Royal College of Obstetricians & Gynaecologists

Reconfiguration of women's services in the UK

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1 Purpose

The purpose of this Good Practice Paper is to help Members and Fellows of the Royal College of Obstetricians and Gynaecologists (RCOG) to understand the principles that should be adhered to during the planning and process of reconfiguring women's health services and to assess the extent to which there is evidence that women's services are of a high standard and of good quality following reconfiguration.

2 Introduction

The RCOG has a major responsibility to define standards of care for maternity and gynaecological services. Decisions about configuration of services should be made by local commissioners and providers, cognisant of public demand where possible. In this Good Practice Paper, we discuss the standards needed to run high-quality and safe services. The Royal College of Midwives (RCM) will make its own recommendations from a midwifery perspective. Inevitably, such service-configuration decisions will be influenced by issues of patient safety, access, sustainability, skill mix, human resources and economic efficiencies of scale, together with the needs of the local population.

The 2011 RCOG report *High Quality Women's Health Care: a Proposal for Change*[1] describes a model that focuses on the needs of the woman and her baby by providing the right care, at the right time, in the right place, provided by the right person in order to enhance the woman's experience.

3 Context

The demands on women's services are increasing. There has been a year-on-year rise in new referrals for outpatient obstetrics and gynaecology,[2] which by 2011 accounted for the highest volume of outpatient attendances, at 11.4% of total annual referrals. In obstetric care, the number of births increased by 19% overall between 2000 and 2011.[1] However, this is not uniform throughout the UK (in Scotland, total births registered in 2009 showed a drop of 1.7% compared with 2008).This has been coupled with an increasing case complexity (Table 1) caused by changing demographic factors such as the increasing average age of first-time mothers, increasing rates of obesity and multiple pregnancy, and an increase in the number of women with existing comorbidities. This shift has added to the pressure on women's services in terms of both the volume of demand and the intensity and types of care required.[1]

Table 1 Delivery outcome data for 1998/99 and 2009/10 by finished consultant episodes (England)

Delivery outcome	Finished consultant episodes		Percentage point change
	1998/99	2009/10	
Normal delivery with complications	17211 (3.1%)	24973 (3.8%)	+0.7
Normal delivery without complications	363955 (65.6%)	385765 (58.9%)	−6.6
Assisted delivery with complications	5403 (1.0%)	9968 (1.5%)	+0.5
Assisted delivery without complications	60679 (10.9%)	74917 (11.4%)	+0.5
Caesarean section with complications	15788 (2.8%)	29830 (4.6%)	+1.7
Caesarean section without complications	91956 (16.6%)	129170 (19.7%)	+3.2
Total	554992	654623	

Source: Hospital Episode Statistics

There are many policy drivers (all of which focus on similar issues):

- extending women's choice of type and location of maternity care (2010 NHS White Paper *Equity and Excellence: Liberating the NHS*[3])

- the 2010 NHS White Paper *Healthy Lives, Healthy People: Our Strategy for Public Health in England*[4]
- the *Payment by Results*[5] maternity pathway tariff
- the National Institute for Health and Care Excellence (NICE) outcomes framework[6] and quality standards[7]
- extending patient choice of provider ('any qualified provider'; AQP)[8]
- shifting care from the hospital to the community[9]
- the 2009 Department of Health (DH) report *Delivering High Quality Midwifery Care: the Priorities, Opportunities and Challenges for Midwives*[10]
- the 2008 RCOG Working Party report *Standards for Maternity Care*[11]
- the 2009 RCM report *Standards for Birth Centres in England*.[12]

Structural reforms also influence maternity services provision, particularly:

- **Commissioning:** transfer of commissioning powers and allocated funding from primary care trusts (PCTs) to clinical commissioning groups (CCGs), and the establishment of NHS England and the development of maternity and children's strategic clinical networks
- **Democratic/local accountability:** Health and Wellbeing Boards (HWBs) and local Healthwatch groups in England; the configuration of maternity services is often driven by the reconfiguration of neonatal and paediatric services.

The example of the reconfiguration in Manchester showed that when the obstetrics and midwifery heads of 12 Manchester maternity units met in 2000 they agreed 'almost from day one' they had too many sites.[13] They feared that national shortages of specialist staff, increased clinical specialisation and EU restrictions on trainee doctors' hours would make it impossible to keep that many units adequately staffed. None, of course, particularly wanted their own units to close but, over time, they were able to agree that there should be eight at most, and to present a choice of possible configurations.

The guidance made in this document is based on the recommendations in several RCOG reports, most notably in *Safer Childbirth*[14] and *Standards for Maternity Care*.[11] A summary of the key considerations for reconfiguration of services appears below.

4 Workforce planning

4.1 Obstetric staffing

The close working relationship between midwives and obstetricians, together with the support from other health professionals, is unique to the UK and emphasises the strength of our maternity services. It allows for:

- the development of differing modes of care
- choice of place of birth
- seamless escalation of care when required (and returning to the original carer when the risk has resolved).

Around one-third of women (often those with a previous uneventful birth) can be assessed as being at low risk of complications and a plan made for them to give birth at home or in a freestanding midwifery-led unit (FMU). Fewer than 5% of these women having their second or subsequent baby will require transfer to consultant care. This allows a significant number of women access to a low-risk environment of their choice with midwife support.

A further one-sixth of women will be classed as being at high risk of complications from previous events or medical problems in the current pregnancy.

In the remaining 50% of women, the level of risk is unknown. This is largely made up of women having their first baby and those women who had some complications in their first pregnancy but are not clearly high risk. Their antenatal care can start in a low-risk environment but one-quarter of them will require step-up care to specialist services prior to labour because of developing concerns such as fetal growth restriction or maternal hypertension.

Of those who continue as low risk and start labour in a low-risk environment, over 40% will need transfer to an obstetric unit in labour.[15] These transfers from low risk to higher risk care need to be seamless. For ease of transfer, labour care in an alongside midwifery unit (AMU) or a mixed obstetric service allows quick, easy and safe escalation of care.

In any setting, the role of the midwife remains central as the main supporter and guardian of women in labour but in the obstetric unit there needs to be immediate access to senior medical obstetric staff. Appropriate obstetric cover to provide care for the number of anticipated births per year should in theory be possible with centralisation, in units with more than 6000 births per year. The 2005 report *The Future Role of the Consultant*[16] suggested that delivery suites supporting large numbers of births (over 5000 a year) and/or a complex caseload should be moving towards a 168-hour-per-week consultant-based service.

Increasing the provision of community-based midwifery-led services would allow for this centralisation of obstetric services. More complex caseloads should be expected in centralised obstetric units and planning for consultant cover should reflect this.

Currently, most maternity services are struggling to provide adequately staffed low- and high-risk services. It is imperative that 24-hour consultant presence on the delivery suite results in improved decision making and healthcare organisations must ensure that these doctors have the appropriate team structures and support from their organisations and protected time to carry out their responsibilities. There is also the need for all consultants (excluding gynaecological subspecialists) to provide obstetric service and delivery suite presence as proposed in the 2009 report *The Future Workforce in Obstetrics and Gynaecology*.[17]

In smaller units (between 2500 and 4000 births per year), 24-hour presence may not be cost-effective and *Safer Childbirth*[14] suggested a 60-hour-per-week presence as a minimum standard. Other circumstances such as geography and location of units must be carefully considered.

The RCOG believes that a 24-hour, 7-day-a-week consultant-led service for women requiring obstetric care improves patient safety and enhances women's experiences.[1] This results from enhanced clinical leadership and decision making with the added advantage of providing better supervision and mentoring of trainee doctors and increased support for midwifery colleagues. Similarly, women have stated that they prefer to be treated by specialists at any time of the day should they require this level of care.[18]

The RCOG recommends that there should be a lead consultant obstetrician on the delivery suite.[11]

Recommendations on consultant presence can be found in the following documents:

- RCOG Good Practice No. 10 (2010) *Labour Ward Solutions*[19]
- RCOG Good Practice No. 8 (2009) *Responsibility of Consultant On-Call*[20]
- RCOG Working Party report (2009) *The Future Workforce in Obstetrics and Gynaecology: England and Wales*[17]

- College of Operating Department Practitioners, Royal College of Midwives, and Association for Perioperative Practice (2009) *Staffing of Obstetric Theatres – A Consensus Statement*.[21]

4.2 Trainee doctor staffing

Organised shift handovers with the whole maternity team are needed to enable better continuity of patient care. Clearly defined roles (taking into consideration individual training needs and skill mix) for trainees are needed. Trainees at ST1–2 level should not be expected to provide the service unsupervised. Better mentoring and supervision for trainees is needed so that training occurs throughout the shift.

4.3 Anaesthetic care and support

Anaesthetists are an integral part of the maternity team and a lead obstetric anaesthetist is an essential requirement in the provision of safe services. In addition, an anaesthetist of appropriate seniority and experience, with appropriate operating department practitioner (ODP) support, should be on duty in an obstetric unit 24 hours a day.

Pain relief should be made available to women who want it and obstetric units must be able to provide regional anaesthesia on request at all times. There should be timely referral to doctors for women choosing epidural analgesia. The anaesthetic team's response time is crucial during emergencies and appropriate planning is needed to manage the response to elective procedures and to detect postoperative complications.

Recommendations on obstetric anaesthetic care can be found in the following documents:

- Royal College of Anaesthetists (2011) *Providing Equity of Critical and Maternity Care for the Critically Ill Pregnant or Recently Pregnant Woman*[22]
- Royal College of Anaesthetists (2013) *Guidelines for the Provision of Obstetric Anaesthesia Services*.[23]

4.4 Neonatal care

Obstetric services should include appropriate levels of staffing (paediatricians and specialist nurses) and facilities (neonatal intensive care unit (NICU)) to care for preterm or ill babies. In cases of suspected preterm labour, a neonatal consultant should be present. Where possible, arrangements should be made for the mother to be with her baby. In units where these services are unavailable, transfers to appropriate care must be planned in advance of birth. The current system to enable quick transfer arrangements exists within NHS Neonatal Networks (www.bapm.org/networks_info).

Recommendations on neonatal services can be found in the following documents:

- British Association of Perinatal Medicine (2010) *Service Standards for Hospitals Providing Neonatal Care*[24]
- British Association of Perinatal Medicine (2008) *The Management of Babies Born Extremely Preterm at Less than 26 Weeks of Gestation: a Framework for Clinical Practice at the Time of Birth*[25]
- Neonatal Expert Advisory Group (2013) *Neonatal Care in Scotland: a Quality Framework*.[26]

4.5 Co-Surgical support

Every obstetric service must have close access to surgical backup for infrequent complications occurring during childbirth, which include damage to bladder, bowel or major blood vessels. In addition, major bleeding complications in obstetrics and gynaecology may need access to interventional radiology[27] and close proximity to laboratory services providing blood transfusion.

4.6 Care of critically ill parturient women

Commissioners of maternity and critical care services must design pathways at a local level which ensure that a critically ill parturient woman accesses equitable care for both components, irrespective of location. Such pathways should facilitate mother and baby remaining together unless precluded by a clinical reason. These arrangements should include defined escalation arrangements for bringing critical care, midwifery and obstetric competencies into the maternity or critical care unit. These arrangements also need to take into account local configuration, size and complexity of maternity and critical care services. Models may include:[22]

- a suitable high-dependency area and equipment with medical input from anaesthetists and obstetricians, staffed by a team of midwives who have the necessary critical care competencies
- local multidisciplinary arrangements with appropriate escalation protocols should level 3 care be required
- appropriate arrangements with local critical care services for collaboration on the delivery suite
- transferring women to a general level 2 unit with local arrangements for providing obstetric and midwifery input and maintaining direct contact with their baby.

4.7 A&E

Admission to emergency gynaecology must be available. Emergency gynaecology departments must be staffed appropriately, with trained medical and nursing staff.

5 Capacity and size of consultant-based obstetric units

There is no published evidence on the ideal size for a maternity unit. Currently, there are nine units in England and Wales that have more than 7000 births per year[28] and the pressure continues to increase annually with the growth in the birth rate.[29] In very large units, more than one obstetric team at a time may be required to cover all responsibilities. Greater numbers of specialists are required during the daytime to service the elective caesarean section commitment.

6 Geographical access to units

Within large conurbations most women will have closer access and choice of provider in maternity services. Women who choose to give birth out of hospital must have access to ambulance services for quick transfer to hospitals in the event of emergencies. The Birthplace study conducted by the National Perinatal Epidemiology Unit (NPEU)[15] has revealed that the transfer rates vary between 9% and 45%, depending on the mother's parity.

7 Systems

7.1 Education and training

Maternity services operate over a 24-hour period and should be staffed according to the size of the unit rather than the time of day. The educational and training needs of doctors must be borne in mind at all times of the day and night. They need to be supported with supervision and mentoring by senior staff.

7.2 Other specialist services

Births are getting more complex. There is a need for enhanced multidisciplinary teamworking in maternity services and this should include the availability of obstetric physicians and perinatal

psychiatrists to deal with a range of maternal morbidities and comorbidities. Arrangements should be made for adequate cover at all times. At least one, and sometimes two, dedicated co-located operating theatres for maternity services is a requirement.[14,30]

8 Other considerations

Alongside the above standards is the need for NHS trusts, health boards and provider organisations (and, in future, the CCGs, working closely with local maternity services, local authorities, women and their families) through the HWBs, to anticipate regional population trends and to forecast future demand for services.

Within hospitals, this is already being done with the roll-out of the *Maternity Dashboard*[31] but use of this is only meant to be for the short term. A more detailed analysis of demographic developments within the local population needs to take into account social and lifestyle changes (for example, increases in average maternal age and in maternal obesity) that will be likely to have an impact on maternity workload and service provision.

8.1 NHS reform and change

The RCOG believes that with growing provision from AQPs in the NHS, commissioners must ensure that non-NHS providers adhere to NHS standards and pathways so that high-quality care can be assured. This includes the use of national clinical guidelines produced by NICE and the RCOG.

The recent RCOG report *Tomorrow's Specialist*[18] found a difference between what doctors perceive women need from healthcare services and what women actually want. There is therefore the need to ensure close working with women so that patient-centred care can be delivered. The new Healthwatch groups and HWBs should be able to advise CCGs on local requirements based on patient-reported outcome measures (PROMs).

NHS England has produced a resource pack[32] to help CCGs make the appropriate decisions on the commissioning of maternity services in England. Similarly, the DH has published the NHS Mandate[33] which outlines the key outcomes for high-quality care and good outcomes in the NHS. During the consultation stage, draft guidance on the extent of patient choice in NHS maternity services was provided in the annexes.[34]

The RCOG has published a resource (www.rcog.org.uk/commissioning) to assist CCGs in their commissioning decisions in obstetric and gynaecology services.

9 Tools for reconfiguration

Before embarking on wide-ranging reconfiguration of clinical services, potential clinical models will need to be considered. The following questions may be helpful to consider.

a) What services could be best delivered within the community rather than on an acute hospital site?
b) What services are required on all hospital sites? These services are likely to be those with a low complexity but high patient numbers.
c) Which services would be better delivered on fewer hospital sites? These services are likely to be more complex or specialised services or those with smaller patient numbers.
d) Are there any opportunities to provide local access to services for which patients currently have to travel out of the area?

With the introduction of AQPs, it is crucial to ensure that non-NHS providers comply with NHS standards of care, which should include measures for adherence to NICE and RCOG clinical guidelines.

Ensuring that integrated care is provided requires close working relationships to be formed between GPs, NHS maternity services and AQPs so that the care offered is seamless. Similarly, monitoring systems and information-sharing between providers of care are essential, especially in the case of high-risk patients. CCGs should ensure that these responsibilities are in place. It is not inconceivable that an NHS healthcare organisation may have to deliver follow-up care that was originally provided by an AQP and there are financial considerations involved in this scenario. Commissioners should also query the education and training commitments of the AQPs so that arrangements can be made by them and the NHS.

The evaluation criteria in Table 2, against which all potential models could be assessed before public consultation, were developed by the Healthier Together[35] collaboration in the South East Midlands and published in their *Clinical Senate and Maternity Clinical Working Group Reports*[36] in March 2013.

Table 2 Evaluation criteria for potential service models, developed by the Healthier Together[35] collaboration

Criteria	Description
Quality/safety	Does the service model improve the clinical standards for quality and safety?
	Does the service model sustain or enhance the patient experience?
	Does the service model improve clinical outcomes?
	Does the service model meet national best practice guidelines?
	Does the service model enable patients to be transported safely by emergency vehicles?
Affordability	Is the service model achievable within current and future financial resources?
	Does it provide the best value for taxpayers' money across the health and social care economy?
	Is the capital expenditure affordable (including its revenue consequences)?
Deliverability	Will the proposed model receive support from NHS staff/clinicians as well as from local stakeholders?
	Does it meet clinical commissioners' strategies for the future shape of health services for their population?
	Are assumptions about transitional funding and capital funding realistic?
	Can the model be supported by a workforce/staffing model which is realistic?
	Can the model be effectively supported by education and training arrangements in the future?
Sustainability	Does the service model address the increased demands that will result from a growing and ageing population over the next two decades?
	Will it help organisations deliver their environmental sustainability responsibilities?
	Is it clinically sustainable over the foreseeable future?
	Are the medium-term workforce implications sustainable?
Equity of access	Does the model allow for equity of access for all sections of our diverse population, including vulnerable people and those with specific needs?
	Does the model enable patients to exercise their right to choice when considering treatment options?
Travel access	Are there sufficient transport options to allow all patients and their families to access relocated services within a reasonable time?

10 Future considerations

To improve women's services, the RCOG has made the case for the reorganisation of reproductive health services (including sexual health) in *High Quality Women's Health Care: a Proposal for Change*[1] and believes that women's health care provided within the structure of strategic clinical networks could offer better care to women, throughout their lives and to their babies.

This requires the reorganisation of care so that all maternity and gynaecological services are linked and services can then be concentrated where they are most needed. Women are willing to travel a little further to hospitals provided they know they will have access to appropriate levels of care throughout the day and night.[18] In order to ensure that women continue to have a range of services closer to home, some care can be provided in community settings. CCGs must work with local hospitals on the services that can be provided outside secondary/tertiary settings.

In the case of maternity services, research has shown that women with low-risk pregnancies, having a second or subsequent baby, have good outcomes if they deliver in freestanding or alongside midwifery-led services or at home.[15] These options should be offered to these women. Strategic clinical networks must ensure that effective, swift and safe transfers to centres of obstetric care can occur where required for the health of mother and baby. The development of strategic clinical networks should ease planning and capacity development.

It must be noted that the birth rate in the UK is increasing year on year, as are the numbers of complex, high-risk pregnancies. Likewise, litigation related to maternity care is also on the rise. It is therefore wise for organisations to invest in more consultants and midwives for maternity services to help prevent serious untoward incidents.

References

1 Royal College of Obstetricians and Gynaecologists. *High Quality Women's Health Care: a Proposal for Change*. London: RCOG; 2011 [www.rcog.org.uk/files/rcog-corp/HighQualityWomensHealthcareProposalforChange.pdf].

2 Hospital Episode Statistics at Health and Social Care Information Centre [www.hscic.gov.uk/searchcatalogue?q=%22hospital+outpatient+activity%22&area=&size=10&sort=Relevance&topics=0%2FHospital+care].

3 Department of Health. *Equity and Excellence: Liberating the NHS*. NHS White Paper. Norwich: TSO; 2010 [www.gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_117794.pdf].

4 HM Government. *Healthy Lives, Healthy People: Our Strategy for Public Health in England*. NHS White Paper. Norwich: TSO; 2010 [www.gov.uk/government/uploads/system/uploads/attachment_data/file/136384/healthy_lives_healthy_people.pdf].

5 Department of Health Payment by Results team. *Payment by Results: Guidance for 2013–14*. Section 10: Pathway payments – Maternity pathway payments. p. 128–39. London: DH; 2013 [www.gov.uk/government/uploads/system/uploads/attachment_data/file/141388/PbR-Guidance-2013-14.pdf.pdf].

6 National Institute for Health and Care Excellence (NICE). Quality and Outcomes Framework [www.nice.org.uk/aboutnice/qof/qof.jsp].

7 National Institute for Health and Care Excellence (NICE). Quality Standards [guidance.nice.org.uk/qualitystandards/qualitystandards.jsp].

8 Department of Health. *Liberating the NHS: Greater Choice and Control*. Government response. Extending patient choice of provider (Any qualified provider). London: DH; 2011 [webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128539.pdf].

9 Department of Health. *Shifting Care Closer to Home*. Care Closer to Home demonstration sites – report of the speciality subgroups. London: DH; 2007 [webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_079801.pdf].

10 Department of Health. *Delivering High Quality Midwifery Care: the Priorities, Opportunities and Challenges for Midwives*. London: DH; 2009 [http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_106064.pdf].

11 Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Royal College of Anaesthetists and Royal College of Paediatrics and Child Health. *Standards for Maternity Care: Report of a Working Party*. London: RCOG Press; 2008 [www.rcog.org.uk/files/rcog-corp/uploaded-files/WPRMaternityStandards2008.pdf].

12 Royal College of Midwives and Birth Centre Network UK. *Standards for Birth Centres in England: a Standards Document*. London: Royal College of Midwives Trust; 2009 [www.rcm.org.uk/EasySiteWeb/GatewayLink.aspx?alId=103143].

13 Dowler C, Heritage A, Wallis S. Labour of love: making a maternity services reconfiguration successful. *Health Service Journal* 6 March 2012 [www.hsj.co.uk/resource-centre/best-practice/qipp-resources/labour-of-love-making-a-maternity-services-reconfiguration-successful/5041433.article].

14 Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Royal College of Anaesthetists and Royal College of Paediatrics and Child Health. *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour*. London: RCOG Press; 2007 [www.rcog.org.uk/files/rcog-corp/uploaded-files/WPRSaferChildbirthReport2007.pdf].

15 Birthplace in England Collaborative Group. Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *BMJ* 2011;343:d7400 [www.bmj.com/highwire/filestream/545014/field_highwire_article_pdf/0/bmj.d7400.full.pdf].

16 Royal College of Obstetricians and Gynaecologists. *The Future Role of the Consultant*. Working Party report. London: RCOG Press; 2005 [www.rcog.org.uk/files/rcog-corp/uploaded-files/WPRFutureRoleConsultant2005.pdf].

17 Royal College of Obstetricians and Gynaecologists. *The Future Workforce in Obstetrics and Gynaecology: England and Wales*. Working Party report. London: RCOG Press; 2009 [www.rcog.org.uk/files/rcog-corp/uploaded-files/RCOGFutureWorkforceFull.pdf].

18 Royal College of Obstetricians and Gynaecologists. *Tomorrow's Specialist*. Working Party report. London: RCOG; 2012 [www.rcog.org.uk/files/rcog-corp/Tomorrow%27s%20Specialist_FullReport.pdf].

19 Royal College of Obstetricians and Gynaecologists. *Labour Ward Solutions*. Good Practice No. 10. London: RCOG; 2010 [www.rcog.org.uk/files/rcog-corp/LabourWardSolutionGoodPractice10a.pdf].

20 Royal College of Obstetricians and Gynaecologists. *Responsibility of Consultant On-Call*. Good Practice No. 8. London: RCOG; 2009 [www.rcog.org.uk/files/rcog-corp/uploaded-files/GoodPractice8ResponsibilityConsultant.pdf].

21 College of Operating Department Practitioners, Royal College of Midwives, and Association for Perioperative Practice. *Staffing of Obstetric Theatres – A Consensus Statement* [www.codp.org.uk/documents/Staffing of Obstetric Theatres.pdf].

22 Royal College of Anaesthetists. *Providing Equity of Critical and Maternity Care for the Critically Ill Pregnant or Recently Pregnant Woman*. London: Royal College of Anaesthetists; 2011 [www.rcoa.ac.uk/system/files/CSQ-ProvEqMatCritCare.pdf].

23 Wee MYK, Mushambi MC, Thornberry A. *Guidelines for the Provision of Obstetric Anaesthesia Services*. [www.rcoa.ac.uk/system/files/GPAS-2013-09-OBSTETRICS_1.pdf].

24 British Association of Perinatal Medicine. *Service Standards for Hospitals Providing Neonatal Care*. 3rd ed. London: BAPM; 2010 [www.bapm.org/publications/documents/guidelines/BAPM_Standards_Final_Aug2010.pdf].

25 British Association of Perinatal Medicine. *The Management of Babies Born Extremely Preterm at Less than 26 Weeks of Gestation: a Framework for Clinical Practice at the Time of Birth*. Report of a Working Group. BAPM; 2008 [www.bapm.org/publications/documents/guidelines/Approved_manuscript_preterm_final.pdf].

26 Neonatal Expert Advisory Group. Neonatal Care in Scotland: a Quality Framework. Edinburgh: Scottish Government; 2013 [www.scotland.gov.uk/Resource/0041/00415230.pdf].

27 Royal College of Obstetricians and Gynaecologists, Royal College of Radiologists and British Society of Interventional Radiology. *The Role of Emergency and Elective Interventional Radiology in Postpartum Haemorrhage*. Good Practice No. 6. London: RCOG; 2007 [www.rcog.org.uk/files/rcog-corp/uploaded-files/GoodPractice6RoleEmergency2007.pdf].

28 Royal College of Obstetricians and Gynaecologists. *Medical Workforce in Obstetrics and Gynaecology: 20th RCOG Report*. London: RCOG Press; 2011 [www.rcog.org.uk/files/rcog-corp/Medical%20Workforce%20Census%202011.pdf].

29 Royal College of Midwives. *State of Maternity Services Report 2012*. London: RCM; 2013 [www.rcm.org.uk/EasySiteWeb/GatewayLink.aspx?alId=325903].

30 Department of Health. *Health Building Note 09-02: Maternity Care Facilities*. London: DH; 2013 [www.gov.uk/government/uploads/system/uploads/attachment_data/file/147876/HBN_09-02_Final.pdf].

31 Royal College of Obstetricians and Gynaecologists. *Maternity Dashboard: Clinical Performance and Governance Score Card*. London: RCOG; 2008 [www.rcog.org.uk/files/rcog-corp/uploaded-files/GoodPractice7MaternityDashboard2008.pdf].

32 NHS Commissioning Board. *Commissioning Maternity Services: a Resource Pack to Support Clinical Commissioning Groups* [www.commissioningboard.nhs.uk/files/2012/07/comm-maternity-services.pdf].

33 Department of Health. *The Mandate. A Mandate from the Government to NHS England: April 2014 to March 2015*. London: DH; 2013 [www.gov.uk/government/uploads/system/uploads/attachment_data/file/256406/Mandate_14_15.pdf].

34 NHS Commissioning Unit. *Our NHS Care Objectives: a Draft Mandate to the NHS Commissioning Board, Annexes*. London: Department of Health; 2012 [consultations.dh.gov.uk/nhs-commissioning-unit/mandate].

35 Healthier Together (South East Midlands) [www.healthiertogethersoutheastmidlands.nhs.uk].

36 Healthier Together (South East Midlands). *Clinical Senate and Maternity Clinical Working Group Reports*. March 2013 [www.healthiertogethersoutheastmidlands.nhs.uk/modules/downloads/download.php?file_name=106].