

# Innovative, integrated and in the interest of families: the Maternity Network approach



NCT welcomes the idea of maternity networks as proposed in the NHS White Paper 'Equity and Excellence: Liberating the NHS' and earlier interim policy papers from government. NCT has drawn on the experience of our 100,000+ members and the one-million-plus parents with whom we are in contact each year to find out what parents - and those who work closely with them – would like to see in the structure and functioning of the new system. Below we set out some questions and suggested answers that reflect our views on the way that planning might go forward.

### **What are maternity networks?**

They are providers of maternity services.

### **Why are they needed?**

The users of maternity services are fundamentally different from most health service patients in a number of ways:

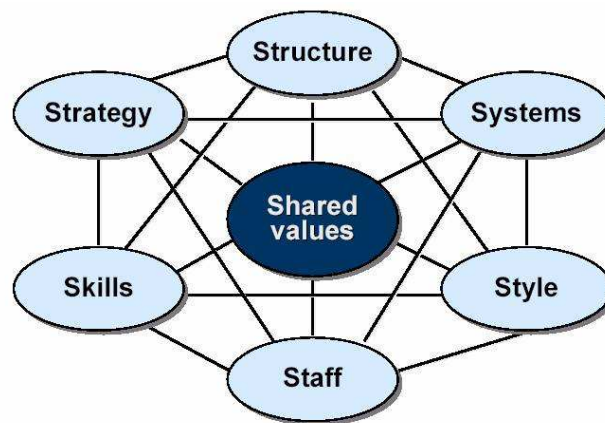
- Most childbearing women are not ill and generally will not need medical attention: however women do need a plan of care, support, information and education tailored to their needs as well as the availability of back-up or additional care from a multidisciplinary team
- The episode of maternity care starts with one woman and usually ends with a mother and (at least one) baby; the mother's partner is also an extremely important person to be engaged in the care during pregnancy and enabled to provide a supporting presence for her through labour, birth and the immediate postnatal period
- The timing of women going into labour and giving birth is unpredictable: immediate care and supporting services must be available at all times and accessible in a variety of locations according to the woman's choice and need
- Problems arising that affect the safety and well-being of mother or baby may be of an obstetric or other clinical nature but are equally likely to be rooted in social or psychological issues such as poverty, inadequate housing, unconfirmed residence status, poor diet and lifestyle, unstable mental health, drug or alcohol misuse and past or present abusive relationships so need a holistic and often community based service.

Despite the evidence that normal birth is the safer option for most women, the current systems create a service that drives up rates of intervention, and the associated cost increases, without improvement in maternal or neonatal outcomes. The current high-fixed-costs system leads to income-maximising behaviour, which means raising the volume and complexity of activity within a service which then operates at the brink of capacity, for financial reasons. This increases risk and damages the experience for users of the service.

Because of the above factors, the form and functioning of maternity services and the associated infrastructure require an approach specific to these needs. Along with clinical staff and their expertise and the quality assurance systems for clinical work, it is crucial to have catering, cleaning, transport and security services that are appropriate to maternity care; in addition, ensuring that

women in labour, who choose to give birth in a maternity unit, have a good birth environment may make different demands on the supply and maintenance of fixtures and fittings in each maternity unit, e.g. birth pools, adjustable light and heat, accommodation for partners.

Reference to the McKinsey 7S framework (Figure 1) confirms that in the past there has been one-sided change in the NHS that was structural only. In our model, although a structural change is part of the proposal, there needs to be a root-and-branch change in the systems used. For example, the service needs to be created as a high-variable-cost system rather than a high-fixed-cost one (in terms of cost structure, therefore, less like an airline or a hotel, more like an internet flower delivery service). There needs to be a re-thinking of the style, skills, strategy and staff (particularly the way they are employed and deployed) so that the organisation commits to shared values which are about enabling families to have a safe and fulfilling start to parenthood - not about equating a successful outcome mainly with efficiency of service.



**Figure 1: The 7-S framework of McKinsey, a value based management (VBM) model that describes how to holistically and effectively organise a company (image courtesy of [www.VectorStudy.com](http://www.VectorStudy.com))**

The Government's White Paper 'Equity and Excellence: Liberating the NHS' states that maternity services will be commissioned by the new NHS Commissioning Board. This offers an excellent opportunity to create an innovative, integrated and flexible structure for a service that will ensure good health outcomes while addressing the key requirements of quality and accountability along with choice and continuity for woman and their families.

### **How would maternity networks be structured?**

The Network Board would seek to be inclusive, drawing on a diverse range of individuals, and consist as a minimum of:

- Non executive chair
- Non executive directors
- Chief Executive Officer

- Director of Obstetrics (responsible for obstetric standards and continuing professional development)
- Director of Midwifery (responsible for midwifery standards and continuing professional development)
- Finance Director
- Director of Operations (responsible for the running of the services including the staff that deliver them and the contracts with other providers of clinical services)
- Director of Facilities (responsible for the premises and services (IT, HR, cleaning etc) to support the functioning of the Maternity Network)
- Contracts Director (responsible for negotiating and monitoring contracts with commissioning bodies)

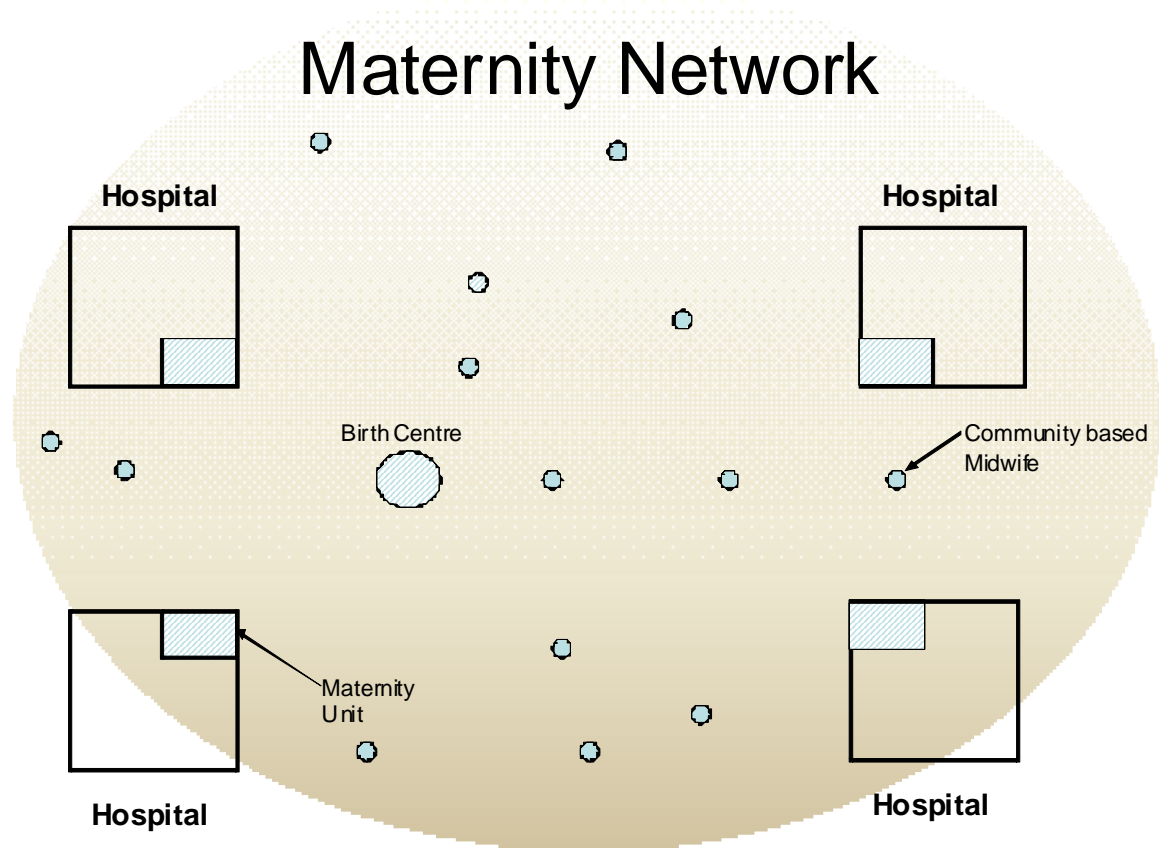
There would be significant user input in the form of a well-supported user advisory group or built upon the current Maternity Service Liaison Committee model.

The Maternity Network would be a small organisation in terms of number of people directly employed. There would perhaps be a few hundred employed staff (mainly midwives) to cover three or four maternity units, and all the community-based staff. However there would be a variable-size contracted or self-employed resource. It would be a lower-fixed-cost, higher-variable-cost organisation than an NHS trust. It would, by the nature of the financial structure, focus on managing its margins rather than covering a fixed-cost base by maximising income. It would therefore operate in a dynamic fashion to enable it to be responsive to need and to changing social trends such as local and national birth rates.

It would:

- employ midwives and ancillary maternity staff and /or use self-employed independent midwives as individuals or working together via the social enterprise organisation Independent Midwives UK (IM-UK)
- employ obstetricians or more probably 'lease in' obstetric time
- lease in health visitor time or possibly employ health visitors or have some on self employment contracts
- lease maternity floor space from trusts, GP practices, children's centres or other community-based facilities and buy in the necessary support such as HR and finance
- buy time in theatre, and from neonatal care, intensive and special care, or other specialist input for mother or baby as needed
- pay for ambulance transfer - between units, between home and hospital if needed and to other facilities outside the Maternity Network such as a Mental Health Trust
- probably be able to buy in social services, services from other agencies and bodies such as NHS direct, social enterprises and voluntary agency support where needed.

Maternity Networks would work with local authorities and the health and wellbeing boards, the public health function, with neonatal networks and with GP consortia.



**Figure 2: Facilities and staff leased or employed or on self employed contracts working for the network**

### What systems would Maternity Networks use?

The Maternity Network would be contracted or accredited to provide services to those expecting a baby, and services relevant to that maternity episode, for up to a year after the birth. This is important to ensure the Maternity Network bears the cost of post-natal complications and therefore is incentivised to reduce them. Any current or planned contracting bodies could be used, for example:

- The NHS Commissioning Board
- GP commissioners

Or

- Women and their partners choosing a provider themselves, using a system such as that in New Zealand which enables choice of maternity professional who is then paid by the state.

A number of models could be used

- Accredited provider (for example, an NHS maternity unit or birth centre, a GP practice with attached midwives or an independent midwifery group practice) which receives payment when a woman chooses them as the provider. This has similar aspects to a private sector model or the model proposed by IM-UK. Each woman attracts a fee to cover their total care. (NB women in categories who are likely to be more costly to the Maternity Network could attract a higher payment – but the Network takes the risk and if they handle care well they will be able to keep costs down )
- Commissioned service: a contract between the network and the commissioning body for provision of services to a given number of women.

The former approach is both more innovative and more user-sensitive; it is more likely to generate a service based around community-located care and normal birth; and it will meet users' needs, as well as putting safety first, because it puts the focus on demand rather than supply.

The accreditation or contract and agreement to transfer payment would be based on outcome measures, and the Maternity Network chosen as an accredited or contracted provider based on safety, effectiveness and the experience of the users.

The Maternity Networks do not 'own a patch' nor are they guaranteed to care for all the women who live within the geographical area. Other Maternity Networks can set up services nearby, as can independent midwives, any or all of whom may be chosen by women.

### ***Outcome measures proposed***

#### Safety

- Maternal and neonatal survival
- Maternal mental and physical health outcomes would need to be measured at a number of stages through pregnancy and for at least one year postnatally. Measurements can be based upon data already collected to ensure that progress is charted in a meaningful way, and indicators should be selected to relate directly to quality of care.

#### Effectiveness

- Infant physical and mental health (to include e.g. emotional well-being, attachment, cognitive development)
- Success at meeting known indicators of long-term infant health (e.g. normal processes at birth, breastfeeding rates, correct use of formula, low depression rates in parents especially mothers, low relationship breakdown rates in the first year after birth, low reported feelings of isolation)
- Families with young babies are functioning well, aware of and addressing improved lifestyle options (e.g. smoking cessation, reduced

alcohol/drug use, more exercise), make use of local networks and know where to seek help from professional services.

#### User experience

- Reported maternal and paternal satisfaction with the service at a series of time-frames post birth – data derived in diverse ways to ensure the experience of a wide group of families is captured
- Analysis of complaints from users should reflect reduced dissatisfaction and/or firm plans are in place to improve aspects that have been the subject of previous complaints.

Pregnancy is a unique opportunity to work with and involve women and their partners from all sections of society in their own health and well being and that of their child. The right support for women and their partners through pregnancy and at the start of the baby's life can have a beneficial effect on a number of medium and long-term health outcomes and can also start to reduce the negative impact of deprivation.

#### ***Payment and funding***

The Maternity Network would be paid a fee for each woman when she confirms her pregnancy to a midwife (or one year after the birth when satisfactory outcomes have been confirmed), i.e. the care for each pregnant woman would attract a payment based somewhere between the overall average cost per birth and the cost per birth *in the most efficiently run service*.

The price paid per birth would not be based on the activity carried out. Instead, the care for women in certain categories - defined on evidence-based criteria - who are likely to need more expensive maternity care because of an increased likelihood of complexity, would attract a higher price. For example, women who are very young, or have concomitant medical or other complications likely to affect birth outcome or maternal or infant health, would receive care that attracts a higher fee.

This means that it is strongly in the interests of the Maternity Network to make sure women have the care that will result in the lowest rates of medical intervention in birth but compatible with the best safety outcomes. The system would financially incentivise simplicity and prevention and would penalise failure to run a safe service as the Network will have to deal with the costs of poor outcomes.

In order to give Maternity Networks control and the ability to enhance their own performance, they would be responsible for assessment, and management would rest with the Maternity Network. They would however not be able to refuse to take on a particular case; this would avoid the practice of 'cherry-picking' the low cost - and therefore profitable - simple cases. They would have the freedom to manage their services to reduce costs – or re-invest in other services - by increasing the number of normal births taking place, promoting babies being breastfed and running the services efficiently.

## ***Clinical negligence and litigation***

It is acknowledged that the specialty of obstetrics currently represents a large proportion of the value of claims made to the NHS Litigation Authority. (Sadly, although claims are rare, there are still occasions when a baby is born with brain damage that may be associated with sub-optimal care at birth and the award may be at a level of £5-6 million). NCT would suggest that maternity networks would apply in their own right for cover from the Clinical Negligence Scheme for Trusts (CNST), using the NHS Litigation Authority's 'CNST Maternity Clinical Risk Management Standards'. Levels of payment would be dependent, as they currently are, upon assessment of policy, practice and performance.

CNST currently recognises the need to have systems in place to ensure interventions are carried out safely; however, for maternity, CNST would be urged to acknowledge the benefits of *not* intervening where the evidence supports this, and would also recognise the importance of building a system that averts the need for intervention arising in the first place.

## ***Choice for woman and families***

Each woman – with her partner - would be free to choose where she decides to have her care. Her choice, backed by finance that follows her route through the episode of care, will reinforce the *no decision about me without me* philosophy. Information on comparative services will be made available to third parties so they can be published to ensure women and their partners have the information they need to make their choices.

## ***User involvement***

Users of the services would be engaged from the beginning in the design, monitoring, audit and evaluation of the network services, as well as being encouraged to respond to satisfaction surveys and other input. Mechanisms for involvement, such as the current maternity services liaison committees (MSLCs), would continue and be supported, along with other local liaison groups or possibly a user advisory group.

## **What strategy would they adopt?**

Maternity Networks would be liberated to choose their own strategy designed to meet or exceed the standards set by the outcome measures suggested above. They would be expected to follow evidence-based policies and adopt NICE guidelines. They would be inspected by the Care Quality Commission and regulated by Monitor. They would be expected to operate in such a way that their users can be transferred seamlessly into other areas of care, should that be needed; when the user is also a patient of clinical services for other health reasons, shared care with that trust will be possible.

Data generated by the Maternity Network would be publicly available in an easy to understand form. Women would carry their own notes as is the case now for maternity. Health Watch England and the Maternity Service Liaison Committee would champion the cause of users of the service.

Successful Maternity Networks would have the opportunity to take on more maternity units covering a greater part of the population. They would do this by being able to offer better lease terms to the trusts from which they lease services because of their improved costs and efficiency.

Maternity Networks that are badly run would shrink because they would not be able to cover their lease costs and their services would be taken over by the more effective networks. There would be no 'bail-out' and no need for bail-outs as leases could easily be transferred to more successful Maternity Networks.

Poor clinical performance would result in greater costs in paying for high caesarean section rates, and special and intensive care. In time, this would make poorly performing networks financially non-viable but, before then, public opinion or commissioner pressure would have compelled them to relinquish the maternity units they lease and so lose their services to others; in this way, poor performance would be penalised without damaging the quality of care for users.

The Maternity Network would also be free to develop its own shared values, within the ethos of the NHS but particular to the needs of maternity, to employ or lease in the staff it needed on terms they determine. The skills of the staff could be further developed using integrated or multidisciplinary training operating with their own particular style to meet the needs of parents-to-be and new parents.

### **What would be the positive and negative effects?**

#### ***Negative effects***

<b>Current system</b>
Service for healthy women managed like a service for patients
Financial disincentive to follow evidence-based policy and practice
Incentive to focus service in few large maternity units which are not liked by users and lead to high midwifery turnover rates
Obstetricians do not have the opportunity to see enough complex cases unless the units are every large.
Poor performance does not result automatically in loss of referrals
High bureaucracy costs
Insufficiently responsive to users
Poor outcomes in neonatal mortality and morbidity; psychological trauma for mother
Top down targets

<b>Maternity Networks</b>
Requires minor structural change
Requires expertise in running leased and other contracted service providers

***Positive effects***

<b>Current system</b>
The way we do things now requires no change

<b>Maternity Networks</b>
Incentivises effective practice in line with evidence
Outcome-based measures easier to introduce
Focus on maternity likely to lead to expertise in a service that is for healthy women
Allows poor services which are not effective to be replaced without a gap in service provision for users
Gives maternity clinicians a lead role in maternity
Can be operated with a variety of commissioning structures.
Facilitates greater openness and accountability
Reduces bureaucracy
Will work with the proposals in the 'Liberating the NHS' white paper
Supports the use of other contracted services from non-traditional NHS providers

Above we have set out proposals based upon the extensive experience of NCT's work and contact with parents over years of increasing involvement with maternal health policy, systems and services. We whole-heartedly support the NHS White Paper's aims to focus on good outcomes for users of the service, to promote involvement and choice for patients and carers, and to make commissioning and provision of care effective and efficient. We believe our recommendations will fulfil these aims. They will provide a better framework for health care workers as well as relieving acute trusts of the responsibility of managing a service that is very different from their normal focus, while enabling them to continue to cover their fixed costs. In particular we believe this system will make significant improvements in the experience and outcomes for pregnant women and their partners, new parents and their babies, and all families with young children while reducing gradually the total costs of the service.

NCT has worked with government before to ensure that all aspects of maternity services are truly parent-centred, and is keen to do so again, bringing the voices of its 300,000 users and 100,000-plus supporters to strengthen the call for these innovative, dynamic and high-quality services.

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