) service at the Chalmers Sexual Health Centre

The new Chalmers Sexual Health Centre opened in Edinburgh in June 2011 as a flagship project to improve the sexual and reproductive health of the local population. It brought together the pre-existing consultant-led family planning and genitourinary medicine (GUM) services in an integrated care model, hosted by a refurbished city centre Victorian hospital with a purpose-built clinical wing.

The community gynaecology service includes:

- gynaecology clinics
- the Edinburgh Menopause Clinic
- premenstrual syndrome clinics
- complex contraception clinics
- complex intrauterine device (IUD)/intrauterine system (IUS) clinics
- colposcopy clinics
- sexual problems clinics
- abortion assessment and treatment.

Women are seen rapidly with a 'one-stop shop' philosophy. The centre provides on-site ultrasound and minor procedures, it takes GP referrals, in-house referrals and those from other specialist centres, and it complements and liaises with mainstream hospital gynaecology services.

The community gynaecology service brings immediate benefit to women who:

- have pain and bleeding with hormonal or intrauterine contraception or hormone replacement therapy
- are drug users, work in the sex industry and/or are imprisoned
- are HIV positive with gynaecological issues
- require abortion assessment and medical treatment within a community setting
- need sexually transmitted infection (STI) testing and treatment as part of their gynaecological management.

In particular, moving the abortion assessment and treatment service to a community setting has improved the uptake of long-acting reversible contraception (LARC) following abortion. In a recent audit, 49% of women in the community setting were on LARC following abortion, compared with 33% in the hospital setting.

Patient satisfaction rates with the service were 96% 'very good/excellent' in the first year of opening.

The staff at the Chalmers Centre are constantly seeking ways to give better access to patients. The Centre offers a mixture of pre-booked and drop-in appointments, telephone triage and quick access. 'Drop-in' IUD/IUS insertion appointments are provided in the morning, afternoon and evening; women are encouraged to watch a video on IUD/IUS on the website and to complete a self-preparation form before they attend.

Northumbria Healthcare NHS Foundation Trust

A seven-day consultant-led and -delivered acute care service across a geographically challenged trust²¹

The geographical challenges of covering ten inpatient and 20 outpatient sites over a coastal area of 89 miles and an inland area of 84 miles dictated that up to 30% of the 220 trust consultants were travelling off site at any one time. Despite service improvements, the ageing population and increased A&E attendance numbers meant that something radically different was needed to sustain continuity of care and the safety of patients.

In view of the above, the doctors' job plans were changed, and on-call commitments were redefined: being 'on call' was part of the working day. Physicians extended their working days from 8 am to 10 pm and this allowed for increased trainee contact. Three more effective and efficient handovers per day could be facilitated. The foundation trainees attained better support 'on the clinical floor', from both consultants and specialist registrars.

A calm, 'healing' environment is now possible for patients, as the frenetic 'emergency' patient flows are dealt with in a radically different way. The knock-on effect to the elective cases is tangible. In the new Emergency Care Centre, the clinical floor will be fronted by a 24-hour resident emergency care consultant. This will be backed by nine consultant-led teams.

The experience of Northumbria Healthcare NHS Foundation Trust highlights that, while it is difficult, it is *possible* to change an entire system, even in a geographically challenging location. Engagement with the public and with local GPs was felt to be fundamental.

Read the full case study [here](#) and a summary [here](#).

Delivering sexual health services to a vast rural county with diverse population needs

The service provides care to a population of about 316 000 people, covering a sparsely populated rural area (63 residents per square kilometre – the seventh lowest population density of all local authorities in England). In 2005, building on the existing community contraceptive service, GUM services were introduced to facilitate an integrated sexual and reproductive health (SRH) service.

The service has been recognised locally and nationally for innovative practice through extending nursing roles and flexible working that meets the diverse needs of the population: from outreach to specialist medical care. This was achieved by proactive, multidisciplinary team working of doctors and nurses.

The service provides:

- all levels of contraceptive care, including long-acting reversible contraception (LARC)
- sexually transmitted infection (STI) testing, treatment, and partner notification
- early pregnancy advice and referral
- psychosexual counselling.

The service operates a hub-and-spoke model through:

- medical specialists providing complex care based mainly in the hub
- a team of specialist nurses trained in contraception and STIs serving all the outlying clinic locations.

The teams deliver a total of about 60 sessions per week across the county, with 38 of these dedicated to young people 'drop-ins'. There is medical specialist input fortnightly or monthly at all the outlying sites to cater for patient choice and access. Patients referred by their GPs for specialist care are seen at their clinic of choice and if required can be referred to their local hospital in Northumberland.

In order to provide an accessible and comprehensive service for the county, the SRH team developed practical and useful examples of partnership working:

- referral pathways for emergency intrauterine devices that include community pharmacies and GPs
- pathways for the management of suspected concealed pregnancies in school
- working with midwives and health visiting teams to identify and refer vulnerable teenage mothers for a sexual health domiciliary pathway to aid prevention of repeat unplanned pregnancies
- a dedicated multidisciplinary-trained health adviser engaging with young people in the 'looked-after' systems
- sessions dedicated to young people in 14 high schools and two further education colleges across the county, working alongside youth workers and drug and alcohol agencies
- nationally accredited training delivered for primary care professionals and nurses working in abortion services to ensure all contraceptive methods are available at the time of abortion.

References

1. Royal College of Obstetricians and Gynaecologists. *High Quality Women's Health Care: A Proposal for Change*. RCOG Working Party Report. London: RCOG; 2011 [www.rcog.org.uk/high-quality-womens-health-care].
2. Royal College of Obstetricians and Gynaecologists. *Tomorrow's Specialist*. RCOG Working Party Report. London: RCOG; 2012 [www.rcog.org.uk/womens-health/clinical-guidance/tomorrows-specialist].
3. Royal College of Obstetricians and Gynaecologists. *Why Should We Consider a Life Course Approach to Women's Health Care*. SAC Opinion Paper 27. London: RCOG; 2011 [www.rcog.org.uk/womens-health/clinical-guidance/life-course-approach-women%E2%80%99s-health-care-why-should-we-consider-sac-].
4. Royal College of Obstetricians and Gynaecologists. *Medical Workforce in Obstetrics and Gynaecology*. 20th RCOG Report. London: RCOG; 2011 [www.rcog.org.uk/files/rcog-corp/Medical%20Workforce%20Census%202011.pdf].
5. The European Parliament and the Council of the European Union. *Directive 2003/88/EC of the European Parliament and of the Council of 4 November 2003 concerning certain aspects of the organisation of working time*. Official Journal L 299 , 18/11/2003 P. 0009 - 0019 [<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:32003L0088:EN:HTML>].
6. Centre for Workforce Intelligence. *Obstetrics and Gynaecology: CfWI medical fact sheet and summary sheet – August 2011* [www.cfwi.org.uk/publications/obstetrics-and-gynaecology-cfwi-medical-fact-sheet-and-summary-sheet-august-2011].
7. NHS Commissioning Board. *The Way Forward: Strategic Clinical Networks*. 26 July 2012 [www.commissioningboard.nhs.uk/files/2012/07/way-forward-scn.pdf].
8. Tyler S. *Commissioning Maternity Services: A Resource Pack to support Clinical Commissioning Groups*. NHS Commissioning Board; 2012 [www.england.nhs.uk/wp-content/uploads/2012/07/comm-maternity-services.pdf].
9. Heslehurst N, Rankin J, Wilkinson JR, Summerbell CD. A nationally representative study of maternal obesity in England, UK: trends in incidence and demographic inequalities in 619 323 births, 1989–2007. *Int J Obes (Lond)* 2010;34:420–8.
10. Wu J, Morris JK. Trends in maternal age distribution and the live birth prevalence of Down's syndrome in England and Wales: 1938–2010. *Eur J Hum Genet* 2013 Jan 30 [Epub ahead of print].
11. Scott-Pillai R, Spence D, Cardwell C, Hunter A, Holmes V. The impact of body mass index on maternal and neonatal outcomes: a retrospective study in a UK obstetric population, 2004–2011. *BJOG* 2013;120:932–9.
12. Royal College of Obstetricians and Gynaecologists. *Labour Ward Solutions*. Good Practice No. 10. London: RCOG; 2010 [www.rcog.org.uk/womens-health/clinical-guidance/labour-ward-solutions].
13. Royal College of Obstetricians and Gynaecologists. *Maternity Dashboard: Clinical Performance and Governance Score Card*. Good Practice No. 7. London: RCOG; 2008 [www.rcog.org.uk/womens-health/clinical-guidance/maternity-dashboard-clinical-performance-and-governance-score-card].
14. Cruickshank C, Davies A, Herd D, Mackintosh J, Reid W, Bryers H. *Development of Maternity Dashboard for Raigmore Hospital*. Poster presentation. NHS Highland; 2011 [www.evidenceintopractice.scot.nhs.uk/media/151290/nhs%20highland.pdf].
15. Thomas V, Dixon A. *Improving Safety in Maternity Services: A Toolkit for Teams. Information and Guidance*. The King's Fund; 2012 [www.kingsfund.org.uk/sites/files/kf/field/field_related_document/Improving-safety-in-maternity-services-toolkit-information.pdf].

16. Chandrabaran E. Clinical dashboards: do they actually work in practice? Three-year experience with the Maternity Dashboard. *Clinical Risk* 2010;16:176–82 [<http://cr.rsmjournals.com/content/16/5/176.full>].
17. Royal College of Obstetricians and Gynaecologists, Department of Health, Royal College of Midwives, Healthcare Financial Management Association. *Maternity Services Pathway Payment System: A Simple Guide 2012/13* [www.rcm.org.uk/college/policy-practice/government-policy/payment-by-results/].
18. Clinical Standards Committee, Faculty of Sexual & Reproductive Healthcare. *Service Standards for Sexual and Reproductive Healthcare – Introduction*. London: FSRH; 2011 [www.fsrh.org/pdfs/ServiceStandardsIntroduction.pdf].
19. NHS Improving Quality. Seven Day Services Case Studies. Women’s Services. *Obstetric and Gynaecological Physiotherapy Services – The Ipswich Hospital NHS Trust*. NHS Improvement; 2011 [http://system.improvement.nhs.uk/ImprovementSystem/ViewDocument.aspx?path=Other%20Specialty%2fNational%2fwebsite%2f7_day%2fFull_versions%2fThe%20Ipswich%20Hospital%20NHS%20Trust.pdf].
20. NHS Improving Quality. Seven Day Services Case Studies. Women’s Services. *Leicester Fertility Centre – University Hospitals of Leicester NHS Trust*. NHS Improvement; 2011 [http://system.improvement.nhs.uk/ImprovementSystem/ViewDocument.aspx?path=Other%20Specialty%2fNational%2fwebsite%2f7_day%2fFull_versions%2fUniversity%20Hospitals%20of%20Leicester%20NHS%20Trust.pdf].
21. NHS Improving Quality. Seven Day Services Case Studies. Integrated System. *A Consultant Led and Delivered Seven Day Services Model Across a Geographically Challenged Trust – Northumbria Healthcare NHS Foundation Trust*. NHS Improvement; 2011 [http://system.improvement.nhs.uk/ImprovementSystem/ViewDocument.aspx?path=Other%20Specialty%2fNational%2fwebsite%2f7_day%2fFull_versions%2fNorthumbria%20Healthcare%20NHS%20Foundation%20Trust.pdf].

