



National Audit Office

Report

by the Comptroller
and Auditor General

Department of Health

Maternity services in England

Key facts

694,241

live births in England
in 2012

£2.6bn

cost of NHS maternity
care in 2012-13

1 in 133

babies are stillborn or die
within seven days of birth

- 87 per cent** of women gave birth in obstetric units in hospital in 2012
- 84 per cent** of women reported that the care they received during labour and birth was excellent or very good in 2010, compared with 75 per cent in 2007
- £482 million** cost of maternity clinical negligence cover in 2012-13
- 12 per cent** increase in the number of midwives since 2007
- 2,300** shortfall in midwives in 2012, calculated using a widely recognised benchmark of 29.5 births per midwife per year
- 152** midwifery-led units in June 2013, an increase from 87 in April 2007
- 79 per cent** of women are within a 30-minute drive of both an obstetric unit and a midwifery-led unit, compared with 59 per cent in 2007
- 28 per cent** of maternity units reported that they closed to admissions for half a day or more between April and September 2012

Summary

Overview of maternity services

1 Having a baby is the most common reason for admission to hospital in England. In 2012, there were 694,241 live births. Maternity is a unique area of the NHS as the services support predominantly healthy people through a natural, but very important, life event that does not always require doctor-led intervention.

2 Maternity care cost the NHS around £2.6 billion in 2012-13, equivalent to some £3,700 per birth. The total cost represents around 2.8 per cent of health spending, about the same proportion as a decade ago.

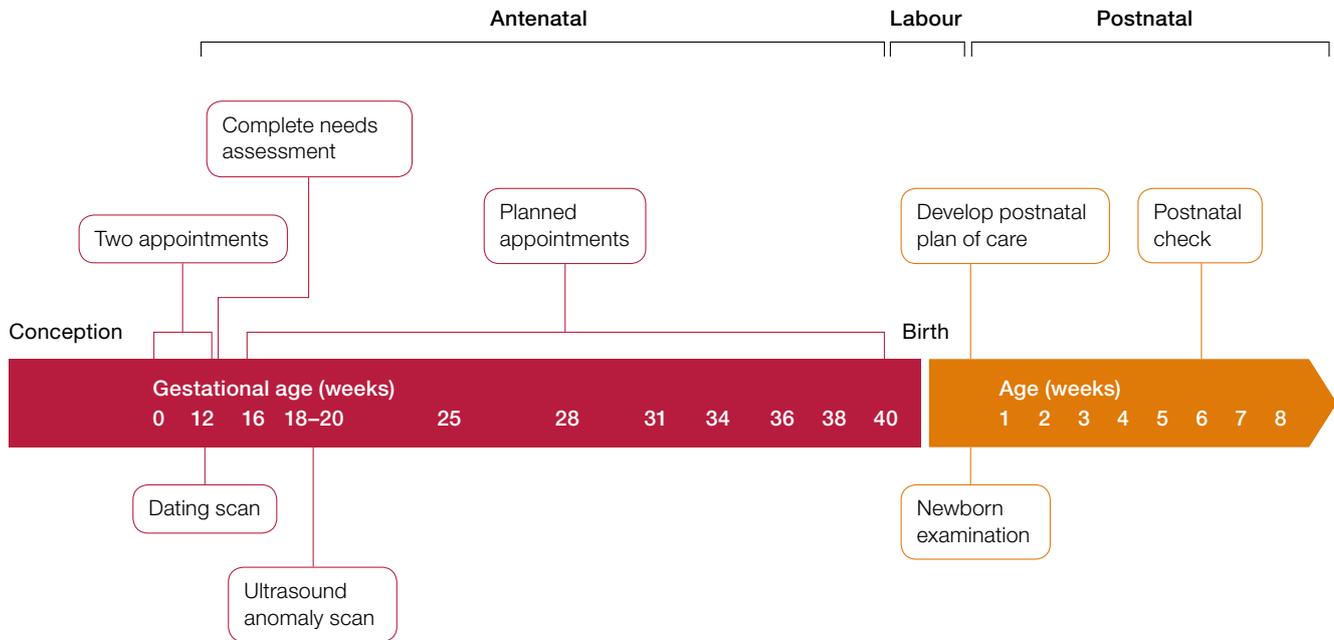
3 The number of births has increased by almost a quarter in the last decade and is currently at its highest level for 40 years, placing increasing demands on NHS maternity services. Over recent years there has also been an increase in the proportion of 'complex' births, such as multiple births (for example twins) and those involving women over 40 or women with obesity or pre-existing medical conditions. These complexities increase the risks of childbirth, meaning care often requires greater clinical involvement.

4 Pregnant women receive care from a range of health professionals. All are cared for by midwives, who act as the coordinating professional for every birth. For women at higher risk or undergoing medical procedures, care is also provided by doctors led by consultant obstetricians.

5 This report examines the performance and management of maternity services. We set out our audit approach in Appendix One and our evidence base in Appendix Two. The report covers the care provided before birth (antenatal), during labour and birth, and after birth (postnatal) (**Figure 1** overleaf).

6 We made our assessment against a variety of indicators. We focused on the Department of Health's (the Department's) objectives for maternity care, although these are expressed in broad terms with few quantified measures of performance. We therefore used comparisons and trends to evaluate performance. In addition, we drew on other measures and benchmarks, including the staffing levels endorsed by the Royal Colleges.

Figure 1
Maternity care pathway



Note

1 The diagram represents a simplified summary of the actual pathway and includes only key, indicative elements.

Source: Adapted from NHS England

Organisations involved in delivering maternity services

7 The Department is ultimately responsible for securing value for money for spending on maternity services. The Department’s Permanent Secretary, as the Accounting Officer, is responsible for the proper and effective use of resources voted by Parliament for health services. With reduced departmental involvement in operational matters, the Accounting Officer relies on a system of assurance around the commissioning, provision and regulation of healthcare.

8 The structures for commissioning healthcare, including maternity services, changed from 1 April 2013 as part of the reforms introduced under the Health and Social Care Act 2012:

- Until 31 March 2013, 151 primary care trusts were responsible for commissioning maternity services, overseen by ten strategic health authorities on behalf of the Department.

- Responsibility for commissioning maternity services now rests with 211 clinical commissioning groups, overseen and held to account by NHS England. NHS England is an arm's-length body of the Department but is operationally independent. It is accountable to the Department for the outcomes achieved by the NHS. Under the old and the new structures, funding for maternity services has not been ring-fenced. For 2013-14, the Department has granted NHS England £95.6 billion, 68 per cent of which has been passed on to clinical commissioning groups. Each clinical commissioning group has an 'accountable officer' who is responsible for the stewardship of resources and the performance achieved.
- 9** Clinical commissioning groups commission maternity services from local providers – NHS trusts and NHS foundation trusts (trusts). In 2012, most women (87 per cent) gave birth in obstetric units in hospitals, with 9 per cent in 'alongside midwifery units' (situated on the same site as an obstetric unit), 2 per cent in freestanding midwifery units, and 2 per cent at home.¹
- 10** Providers are regulated by the Care Quality Commission. The Commission assesses whether services meet essential standards of quality and safety. Individual healthcare professionals are regulated by the Nursing and Midwifery Council and the General Medical Council.

The Department's objectives for maternity care

- 11** The Department's main aims for maternity services are:
- to improve performance against quality and safety indicators;
 - for mothers to report a good experience;
 - to encourage normality in births by reducing unnecessary interventions;
 - to promote public health with a focus on reducing inequalities;² and
 - to improve diagnosis and services for women with pregnancy-related mental health problems.
- 12** The Department outlined its strategy for maternity services in 2007 in *Maternity Matters*.³ It intended to achieve its aims by: offering choice in where and how women have their baby; providing continuity of care; and ensuring an integrated service through networks and agreed care pathways.

¹ A very small number of women receive exclusively private care (0.4 per cent of births are in private hospitals or maternity units). There are also around 150 independent midwives (less than 1 per cent of the NHS midwifery workforce) who work outside the NHS in a self-employed capacity and provide some or all of a woman's care during pregnancy.

² While reducing inequalities is a specific focus of the public health aim, as a general aim of the NHS, reducing inequalities is also inherent in the other maternity aims.

³ Department of Health, *Maternity Matters: Choice, access and continuity of care in a safe service*, April 2007.

Key findings

Performance of maternity services

Women's overall experience

13 Women's experiences of maternity care are positive. In 2010, 84 per cent of women reported that the care they received during labour and birth was excellent or very good, compared with 76 per cent for the care received during pregnancy and 67 per cent for the care received after the birth. Between 2007 and 2010 there was similar improvement across all three parts of the care pathway. There were, however, significant inequalities in reported satisfaction between white women and black and minority ethnic women (paragraphs 1.4 and 1.5).

Providing safe care and reducing unnecessary interventions

14 Outcomes in maternity care are good for the vast majority of women and babies but, when things go wrong, the consequences can be very serious. In 2011, 1 in 133 babies were stillborn or died within seven days of birth. This mortality rate has fallen, but comparisons with the other UK nations suggest there may be scope for further improvement. There are wide unexplained variations in the performance of individual trusts in relation to complication rates and medical intervention rates, even after adjusting for maternal characteristics and clinical risk factors. This variation may be partly due to differences in aspects of women's underlying health not included in the data and inconsistencies in the coding of the data (paragraphs 1.7 to 1.12, 1.19 and 1.20).

15 Maternity care accounted for a third of the clinical negligence bill in 2012-13, which highlights the importance of improving safety. As in other parts of the NHS, litigation in maternity care is rising – the number of claims increased by 80 per cent in the five years to 2012-13. The cost to the NHS for litigation cover against maternity claims totalled £482 million in 2012-13. Nearly a fifth of spending on maternity services is for clinical negligence cover (paragraphs 1.14 to 1.17).

16 The level of consultant presence on labour wards has improved substantially, but some trusts are failing to meet recommended levels. At September 2012, 73 per cent of obstetric units provided 60 hours or more of consultant presence per week (equivalent to at least 8am to 8pm, Monday to Friday), compared with just 8 per cent of units in March 2007. However, more than half of the units were not meeting the levels of consultant presence recommended by the Royal College of Obstetricians and Gynaecologists (paragraph 1.22).

Continuity of care

17 Women's experiences relating to continuity of care are mixed. In 2010, 92 per cent of women reported having a named midwife they could contact during pregnancy. However, 22 per cent stated that they had been left alone, during or shortly after birth, at a time when it worried them. In 2013, 78 per cent of maternity units reported that they provided one-to-one care for at least 90 per cent of women (paragraphs 1.25 and 1.26).

18 The number of midwives has increased but the NHS is not meeting a widely recognised benchmark for midwife staffing levels. The availability of sufficient midwives is a key factor in providing continuity of care. Since 2007, midwife numbers have increased by some 12 per cent compared with a 6 per cent increase in the number of births. Nationally, there were 21,132 full-time equivalent midwives, on average, in 2012. This equated to 32.8 births per midwife. Meeting the national benchmark suggested by an established workforce planning tool (29.5 births per midwife) would have required around 2,300 extra midwives nationally. Even after excluding the highest and lowest 10 per cent of trusts, the birth-to-midwife ratio in individual trusts in 2011-12 ranged from 26:1 to 39:1 (paragraphs 1.30 to 1.33).

19 The government has commissioned more places to study midwifery, but it is unclear whether these will be sufficient to meet future demand for maternity care. The pressure on midwife numbers will increase in the coming years, in part because an increasing number are nearing retirement age. Around 2,500 student midwife places were commissioned in each of the four years to 2012-13, but a growing proportion of students are failing to complete their courses. A 2013 report commissioned by the Department suggests that changes in demand for maternity care are likely to be met by the expected growth in midwife numbers to 2016. However, this projection was based on broad assumptions and did not consider, for instance, what staffing levels would be needed to meet the Department's policy objectives (paragraphs 1.35 to 1.37).

Choice

20 The number of midwifery-led units has increased, and more women now live within a 30-minute drive of both an obstetric unit and a midwifery-led unit. Seventy-nine per cent of women were within 30 minutes of both types of unit in 2013, compared with 59 per cent in 2007. In 2010, 84 per cent of women reported they had a choice of where to have their baby, although this varied between regions. Combining these findings suggests that the NHS has not fully achieved the Department's aspiration that all women should be able to choose where they give birth, depending on their circumstances (paragraphs 1.40 to 1.45).

21 Where the demand for maternity services might outstrip capacity, some trusts are restricting access through pre-emptive caps on numbers or reactive short-term closures in order to safeguard the quality and safety of care. Twenty-eight per cent of units reported that they closed for half a day or more between April and September 2012. Of these units, 11 per cent (eight units) had been closed for the equivalent of a fortnight or more. The main reason for closing was a lack of either physical capacity or midwives. Caps and closures are designed to manage demand and safeguard the quality and safety of care. However, they limit choice and also indicate a service that can, at times, be overstretched (paragraphs 1.46 to 1.48).

Managing maternity services

22 The Department did not fully consider the implications of delivering the ambitions set out in its strategy for maternity services. The Department has failed to demonstrate that it satisfactorily considered the achievability and affordability of implementing the strategy. There are potential tensions between different elements of the strategy, such as between choice and quality-and-safety considerations. Reconciling these different elements is challenging for NHS bodies. The Department intended that strategic health authorities and primary care trusts would monitor maternity services through the established NHS performance management arrangements. The Department has not regularly or comprehensively monitored national progress against the strategy (paragraphs 2.2 to 2.7).

23 It is unclear how local commissioners are monitoring the performance of the providers of maternity services and holding them to account. Twenty-eight per cent of trusts did not have a written service specification with their lead commissioner in 2012-13. In addition, 31 per cent of trusts did not expect to have a specification in place with their clinical commissioning group by the time the groups assumed responsibility for commissioning in April 2013 (paragraph 2.15).

24 There is scope for more local commissioners and providers to work together in networks to meet local needs. Maternity networks can support the effective planning and delivery of a full range of services. The coverage of networks has increased since 2007, although around a quarter of trusts are not part of one. In addition, less than 40 per cent of trusts belong to a network with a paid coordinator, which may limit networks' effectiveness (paragraph 2.18).

25 There is substantial variation between trusts in the costs of delivering maternity care. In 2011-12, the reported costs for individual procedures varied considerably. For example, the cost of a normal, uncomplicated delivery ranged from £620 to £1,535, even after excluding the highest and lowest 10 per cent of trusts. Totalling the costs of all maternity-related procedures also indicates wide variation between trusts. We identified some instances where commissioners were providing funding to support services that would not otherwise be financially viable. It is hard to see that supporting unviable services in this way will be sustainable as the NHS seeks to make efficiency savings during a period of greater financial constraint (paragraphs 2.12, 2.13 and 2.20 to 2.22).

26 Efficiency, in terms of lengths of stay, has improved in recent years but local bed occupancy levels vary significantly, and some small maternity units are unlikely to be viable in the long-term unless occupancy is better managed.

Nationally, the proportion of women staying for more than two days after giving birth fell from 23 per cent in 2007-08 to 18 per cent in 2011-12. However, there is substantial variation in lengths of stay and bed occupancy at unit-level. Ten per cent of units with at least four beds reported that they were empty at midday on a sample day in February 2013. All of these units had fewer than ten beds. Unless occupancy rates are better managed, trusts will face difficult decisions about whether they can afford to keep units open (paragraphs 2.25, 2.26 and 2.28).

Conclusion on value for money

27 For most women, NHS maternity services provide good outcomes and positive experiences. Since 2007 there have been improvements in maternity care, with more midwifery-led units, greater consultant presence, and progress against the government's commitment to increase midwife numbers.

28 However, the Department's implementation of maternity services has not matched its ambition: the strategy's objectives are expressed in broad terms which leaves them open to interpretation and makes performance difficult to measure. The Department has not monitored progress against the strategy and has limited assurance about value for money. When we investigated outcomes across the NHS, we found significant and unexplained local variation in performance against indicators of quality and safety, cost, and efficiency. Together these factors show there is substantial scope for improvement and, on this basis, we conclude that the Department has not achieved value for money for its spending on maternity services.

Recommendations

- a The Department and NHS England should develop a framework to gain assurance about the performance of maternity services.** Without comprehensive data on key outcomes and activity, the Department has only limited assurance on progress and value for money. There is also a risk that, at local level, the NHS focuses disproportionately on performance against the limited measures that are available or overlooks areas where data are poor. The new maternity dataset, in conjunction with information held by other stakeholders, provides the opportunity to better monitor performance.
- b The Department should assess the affordability of implementing the various commitments in its strategy for maternity services.** The Department did not satisfactorily consider the achievability, affordability and local implications of implementing its 2007 strategy, and there are concerns that the available resources are not sufficient to meet all the objectives in full.

- c NHS England and Monitor should ensure that the payment framework for maternity services is fair and incentivises cost-effective behaviour.** Many commissioners pay for services outside the payment by results framework and the reported costs of providers vary substantially. NHS England and Monitor should review the recently introduced pathway tariffs to check that the tariffs are set at the correct level and are working as intended.
- d NHS England should support the NHS to understand how to implement the Department's choice commitment cost-effectively.** Against a backdrop of large variations in bed occupancy, there is limited understanding of the factors that affect demand for different settings of maternity care. NHS England should oversee research to understand what affects women's choices, such as travel distances, demographic factors and the availability of specialist services. Such research would help the NHS bodies within each local area to manage occupancy better.
- e Clinical commissioning groups and trusts should agree long-term, sustainable plans for the distribution and capacity of maternity services in their locality.** The plans should be agreed regionally and involve other relevant bodies, including NHS England, and representatives of service users. The plans should include agreements on how neighbouring trusts and maternity units will cooperate, for example through networks, and arrangements for ensuring that resources are used efficiently if expected occupancy levels are not met.
- f All clinical commissioning groups should have agreed service specifications with their trust.** These should include how local maternity care is expected to contribute to achieving the Department's objectives, including those that have historically received less attention, such as mental health and reducing inequalities. In developing the service specifications, local NHS bodies should compare local performance and resources against suitable benchmarks and investigate significant variations.