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Subject: Maternity Services

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1. Maternity care pathway

(a) Looking at the entire care pathway, four stages can be broadly identified[1]:

1. pre-pregnancy care
2. antenatal care
3. care during labour and delivery
4. postnatal care

2. Location of birth

(a) Before 1945, the majority of births occurred in the home. By 1970, almost 90% of births took place in hospital. The 1993 report *Changing Childbirth* recommended the availability of more choice in the place of birth. The 2004 *National Service Framework for Children, Young People and Maternity Services*[2] and 2007 *Maternity Matters*[3] actively promoted midwife and home birth services[4].

(b) A commitment to choice in maternity services was more recently made in the NHS Operating Framework for 2011/12[5].

(c) Broadly speaking, the options for place of birth are fourfold[6]:

1. Home birth, supported by a midwife.
2. Freestanding Midwifery Unit (FMU), separate from an obstetric unit.

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[1] Healthcare for London, *Maternity care pathways*, http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/Maternity-services-care-pathways1.pdf

[2] Department of Health, National Service Framework for Children, Young People and Maternity Services: Maternity services, September 2004, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4089101

[3] Department of Health, *Maternity Matters*, April 2007, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_074199.pdf

[4] National Institute for Health and Clinical Excellence, *Intrapartum care*, p.48, http://www.nice.org.uk/nicemedia/live/11837/36275/36275.pdf

[5] Department of Health, The Operating Framework for the NHS in England 2011/12, p.28 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122736.pdf

[6] Healthcare Commission, *Towards better births. A review of maternity services in England*, p.31, http://www.cqc.org.uk/_db/_documents/Towards_better_births_200807221338.pdf

3. Alongside Midwifery Unit (AMU), next to, or integrated with, an obstetric unit.
4. Obstetric unit, in an acute setting, consultant-led and supported by a maternity team.

(d) Care in the first three settings is mainly provided by midwives handling low risk births.

(e) Across England as a whole, in 2008, 93% of births took place in obstetric units, 3% in alongside midwifery units, 2% in freestanding midwifery units and 2% at home. The review of maternity services carried out by the Healthcare Commission in 2008 revealed that out of 150 Trusts in England, two-thirds had no AMU or FMU. Across all the Trusts there were 181 obstetric units, 57 FMUs and 25 AMUs[7].

3. Midwifery and Consultant Staffing Levels

(a) All maternity services in the South East Coast region use the nationally recognised Birthrate Plus planning tool in assessing midwifery numbers. Trusts collect data on a large sample of births and allocate each to different categories relating to complexity and need[8].

(b) "Integral to Birthrate Plus® is the classification of case mix by categories I–V:

- Category I and II: Low-risk midwifery care: normal birth, no intervention, good birth weight and Apgar, no epidural.
- Category III: Moderate degree of intervention: instrumental delivery, induction, fetal monitoring, third-degree tear, preterm.
- Category IV: Higher-risk/higher choice or need: normal birth with epidural for pain relief, elective caesarean sections, post-delivery complications, induction and instrumental tear, preterm birth.
- Category V: Highest risk, including emergencies: emergency caesarean sections, medical or obstetric complications, multiple births, stillbirths, severe pregnancy-induced hypertension.
- Other categories: Other events reflecting additional client needs are also recognised within the Birthrate Plus® evaluation; for example, antenatal admissions to obstetric labour ward."[9]

(c) Standards for the obstetric consultant role have been set by the Royal of Obstetricians and Gynaecologists. The recommended standards for consultant presence on delivery suite units are as follows:

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[7] Healthcare Commission, *Towards better births. A review of maternity services in England*, p.31, http://www.cqc.org.uk/_db/_documents/Towards_better_births_200807221338.pdf
[8] Ibid., p.88.
[9] Royal College of Obstetricians and Gynaecologists, *Safer Childbirth*, October 2007, p.64-5, http://www.rcog.org.uk/files/rcog-corp/uploaded-files/WPRSaferChildbirthReport2007.pdf

- "Units delivering 2500–4000 births/year should have a 60-hour presence, those delivering 4000–5000 births/year a 98-hour presence; those delivering over 5000 births/year should achieve a 168-hour presence at varying times. Those units delivering less than 2500 births would need to reach a local decision based on availability, financial resource and other clinical demands"[10]

4. PbR and maternity[11]

(a) Commissioning responsibility for maternity services currently rests with Primary Care Trusts. In the future, responsibility is set to rest with Clinical Commissioning Groups, supported by the NHS Commissioning Board to enable the improvement of quality and extensions of choice, and may involve the proposed clinical senates and networks.[12] The NHS Commission Board will commission specialist neonatal services directly.[13]

(b) Under PbR, maternity services are divided into three discrete elements:

1. birth
2. antenatal care
3. postnatal care

(c) The national tariff applies whether the birth occurs in an obstetric unit, AMU or FMU, though the Market Forces Factor (MFF) also applies. The MFF is used to reflect the fact that providing services in some areas of the country is more expensive than in others due to staff costs, land and so on.

(d) Home births have the same tariff as a normal birth without CC (see below).

(e) Routine antenatal care (attendance and scans) is paid for through the outpatient tariff, regardless of location. The exception is antenatal care provided in the woman's own home. Postnatal care is similar, with a tariff for care in a clinical setting but not where planned postnatal care is delivered in the mother's home.

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[10] Royal College of Obstetricians and Gynaecologists, *The Future Workforce in Obstetrics and Gynaecology*, June 2009, p.47, http://www.rcog.org.uk/files/rcog-corp/uploaded-files/RCOGFutureWorkforceFull.pdf

[11] Where otherwise indicated, information in this section derived from: Department of Health, *Maternity Services and Payment by Results*, July 2010, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_118002.pdf

[12] Department of Health, *Government response to the NHS Future Forum* Report, June 2011, p.22-23, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127719.pdf

[13] Department of Health, *Liberating the NHS: Legislative Framework and Next* Steps, p.80, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122707.pdf

(f) Community midwifery can be funded through PbR where the functionality exists, or through other arrangements such as the block contract.

(g) There is no set price for parent education or antenatal classes. There is no tariff currently for health visiting, but currency options for the Healthy Child Programme have been published[14].

(h) Maternity service tariffs are currently based on average reference costs, but maternity is one area where best practice tariffs are being considered[15].

(i) Table showing birth episode tariff prices:

Description	2010/11 prices (£)	Long stay trim point	Excess bed day payment (3)
Normal delivery 19 years and over with CC	2,101	9	367
Normal delivery 19 years and over without CC	1,324	4	384
Normal delivery 18 years and under with CC	2,160	9	342
Normal delivery 18 years and under without CC	1,393	4	412
Assisted delivery with CC	2,612	7	379
Assisted delivery without CC	1,970	6	373
Caesarean section 19 years and over	2,539	5	378
Caesarean section 18 years and under	2,864	7	390
Caesarean section with complications	3,311	8	385

Key:

1. Trim point = the period the payment covers. the excess bed day payment is what the commissioner pays for each extra day the mother needs to stay in hospital.
2. CC = complications and co-morbidities.

[14] Department of Health, *Currency options for the Healthy Child Programme*, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113833

[15] Department of Health, *Government response to the NHS Future Forum* Report, June 2011, p.26, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127719.pdf