Government Response to House of Commons Health Committee Reports

Fourth Report Session 2002–03
Provision of Maternity Services

Eighth Report Session 2002–03
Inequalities in Access to Maternity Services

and

Ninth Report Session 2002–03
Choice in Maternity Services

Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
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Government Response to the Health Select Committee's Fourth, Eighth, and Ninth Reports of Session 2002-03 on the Provision of Maternity Services, Inequalities in Access to Maternity Services and Choice in Maternity Services

INTRODUCTION

This Command Paper sets out the Government's response to the Health Select Committee's Fourth Report of Session 2002-03 on the Provision of Maternity Services; Eighth Report of Session 2002-03 Inequalities in Access to Maternity Services; Ninth Report of Session 2002-03 Choice in Maternity Services.

The Government recognises that maternity services are one of the many success stories of the NHS. Just over 600,000 babies are born in the United Kingdom each year and the NHS spends around £1 billion a year on maternity services. It represents a good investment in an area of the NHS that has grown increasingly successful over the years. Maternity services are of high quality and childbirth is safer than ever for both mothers and babies. Much of this is due to the hard work and commitment of dedicated NHS staff.

The Government is committed to maintaining and improving the quality of maternity services. We recognise that the rate of improvement can be governed by factors such as resource constraints, the speed of carrying out building projects and recruiting more midwives. Our highest priority must be to tackle inequalities in access to services and inequalities in health outcomes for women and their babies. Alongside this key focus on inequalities, we are also committed to improving and promoting choice for all women and their families in their use of maternity services.

Maternity services in England – Government Action

Children's National Service Framework (NSF)

The development of the NSF for Children, which includes maternity services, is the Department of Health's main activity in this area. The Children's NSF will be published later this year and will address many of the issues raised in the three reports.

The Children's NSF will set out a ten year strategy for improving services for children and young people including maternity services. The purpose of the maternity module of the NSF will be to set national standards of care, which will cover antenatal, birth and postnatal services. The maternity module of the NSF will look at how to make maternity services more flexible, accessible and appropriate for all women.

NICE Guidelines

To improve the safety and well being of mother and baby the Department of Health asked the National Institute for Clinical Excellence (NICE) to issue clinical guidelines on:

- Use of electronic fetal monitoring
- Induction of labour
- Anti-D prophalaxis
- Routine antenatal care

Further guidelines are being produced on:

- Use of Caesarean section
- Intra partum and post natal care

Caesarean Sections

The Government fully supports the view that women should not undergo unnecessary surgery. The decision to undergo a caesarean section should always be taken during informed discussions between the woman and the healthcare professionals responsible for providing her care.

The National Institute for Clinical Excellence (NICE) is launching their clinical caesarean section guideline on 29 April 2004. This guideline will include advice on the risks and benefits of caesarean section, the indications for caesarean section, healthcare interventions that may reduce the need for caesarean section and the care of the woman who has a caesarean section. The guidelines on caesarean section will provide clarity and guidance to clinicians on when to perform a caesarean section.

Antenatal Screening

The NHS Plan outlines a commitment to establish effective and appropriate screening programmes for women and children. This will help modernise antenatal screening programmes following advice from the UK National Screening Committee (NSC). In forming its proposals, the NSC draws on the latest research evidence and the skills of specially convened multi-disciplinary expert groups.

The current position on Group B Streptococcus is that routine screening should not be offered to all pregnant women. Ministers have asked the UK National Screening Committee (NSC) to undertake further work to assess the existing evidence on screening and treatment for GBS in pregnancy in the UK.

Inequalities in Access to Maternity Services

Minimising the effects of inequalities is an essential and vital part of maternity care. The Government welcomes the issues the Committee raised in this area. However, the Department of Health recognises that far more fundamental work than was covered in the Committee's report needs to be undertaken to alleviate the full impact of inequalities in outcomes and access. Maternity services can respond to the challenge of addressing health inequalities by identifying those women who are likely to experience inequalities of access or outcome; plan, commission and deliver care that is individual and personal for each woman and recognise that care of a pregnant woman and her family is not exclusive to the NHS. A key theme of maternity module of the Children's NSF is to reduce inequalities in health and improve access to services.

The document *Improvement, expansion and reform the next 3 years priorities and planning framework 2003-2006* published in 2002 sets out the following objectives, targets and capacity assumptions:

- To reduce inequalities in health outcomes across different groups and areas in the country. Initially the focus is on reducing the gap in infant mortality and life expectancy at birth.
- Deliver a one percentage point reduction per year in the proportion of women continuing to smoke throughout pregnancy, focusing especially on smokers from disadvantaged groups as a contribution to the national target to reduce by at least 10% the gap in mortality between "routine and manual" groups and the population as a whole by 2010, starting with children under one year.
- Improved access to services for disadvantaged groups and areas, particularly antenatal services.

Choice in maternity services

The Department of Health is committed to extending choice in maternity services for all women and not just the articulate. The Department of Health held a national consultation on how best to improve choice, responsiveness and equity in the NHS and social care. The main aim is to improve patient and user experience and build new partnerships between those who use health and social care and those who work in them. Maternity services formed a key part of this exercise.

The consultation closed on 11th November 2003 and on 9 December 2003, the government published a strategy paper "Building on the Best; Choice, Responsiveness and Equity in the NHS" which draws out and develops the main themes that emerged from the "Choice, Responsiveness and Equity" consultation. The document broadly sets out how we will make NHS services more responsive to patients, by offering more choice across the spectrum of healthcare. The findings of the Maternity Care Expert Task Group will shortly be published on the Department of Health Choice website.

The main themes in maternity care were:

- **Promoting choice in antenatal care –** the development of the Children's NSF, taking on board the results of the choice consultation will aim to increase choice and support for pregnant women.

- **Direct access to midwives –** this encourages local services to publicise contact details for midwives so that all women will know they have the option of going direct to a midwife rather than first having to contact a GP.
- **Promoting birth plans –** this encourages local services to offer all women the option of having a birth plan that is developed with the woman's midwife and updated as the pregnancy progresses to take into account any changes in a woman's choices or situation.
- **Building the capacity to offer real choice –** this highlights action taken to increase the number of midwives and encourages local services to examine their skill mix and explore the scope for using support workers. This will help to create greater capacity to provide a range of choices women want.

The Government is strongly committed to extending choice and encourages the NHS to continue to develop a culture of promoting patient choice. However choices will inevitably sometimes be limited by factors such as location – not all types of services are available near to where women and their families live and some choices are not safe or appropriate for some women and their babies.

You're Pregnant – Local Maternity Guides

The Government recognises that women and their families need appropriate and timely information to be able to make informed choices. The Department of Health worked with the organisation Dr Foster to produce 99 local maternity guides, which were published on 22 December 2003.

The aim of the guides is to improve access to services for pregnant women and to provide information on a regional basis covering the key aspects of ante-natal and post-natal care.

Each edition of *You're Pregnant* covers eight maternity units and will enable women and their families to identify what services are available in their area, and allow comparison between different types of maternity units. The guides enable women to compare local services and encourage them to think about the sorts of services they and their families would like to use.

You're Pregnant includes celebrity and real life stories as well as important health advice. It is available to all pregnant women free of charge and will be offered to them by their midwife or GP.

The Department of Health is currently working on a research proposal to examine and analyse the impact of You're Pregnant in promoting choice and access to a variety of services. The findings will feed into future editions of You're Pregnant.

You're Pregnant is a useful addition to the information provided in The Pregnancy Book and Birth to Five which are also given free to mothers.

Midwife Recruitment

Recruitment, Retention and Return Initiatives

The Government recognises that some areas have difficulties in attracting and retaining midwives and this may have an impact on the choices offered to the woman and her family.

The Government is implementing a range of measures to recruit more midwives. These include improving pay and conditions, encouraging the NHS to become a better, more flexible and diverse employer, increasing training, investing in childcare and continuing professional development, attracting back returners and running national and international recruitment campaigns.

Figures published recently by the Nursing and Midwifery Council (NMC) show a decrease in the number of midwives intending to practise. This is not consistent with NHS employment data which shows that there are 700 more midwives working in the NHS today than there were in 1997, an increase from 22,380 to 23,080. The Department of Health is working with the NMC and Local Supervisory Authorities to improve data collection and to seek consistency within the statistics published by the Department of Health and the NMC.

Since 1997 the number of students entering midwifery has increased from 1652 in 1996/97 to 2122 in 2002/3.

Recruitment Initiatives

A range of recruitment, retention and returner (R, R&R) initiatives are in place to help facilitate the NHS meet the challenging targets set out in the *NHS Plan and Delivering the NHS Plan*. The NHS is striving to be an employer of choice and is in the process of developing and implementing modern recruitment practices. The Government is committed to increasing the numbers of midwives working in the NHS in order to expand service provision. A Six Point Action Plan, agreed by key commissioners and deliverers of maternity services, will be rolled out over the next 12 – 18 months.

The Government will increase midwife numbers by:

- increasing training places
- promoting careers in the NHS through the NHS Careers service
- running national and local recruitment campaigns
- attracting former staff back to the service
- running competitions in secondary schools to promote NHS Careers
- encouraging work placements for the unemployed through the New Deal
- recruiting internationally
- increasing further the number of training commissions and encourage flexible training

- improving retention by continuing to make the NHS a better employer
- offering flexible retirement schemes and flexible employment opportunities
- implementing a strategy to provide good quality, accessible and affordable childcare
- improving diversity and tackling discrimination and harassment.

The Department of Health advocates local decision making in designing appropriate, effective services that fit in with the ethos of woman-centred care. It is inevitable that the requirements of women will vary in different parts of the country and this is why it is so important that decisions about service provision are made at a local level.

Investment and resources in maternity services

The total expenditure on maternity functions by the NHS is approximately £1bn per year.

£100m capital allocation to improve facilities in maternity units

In 2001 the Secretary of State for Health, Alan Milburn announced a £100m capital allocation for improving facilities in maternity units to be spent over two years. The money was allocated to improve the quality of maternity unit surroundings and to promote choice for women and their families.

Examples of how the money was spent included:

- En suite bathrooms
- Single rooms for women in early labour – where partners can also stay
- Counselling and quiet rooms – mothers and fathers making difficult choices may prefer time to reflect away from busy areas
- New home from home areas – more women can choose more comfortable birth environment
- New birthing pools – extending birth options for women

The £100million was allocated on the basis of individual bids submitted by maternity units after consultation with local staff and users. Over 200 units across the country received a share of this investment.

Cross Government action

Sure Start Local Programmes and Children's Centres

- Sure Start Local Programmes and Children Centres are a cornerstone of the Government's drive to tackle child poverty and social exclusion.

- They work with parents-to-be, parents and children to promote the physical intellectual and social development of babies and young children under 5 – particularly those who are disadvantaged – so that they can flourish at home and when they get to school, and thereby break the cycle of disadvantage for the current generation of young children.
- Each programme is different, being individually tailored to meet the needs of the local area, but all provide core services including outreach with a visit to each family within two months of a new birth, and primary and community health care, including advice about family health and child health and development.
- The main public health issues concerning pregnant women and those with young babies addressed by Sure Start local programmes and Children Centres include: a reduction in smoking (during pregnancy as well as raising the awareness of the harmful effects of passive smoking); increased ante-natal support; increased breast feeding rates and improvements in diet and nutrition amongst pregnant women and their children; increased support for women with post-natal depression; a reduction in teenage pregnancy rates; accident and injury prevention and improvements in children's social and emotional development and early identification of children with special needs.

  Sure Start local programmes and Children Centres offer a range of activities to prepare families for birth and parenthood and deliver key public health Sure Start targets. Activities include, for example:
- Increasing contact during the ante-natal period including home visits;
- Improving diet and nutrition, by, for example, setting up initiatives such as 'Get Cooking' groups looking at healthy eating on a budget;
- Taking steps to reduce accidents and injuries in the home such as providing seminars for parents on safety in the home and garden;
- Improving children's social and emotional development by, for example, providing parenting courses and workshops for parents and carers to help parents understand children's behaviour and to learn how best to respond to their children.
- There are 524 Sure Start local programmes helping up to 400,000 children living in disadvantaged areas, including a third of under 4s living in poverty. 61 children's centres have been established following announcements in June and September 2003.

Sure Start Health Targets

Sure Start has a range of health related targets for families in their areas. These include:

- an increase in the proportion of young children with normal levels of personal, social and emotional development;
- a 6 percentage point reduction in the proportion of mothers who continue to smoke during pregnancy;
- All families with new born babies to be visited in first 2 months of their babies' life and given information about the services and support available to them.

- Information and guidance on breastfeeding, nutrition, hygiene and safety.
- Reduce by 10% the number of children aged 0-4 admitted to hospital as an emergency with gastro-enteritis, a lower respiratory infection or a severe injury.
- Ante-natal advice and support available to all pregnant women and their families.

Children's Trusts

Children's Trusts are a key organisational vehicle in the drive to achieve the five main outcomes for children identified in the recent Green Paper 'Every Child Matters' – being healthy, staying safe, enjoying and achieving, making a positive contribution and economic well-being. In the Green Paper the Government stated that its long-term vision was to integrate key children's services within a single organisational focus. The preferred model for achieving this integration is Children's Trusts. The Green Paper indicated that most areas should have Trusts by 2006.

Children's Trusts will help to deliver better services and outcomes for children, young people and their families. Children's Trusts are the government's preferred model for achieving local integration.

Teenage Pregnancy Strategy and Connexions

Goals:

- To halve the under 18 conception rate by 2010; with an interim 15% reduction target for 2004 (NHS Plan)
- To increase to 60% the participation of 16-19 year old mothers in education, training and employment by 2010.

Two key elements of the Teenage Pregnancy Strategy are:

Sure Start Plus: A pilot programme to provide specialist dedicated advisers to support pregnant teenagers and young parents to improve the health and social outcome for them and their children. Programme runs to 2006. Final evaluation end 2004. Key ingredients of success to be mainstreamed beyond 2006.

Tailored maternity services for young parents: Commissioning guide for PCTs produced by Teenage Pregnancy Unit, Department of Health and the Royal College of Midwives. This is aimed at improving earlier uptake of antenatal and postnatal care and partnership working with health and other relevant professionals, e.g. Connexions, to provide on-going support for young parents to improve long term outcomes. The Guide was launched at a conference on 5 February by the health minister Dr Stephen Ladyman.

Response to the Health Select Committee

A comprehensive response to all 91 of the Health Select Committee's conclusions and recommendations contained in their three reports follows. Due to the breadth of the recommendations and the decision to incorporate the findings of the recent choice consultation this response has regrettably taken longer to publish than expected.

Select Committee on Health Fourth Report of session 2002-03 Provision of Maternity Services Detailed Response to the Committee's Recommendations

1 We are concerned that the accuracy of maternity care statistics is adversely affected not only by missing data but by data submitted according to different interpretations of the terms used to define the data required by the Maternity Hospital Episode Statistics. We recommend that the NHS Information Authority clarify the progress made to date on the Maternity Care Data Project, and in particular on the compilation of the "data dictionary". We further recommend that work on this important area continue, overseen by a "national champion" for maternity care data, alongside efforts to ensure that all maternity units submit data to the Maternity HES. (Paragraph 24)

The Maternity Data Dictionary (MDD) was presented to the Information Standards Board (ISB). However it was not approved as a NHS standard at that time in part because there was "no policy driver" for it. With the imminent publication of the National Service Framework for Children the MDD is to be resubmitted to the ISB with sponsorship from the Department of Health Policy team.

2 We recommend that data on breastfeeding rates, in terms of initiation and duration, should be standardised and collected at national level. (Paragraph 29)

Guidelines for hospital trusts on the collection of statistics on breastfeeding initiation were made available to NHS staff on 28th November 2003 via the strategic executive information system, the Department of Health's data collection website. This information is also available to the public at http://www.doh.gov.uk/infantfeeding/pdfs/breastfeedingfinal.pdf

These guidelines relate to the collection of statistics on breastfeeding which support the Priorities and Planning Framework (PPF) target to "Deliver an increase of 2 percentage points per year in breastfeeding initiation rate, focussing especially on women from disadvantaged groups" for 2003/04 to 2005/06.

Hospital trusts are responsible for collecting data, based on the guidelines issued on 28th November 2003 on breastfeeding initiation, for the third quarter of 2003/04 and for each quarter after then.

Information is collected, on a national basis, on breast feeding initiation and duration through the Infant Feeding Survey. The last survey was in 2000 and results were published at http://www.doh.gov.uk/pdfs/infantreport2000.pdf The Department of Health has developed an Infant Feeding Audit Tool for primary care trusts to enable the collection of local data on infant feeding, including duration of breastfeeding in a standard format. The tool is available on the web at http://www.doh.gov.uk/infantfeeding/audit.htm.

3 We recommend that the Department of Health take immediate action to ensure that maternity care data systems and population-based child health systems for both sick and healthy babies, should be linked together at national and local level in order that health professionals have all the information relevant to mother and baby in order that the long- term outcomes of pregnancy and childbirth for maternal and child health can be measured. (Paragraph 31)

The National Programme for Information Technology is currently addressing this through the development of the NHS Care Records Service (NCRS)

This recommendation is being supported by investment in integrated systems across all the health service and the many organisations involved (hospitals, PCTs etc) and will be delivered locally through Local Service Providers (LSPs) and nationally by the National Application Service Provider.

The development of the NHS number for babies means that for the first time ever the second part of this recommendation is now possible. It will enable maternity and a public health system to link and also allow links with all other health IT systems.

4 Changing Childbirth recommended that all women should carry their own maternity notes. We are disappointed that ten years later there are still some units where this does not happen. We recommend that the Department should insist that all units support the use of woman-held notes. We further recommend the development of a national format of these notes in preparation for the Electronic Patient Record. (Paragraph 32)

The development of a national format for the personal maternity record is a policy decision that could be fully supported by the NCRS (the current programme that encompasses the notion of an electronic patient record). This is being discussed by the NHS Information Authority and they are currently reviewing the preferred model (from the West Midlands Perinatal Institute) to ensure that it is aligned with the MDD.

5 We welcome the Department's efforts to reduce incompatibilities between data systems and to review policy on the collection of maternity care data. We recommend that this review take account of calls for a renewed focus on normal birth and of the need for accurate data on antenatal and postnatal care in order to monitor progress towards targets and reducing health inequalities. We further recommend that in reviewing the Maternity HES the Department should ensure that the figures compiled for each maternity unit take account of factors such as privately – run units within hospitals, and reflect the configuration of services which take in community midwifery teams and midwifery led units under the auspices of a hospital unit. The Department should also take steps to ensure that data are collected on births in privately- run units and on home births. (Paragraph 36)

The HES development team is examining options for collecting detailed site level information, where currently the records identify only the relevant Trust. The data flow problems that have limited the number of home birth records on HES are also being examined. The Department of Health currently has no plans to extend the scope of HES to include private patients.

6 We were appalled to hear of the burden of work imposed on maternity care staff in units where maternity care data systems were inadequate or non-existent. The dramatic variation in the reliability and availability of maternity care data systems across the country cannot be rationalised by differences in size or configuration of units. We were struck by the disparity between this unacceptable situation, where staff could not retrieve information about their patients, and in turn where reliable national statistics could not be generated, and the Government's intention to use information technology to "enable NHS professionals to have the information they need both to provide....[the best possible] care and to play their part in improving the public's health". (Paragraph 50)

The duplicate collection of data (once for care purposes and once again for other reasons such as submissions) leads to poor quality data gaps in completeness and over burdening of work. It is hoped that with the establishment of the NCRS that this burden will be reduced considerably as data will be entered only once.

7 We recommend that the Department of Health Statistics Division 3G liaises with other relevant parts of the Department and the NHS Information Authority to issue a direction to trusts on the provision and maintenance of maternity care data systems, and on links between these systems and other health information systems, so that maternity units can collect and retrieve accurate data in a more efficient way to meet both local and national data needs. (Paragraph 50)

SD3G, the NHS Information Authority and other relevant parts of the Department of Health have met and will be considering collection and retrieval of maternity data in the context of the NSF and the move to Integrated Care records

8 The process of entering data on maternity care must not compromise the quality of care that pregnant women, and new mothers and babies receive. Adequate managerial and systems support is vital. Maternity care teams should have access to the services of administrative staff who have been trained to use the data system. While clerical staff can help to alleviate some of the pressure on maternity staff in terms of data entry, it is essential that the ultimate responsibility for overseeing the quality and clinical accuracy of data lies with a senior member of the clinical team. We recommend that the Department ensure that maternity units have access to reliable hardware, systems which can support the handling of individual records, to software which can be used for data analysis, and to appropriate statistical and IT support. Provision should be made for midwives who wish to do so to acquire skills in data analysis for monitoring and audit. (Paragraph 56)

Reliable hardware and systems are key to delivering the National Programme for Information Technology (NpfIT). Not just for Maternity services but throughout the NHS to support the drive for the delivery of quality care.

Training in data analysis and other informatics skills will be a key recommendation within the Information Strategy for all professionals involved in children and maternity services (not just midwives). All professionals have a responsibility for maintaining their professional competency and this would include informatics skills and knowledge. This is currently supported by the NHS Information Authority through the National Health Informatics Development (NHID) programme.

9 We recommend that in reviewing policy on the collection of maternity care data, the Department consider the merits of the system used in Scotland, not only in terms of the system itself but also in terms of other factors which might contribute to its success, such as the allocation of resources and the existence of a culture which supports staff who collect, enter and analyse data. (Paragraph 61)

The Government recognises that the experience of Scotland is very useful in the NHS understanding what is required and what might be possible in England. However their requirements are not the same and they are at a different point in the infomatics development cycle to England.

10 Most of the midwives and doctors who spoke to us did not recognise the requirements of the Maternity HES as a common data set, because they had not heard of them, or because they felt that definitions of the data required were not clear, or because the Maternity HES did not correspond with the more detailed information they collected independently for the purposes of care for individual mothers and babies, and development of their service. This is an indication of the disparity between national policy on and local knowledge of, collection of maternity care data. If maternity unit data collection systems are to be improved, communications between the Department and individual trusts and maternity units must be strengthened. We recommend that the Department should set out the implications of the electronic patient record initiative for maternity care data systems, including agreement of data definitions for maternity care, and further that it should consult and communicate with trusts on developments relating to the minimum dataset required by the Maternity HES. (Paragraph 62)

Clarity of communication between the centre and local units has been recognised as important on a number of issues (not just information technology). As the NPfIT develops the NCRS it is expected that there will be greater awareness among clinical staff of the informatics implications and benefits that will be realised.

11 We believe the current state of maternity care data systems at units across the country to be so grave as to warrant specific attention by PCTs and trusts, and, where needed, the allocation of funds for the purpose of installing and maintaining adequate systems and for recruiting and training appropriate staff to undertake data entry, analysis and system support. We recommend that maternity care data systems should form part of Local Delivery Plans. (Paragraph 63)

There is a key role here for the Chief Information Officers of Strategic Health Authorities (SHA) in ensuring that PCTs and Trusts address these issues in a way that addresses current state of maternity systems in line with the overall delivery plans for IT systems and training in any particular health community.

12 We recommend that in undertaking caesarean section audits, all hospitals should classify the degree of urgency of a caesarean section in the same way. We further recommend that the classification scheme used by the National Sentinel Caesarean Section Audit be considered as a standard scheme and that the data items needed to construct it should be included in the Maternity Care Data Dictionary. (Paragraph 82)

The classifications in the MDD are currently being reviewed and will take into account the scheme used in the National Sentinel Caesarean Section Audit, as well as the guidance to be issued shortly by NICE.

13 The issue of women's choice in undergoing caesarean section when there is no clinical need is a fraught one. The NHS does not generally provide other major operations for patients when there is no clinical need, nor does the NHS tend to offer choices of treatment to patients when one costs on average £760 more per patient than the alternative, since it is obliged to make the best use of NHS resources. It remains to be seen whether the National Institute for Clinical Excellence will allow choice for caesareans when in other areas of the NHS patients do not have comparable freedom. We would like to see a distinct shift in emphasis to ensure that elective caesareans as a 'lifestyle choice' are not supported by the NHS and that caesarean section should be a procedure undertaken only when medically or psychologically necessary and after appropriate support and counselling. (Paragraph 98)

The Government fully supports the view that women should not undergo unnecessary surgery. The decision to undergo a caesarean section should always be taken during informed discussions between the woman and the healthcare professionals responsible for providing her care.

The National Institute for Clinical Excellence (NICE) is launching their clinical caesarean section guideline on 29 April 2004. This guideline will include advice on the risks and benefits of caesarean section, the indications for caesarean section, healthcare interventions that may reduce the need for caesarean section and the care of the woman who has a caesarean section. The draft guideline can be viewed at www.nice.org.uk.

14 We look forward to the publication of NICE guidelines on caesarean section and recommend that these should serve to support maternity care staff not just in assessing the medical indications for caesarean, but also in giving consistent advice and information to women considering the procedure. (Paragraph 99)

The forthcoming NICE guidelines on caesarean section should provide clarity and guidance to clinicians on when to perform a caesarean section. They will also be accompanied by patient information that will provide women with useful information on the procedure. Additional information on caesarean section can be found in *The Pregnancy Book* which is produced by the Department of Health and is given free to all first time mothers. The book outlines the procedure and explains why it is sometimes necessary to have a caesarean section. Further information on caesarean sections can be found in the recently published You're Pregnant, which like *The Pregnancy Book*, is free and will be given to the woman by her midwife in the early stage of pregnancy.

15 We share the concerns of maternity care staff who wish to protect women from the risks associated with caesarean section. We are particularly concerned for those women who choose caesarean section because they are anxious about delivering their babies. While their fears about childbirth should not be compounded by new anxieties about the risks of caesarean section, these women should be made aware of the implications of surgery for women and babies and of services which help to reduce anxiety. We recommend that maternity units examine how women who request caesarean section are cared for, what kind of information and advice they receive, and how the women themselves feel about their discussion of caesarean section with midwives and consultants. (Paragraph 100)

The Government agrees that women should be made aware of the full implications of caesarean section. It is not always the best solution for those women with a fear of childbirth to have a caesarean section. Women should be given ample opportunity to discuss their concerns and fears about childbirth with their midwife and other health professionals responsible for her care.

16 We understand that in some cases interventions in labour are necessary to protect the health of mother and baby. However, women should be made aware that interventions such as EFM, epidural and induction may increase the likelihood of a caesarean delivery. Raising a woman's awareness in these areas should not entail merely the transmission of clinical information but rather it should involve discussion with a health professional in the context of the individual woman's background and concerns. (Paragraph 104)

The Government agrees that women should have full information and the opportunity to discuss the likely consequences of procedures such as EFM, epidural and induction and that this information should not be based simply on the clinical facts but also on the individual situation of the woman.

The National Collaborating Centre is leading the development of the NICE caesarean section clinical guideline. The Guideline Development Group has met regularly to oversee and assist the identification, review and synthesis of the evidence, the incorporation of expert consensus opinion and the translation of the evidence into recommendations for practice and audit criteria. Three versions of the guideline are being prepared: a full guideline, a NICE short-form guideline and a patient version. The patient version will be based on the clinical guideline. It will be written chiefly for pregnant women but it will also be useful for partners and family members.

We agree that women should also be fully informed of the effects of procedures such as EFM, epidural and induction. NICE has published guidelines on EFM (May 2001) and Induction of Labour (June 2001). As with other guidelines produced by NICE these guidelines have accompanying patient information.

17 We were disappointed to hear that so few caesarean section audits involved the views of users. The woman's experience is an important facet of the analysis of caesarean section rates and we recommend that maternity units consider this aspect of the audit process, even if women's views can only be sought through questionnaires. (Paragraph 112)

The Government recognises the importance of gathering the views of women and their families who have used NHS maternity services. These views are valuable in the designing of services that women want and feel comfortable using. We are aware that some units use questionnaires and find this useful when planning their services. We would encourage all units to develop methods of collecting views from women and their families.

18 We agree with those witnesses who told us that ideally the decision to undertake a caesarean section should be made in the physical presence of a consultant. Whilst this is not practicable within current staffing levels we believe that consultants should always be consulted over the decision to undertake a caesarean section except in the rare cases where immediate section is necessary. Although caesarean section is now a much safer procedure than it once was, we are concerned that some women undergo unnecessary sections on the recommendation of doctors who lack experience owing to the time limitations imposed by the New Deal and the European Working Time Directive on their training. This situation renders the process of auditing caesarean sections at individual maternity units all the more important as a form of training for junior staff as well as a means of ensuring that decisions made by consultants have been appropriate. We recommend that the forthcoming NICE guidelines on caesarean section should be supported by advice on audit procedures. (Paragraph 113)

The Government agrees that, where practicable, the decision for a woman to undergo a caesarean section should be made jointly with the consultant and the woman following discussions.

19 Such variations in clinical practice, while they might not compromise a woman's safety, may affect her role in making decisions on the mode of delivery for her baby if she does not have access to information on the risks and benefits of caesarean section. We are not convinced that it can be justified for women to have a significantly increased chance of a major operation because of an individual consultant's judgement of the risks of caesarean against normal birth and we hope that the NICE guidelines will create a consistency of approach across the country. Although we recognise the sensitivity of releasing individual consultant data we believe this data should be given to all users together with national and local comparisons so that women are aware of their consultant's caesarean section rate. (Paragraph 122)

See recommendation 14.

The Government agrees that women should have access to information on the risks and benefits of caesarean section in the antenatal period. Midwives and GPs provide support, information and advice to women as well as written sources of advice such as *The Pregnancy Book* and *You're Pregnant*.

The Government has no plans to make available individual consultant data regarding the number of caesarean sections performed. We believe that such information would not be necessarily be helpful to women.

20 We strongly endorse innovative approaches to reducing caesarean sections which involve women in detailed discussion about their maternity care and help to raise awareness of the risks and benefits of the different kinds of intervention in labour. We believe that this involvement is key to a positive experience of childbirth and of maternity care, and that the development of strong relationships between women and well-trained, confident midwives is crucial. The information gathered from discussion of previous experiences could be vital to the development of maternity services, particularly in relation to caesarean section. We recommend that information from women on their previous caesarean section should be incorporated into audits. (Paragraph 136)

The Government supports the use of innovative approaches aimed at reducing the number of caesarean sections performed. Women should have access to appropriate information on the procedure and their views should be sought and used in the development of maternity services. We recognise the importance of the development of strong relationships between a woman and her midwife. Such a relationship gives a woman confidence in her ability to give birth naturally, normally and without intervention.

21 We are encouraged to hear that maternity care staff value NICE guidelines and evidence based on research commissioned by the Department as tools for developing strategies to reduce caesarean section rates and to increase 'normal' birth rates. We recommend that the Department continue to support research and evidence-gathering initiatives and in particular the work on caesarean section audit. (Paragraph 137)

The Government will continue to support research and evidence gathering initiatives in this area, including seeking the views of women.

22 Based on evidence we heard from maternity units, we see a relationship between high rates of caesarean section and low levels of staffing. It seems to us unacceptable that a woman should undergo a surgical procedure that might have been avoided had she been better supported during pregnancy and/or during labour. It is clear from strong evidence that one of the most important means of reducing the caesarean section rate is to provide adequate support for women in labour. The level of staffing and organisation of care should enable women to be supported at all times. (Paragraph 142)

The Government recognises the importance of support for women in labour and is committed to increasing the number of midwives to achieve this as outlined in the response to recommendation 26.

23 We recommend that the Department research further how staff, including support staff, volunteers, and staff employed by voluntary organisations, could enhance maternity services and provide links to other providers of postnatal care, such as health visitors. In particular, the use of voluntary breastfeeding counsellors and supporters to contribute to the education of a range of healthcare professionals and other workers should be considered. We further recommend that the NHS consider funding or sub-contracting to voluntary organisations which could support the provision of specific services such as breastfeeding support. (Paragraph 155)

The Government supports this recommendation in principle. It is a good idea for women to receive advice from those people best able to provide it. This issue has been considered during the development of the Children's NSF. The Government welcomes innovative ways to provide this valuable support and it is for local policy makers to develop these within their communities.

24 Maternity care has always been a team effort but the professions involved seem to us to work better and with more mutual respect than they did perhaps even ten years ago. However, in the majority of cases, GPs are also members of a woman's maternity care team as they presently provide a first point of contact with maternity services and offer advice on care. In some areas there is room for improvement in terms of communication and understanding between GPs and midwives who support births in the community and in the home. (Paragraph 158)

The Government welcomes the improvements in working relationships between the health professionals involved in maternity services and also acknowledges that there is room for improvement in communication between midwives and GPs. Whilst the GP may currently be the first port of call for the majority of women work is now in hand to encourage women to have direct access to a midwife as outlined in the response to recommendation 29.

25 Depleted midwifery establishments and closures of maternity units are not conducive to the return of midwives to the profession. We recommend that the Department assess whether its strategy to encourage midwives to re-register for practice takes into account the extent to which these problems influence a midwife's decision to leave the profession in the first place. The Department also needs to understand why there is a high drop-out rate on some midwifery courses and take measures to reduce the problem. (paragraph 175)

The Department of Health is investing £70,000 to fund Professor Mavis Kirkham and her team at Sheffield University to carry out a follow-up study to the RCM research 'Why do midwives leave?' The research will examine 'Why do midwives stay and why do midwives return'. The results will inform future midwifery recruitment and retention policy.

26 Evidence we heard throughout our inquiry has led us to conclude that it will be difficult to invest sufficient time to allow midwifery and medical staff to gain experience of normal birth but it is crucially important to the range of skills they practise and the quality of care they provide. We welcome the introduction of workforce planning tools and the drive to train and recruit more midwives. However, particularly in consultant units, some midwifery establishments are depleted to seriously low levels, as workforce-planning tools have shown. In some units staffing cannot be reconfigured to compensate for shortages and where unit mergers or closures are poorly handled staffing problems are compounded. Several witnesses told us that they had seen no evidence at all of Government initiatives to increase staffing levels. We recommend that the Department takes steps to ensure that every maternity unit has the opportunity to use Birthrate Plus to make an assessment of minimum and maximum staffing levels. We further recommend that the Department asks PCTs and hospital trusts to review their investment in midwifery and critically examine their caesarean rates. There needs to be adequate staffing to provide good maternity services. The Department also needs to review and renew its efforts to recruit, and bring back to practice, midwives. (Paragraph 178)

The Department of Health recognises that Birthrate Plus is a useful tool to assess midwifery staffing levels. Every maternity unit does have the opportunity to make use of Birthrate Plus. It is however for local health economies to decide whether or not they wish to use Birthrate Plus to help them meet their local needs and priorities.

As emphasised at the Committee hearings, the Government has been successful in increasing the number of midwives. There are 700 more midwives working in the NHS than in 1997 and some areas of the country do not have recruitment problems. The Department of Health recognises that there is more to be done, particularly in areas where there are shortages. The Department is planning to host a national Midwifery Recruitment, Retention and Return conference in early 2004 with Heads of Midwifery. Key stakeholders have already drawn up a six-point action plan around the retention of midwives and the conference is designed to promote this.

In addition the Chief Nursing Officer is writing to midwives on the lapsed register telling them how the NHS is changing and how they can play a part. The letter describes how the NHS now offers a wide range of supportive and flexible terms and conditions and invites them to consider returning. Not all areas have midwifery shortages so the mailshot will concentrate on those Strategic Health Authority areas with the greatest difficulty in recruiting and retaining midwives. It is disappointing that not all witnesses were aware of the strenuous efforts being made at national and local level around recruitment and retention. The Department has developed a 6 point action plan with the Royal College of Midwives which both organisations will be delivering over the next 12 – 18 months, in co-operation with the key people and organisations who commission and deliver maternity services.

27 Given the positive effect of midwifery-led services on recruitment and retention we would urge PCTs and hospital trusts to do all they can to develop midwifery-led services and to be aware of the possible impact of closing units on staff morale, recruitment and retention. Given the general recruitment problem in the South of England and the high cost of living in these areas, we recommend that the Government assess whether the Agenda for Change proposals will tackle the geographical differences in recruitment that we have seen in our inquiry. (Paragraph 179)

Staff morale can be affected when midwifery services are closed due to staff shortages. The Department of Health is working closely with managers to help them think creatively about how to deliver maternity services and how best to avoid closures. There is a range of effective recruitment and retention policies and practices now in place (e.g. improved pay, changing workforce programme, Improving Working Lives, Return to Practice, flexible retirement, childcare etc) and the Department of Health will be working with Strategic Health Authorities, local employers and other key stakeholders to spread good practice.

The Agenda for Change pay system is currently being tested in twelve "Early Implementer" sites, with a view to implementing the new pay system across the UK from October 2004. There are two "early implementer" employers in London and the South East of England. These sites will be monitored against a set of agreed success criteria, one of which is better recruitment and retention, before a final decision is made about full roll out across the NHS.

To build on the new system of high cost area payments and recruitment and retention premia, the Department of Health is working with Strategic Health Authorities – particularly in London and the South East – to improve shared intelligence on regional and local labour markets for key staff groups and their impact on recruitment and retention.

In addition the terms of reference of the Nursing and Midwifery pay review body have been changed so that in future it will be required to take account of regional and local labour markets before making recommendations. The review body will be able to make recommendations on both the level of, and the geographic coverage of high cost area payments.

28 Moves to implement the New Deal and the European Working Time Directive have already had a profound impact on the levels of experience that obstetricians gather as trainees and are already threatening the viability of maternity units which currently serve as consultant obstetric units. This might create welcome opportunities for the development of midwifery-led units for women with low-risk pregnancies but we are extremely concerned that women who experience complications in pregnancy and in labour should have access to skilled, experienced and confident obstetricians. We welcome the Department's work to assess the implications of the EWTD but are concerned that any action on this work will come too late for the current generation of trainee obstetricians, and indeed for those units threatened with closure. If the EWTD is to be implemented, more investment in training and recruitment of doctors is required so that adequate levels of staffing and levels of experience can be maintained. We are very concerned that the Government is not sufficiently aware of the difficulties the professions face on account of the European Working Time Directive. (Paragraph 192)

The Government is aware that the implementation of the Working Time Directive (WTD) creates challenges that the NHS can rise to. Implementation links in with ongoing work including Modernising Medical Careers, pay modernisation for medical and non medical staff, the Changing Workforce Programme, and the objectives of the Improving Working Lives for Doctors initiative.

Keeping the NHS Local – a new direction of travel was published last year and set out to show that service redesign offers real potential to maintain a wider range of services in smaller hospitals than traditional models of care might allow. It did not address maternity and paediatrics specifically, but recognised that these specialities have their own complexities and made a commitment that we would consider them in the next phase of work, alongside emerging recommendations from the Children's National Service Framework. This is now being taken forward as part of the Hospital at Night project.

The Hospital at Night project is taking an evidence based approach to set up competency based multi-disciplinary teams to staff hospitals out-of-hours. Three pilots are specifically considering how the Hospital at Night approach can apply to maternity services. The Department is also funding over twenty WTD pilot projects testing different approaches to achieving WTD compliance for junior doctors. Some of these pilots are testing approaches that may help to achieve WTD compliance within maternity services.

Many of the long hours worked at night and weekends by trainee doctors in the past had little or no training value as it was unsupervised and of variable content. We believe in providing a high quality obstetrics service using a mix of different professionals including nurses, midwives and specialist doctors. There is no evidence that we have a shortfall in the number of specialists nor is there any evidence that the quality of new consultants has been affected by reduced hours. We know, however, that if trainees are to spend less time at work under the WTD we will have to manage and organise training better to ensure that we exploit all training opportunities in a meaningful way. Indeed, the postgraduate deans have already published *Liberating Learning* containing guidance on this point.

29 Women should be able to take time over their initial decisions on maternity care. It is important at this early stage in pregnancy that women should not be subject to any undue influence in relation to the type of maternity unit they are to choose. We recommend that national guidance be issued to support GPs in referring women for appropriate maternity care and in particular to clarify the role of the GP in relation to home birth i.e. that GPs do not need to take responsibility for this. We further recommend that the Government consider the idea of making the midwife rather than the GP the first point of contact for a discussion of maternity care choices. (Paragraph 199)

The Government agrees that it is important that women have access to appropriate and timely information to enable them to make informed decisions about the type of maternity care they wish to receive. It is important that this information is provided early in a woman's pregnancy to allow her and her family to consider the options available. The Government recently launched 99 local maternity guides produced jointly by the Department of Health and the organisation Dr Foster. These guides, entitled *You're Pregnant* give women and their families information about a range of maternity services in their area. Each edition covers eight local units and allows women to compare local services and encourages them to think about the type of maternity services they and their families would like to use. *You're Pregnant* has been produced in a popular magazine format and as well as local information it includes celebrity and real life stories and important health information. *You're Pregnant* will be given to women by their midwife early in their pregnancy and will enable women to make informed choices.

The Government has considered the issue of direct access to a midwife rather than a GP. Women can already go direct to a midwife rather than being referred by a GP, but most women are not aware of this option. *Building on the Best – Choice, Responsiveness and Equity in the NHS* was published in December 2003 draws out and develops the main themes that emerged from the Choice, Responsiveness and Equity consultation. The document broadly sets out how the Government needs to make NHS services more responsive to patients, by offering more choice across the spectrum of healthcare including maternity services. The document highlights the issue of direct access to midwives and asks local services to publicise contact details for midwives so that all women know they have the option of direct access. This will save some unnecessary GP appointments and will bring women into contact with maternity services as early as possible. We agree that the GP does not have to take responsibility and should support women by referring them to a midwife. The NSF has been exploring ways in ensuring women have time to make decisions.

30 We agree that the issue of continuity of care is of crucial importance to women and families and we urge the Department to facilitate the sharing of good practice in configuring services to provide continuity of care-giver across the country. In particular, we recommend that the Department liaise with PCTs to promote the development of services based on one-to-one care. We would welcome the creation of midwifery networks to share examples of innovative practice in the primary care setting. We recommend that the Department issue guidance on standard definitions for one-to-one care, continuity of carer and continuity of care. (Paragraph 212)

The Government recognises the importance of continuity of care and the sharing of good practice. We know of many areas that have successfully and innovatively designed their services to meet the needs of women and fully support the need to share this good practice. This is an area that is being looked at in the development of the NSF.

31 We recommend that the Government should ask the appropriate bodies to commission a review of training for health professionals in maternity services. In our view all members of the maternity care team should receive training on and gain experience of normal births in a range of settings. Midwives play a crucial role in supporting normal birth. The Nursing and Midwifery Council should ensure that curricula, and practical experience elements of training allow student midwives to develop appropriate skills in the support of normal birth. All student midwives should undertake placements within a midwifery-led unit or birth centre, and with a team of midwives who assist at home births, and the Government should also encourage the use of midwives in educating junior doctors on normal births. (Paragraph 219)

See recommendation 33

32 We recommend that all midwives and doctors receive training together in emergency procedures, including the use of appropriate equipment. (Paragraph 223)

See recommendation 33

33 We recommend that a review of training programmes should emphasise the importance of skills in informing, advising and counselling mothers and families, and in promoting the development of bonds between parents and their babies. In particular, we recommend greater emphasis on support for breastfeeding. All newly-registered maternity staff should be aware of the special support needs of some families. (Paragraph 227)

The education of nurses, midwives, doctors and AHPs has already been extensively reviewed along with associated quality assurance processes. Benchmark statements and standards for midwives and other professions have been produced on a collaborative basis between the Quality Assurance Agency for Higher Education/Higher Education Institution's, the regulatory bodies and Workforce Development Confederations. These support the development, validation and review of educational programmes. In the light of these recommendations we will take steps to discuss with NMC, GMC, WDCs and Universities UK, the specific areas highlighted in the report relating to supporting normal and home births, breast-feeding, counselling and information for mothers and families, emergency procedures and practice placement experience.

For the postgraduate medical aspects of this the content and standard of postgraduate medical training is the responsibility of the UK competent authorities, the Specialist Training Authority (STA) for specialist medicine and, for general practice, the Joint Committee on Postgraduate Training for General Practice (JCPTGP). Their role is that of custodians of quality standards in postgraduate medical education and practice. They are independent of the Department of Health. In addition, the General Medical Council's Education Committee has the general function of promoting high standards of medical education and co-ordinating all stages of medical education to ensure that students and newly qualified doctors are equipped with the knowledge, skills and attitudes essential for professional practice.

All of these bodies have a vested interest in ensuring that doctors are equipped to deal with the problems they will encounter in practice – including, where appropriate, the safe provision of maternity services. It is not however practicable or desirable for the Government to prescribe the exact training that any individual doctor will receive.

However, In February 2003, the Department of Health launched the Modernising Medical Careers initiative, which involves a radical look at medical training and careers. As part of this process the training curricula will be revisited, which provides the opportunity to ensure maternity services are appropriately covered. This will also include consideration of the opportunities for increased multi-professional learning.

It is government policy to foster and generate inter professional educational development and training wherever this is possible.

The Government recognises the importance of the development of bonds between babies and their mothers and families and agrees that there is a role for maternity staff to facilitate this. Extra assistance should be provided for those women with special support needs.

34 Current training seems to us not fully to acknowledge the changed nature of maternity care today. We therefore recommend that steps should be taken promptly to ensure that the Colleges and the Nursing and Midwifery Council develop appropriate training on a multi-disciplinary team basis, including where possible the participation of such members of the maternity care team as physiotherapists and health visitors. (Paragraph 235)

The Government is are already taking significant steps to enhance inter professional learning in both pre and post registration education programmes. We will ensure this recommendation informs our work, with key partners in the NHS, higher education and the professions, in this area, in particular:

- The mainstreaming of common learning/inter-professional education within pre-registration/undergraduate education
- The development of a multi-professional framework for learning beyond registration
- Raising the profile of this important dimension of inter professional education with the new Council for the Regulation of Health Professions, who have a key interest in supporting collaborative approaches to learning.

- Implementation of a recent joint statement (DH, regulatory bodies and UUK) on enhancing communication skills in pre-registration education.

The Chief Nursing Officer, Sarah Mullally is chairing a Nursing Task Group looking at the current approach to the education and development of nurses and midwives beyond registration. Reporting to the Strategic Learning & Advisory Group for Health and Social Care (StLaR), the Nursing Task Group will make recommendations to strengthen approaches to the education and development of nurses and midwives. This will be with particular regard to levels of practice and opportunities for shared learning with other professions. This is in the context of increasing demand for specialist nurses and midwives and those with advanced knowledge and skills.

Select Committee on Health Eighth Report of session 2002-03 Inequalities in Access to Maternity Services Detailed Response to the Committee's Recommendations

1 We recommend that detailed socio-economic and ethnic data should be recorded in a standardised way in all national datasets and that analyses of these data should be routinely published as well as being made available to researchers for more detailed analyses. (Paragraph 14)

The Government recognises that the collection of such detailed information is valuable to the planning of health services and meeting the needs of local populations. The Government agrees with this recommendation to standardise data. This will be made possible through the adoption of the Maternity Data Dictionary.

2 If maternity services are to meet the needs of disadvantaged women, babies and families, the evidence base on which policy decisions and service developments are made must be expanded. We recommend that the Department commission programmes of quantitative and qualitative research so that an accurate assessment of the extent to which women who do not gain full access to maternity care can be made, the reasons for inequalities and inequities established and further action taken to address these inequalities. (Paragraph 22)

The Government recognises that there already exists considerable evidence to demonstrate the negative impact that a wide range of socio-economic, cultural, behavioural and other determinants has on the health outcomes of women and babies.

The independent inquiry into inequalities in health chaired by Sir Donald Acheson (1998) found that inequalities in health range across geographical areas, social class, gender and ethnicity. The report recommended that the needs of pregnant women, young families and infants should be a high priority for efforts to reduce inequalities in health to ensure a healthier nation. The latest report of the Confidential Enquiries into Maternal Deaths 1997-1999 *Why Mothers Die* provides stark evidence of the inequalities in maternity care.

The report emphasised that women from the most disadvantaged groups in society are about twenty times more likely to die in childbirth than women in the highest two social classes and their babies are more than twice as likely to die before reaching their first birthday.

The Inequalities and Access Sub Group working on the development of the Children's NSF has examined a wealth of existing research using the National Perinatal Epidemiology Unit's research database and the expertise of researchers in this field. The forthcoming Children's NSF will recommend strategies to enable local services designers to take action to enable the most vulnerable women in their communities to access effective maternity care. The NSF will also recognise that local trusts will need to take account of the reasons why some women find it difficult to access services and involve them in helping plan services that meet their needs.

3 We recommend that the Department provide PCTs and acute trusts with relevant and timely information to enable maternity care teams to use the opportunities and resources offered by the Government through projects and initiatives such as Sure Start, to recruit more staff and provide specialised services for disadvantaged women and their families. We further recommend that the Department should ensure that best practice be shared in relation to these centrally-funded projects. We further recommend that the Department should ensure that best practice be shared in relation to sustaining the work of a project after the allocated funds have been used. (Paragraph 40)

The Department of Health uses a number of targeted e-mail bulletins to communicate policy developments and the latest developments in the NHS and social care. Targeted e-mail bulletins were introduced to reduce the number of individual management communications sent by the Department of Health and to help reduce the burden of too much paperwork in the NHS and social services. Those who are sent these bulletins include trust Chief Executives, GPs, Medical directors of trusts and nurse executive directors of trusts.

The Government's aim, as set out in the "Every Child Matters" Green Paper is: "to extend the principles developed in Sure Start local programmes across other services. These principles focus on: working with parents and children; starting very early and being flexible at the point of delivery; providing services for everyone and ensuring services are community driven, professionally co-ordinated across agencies and outcome focused."

It is about encouraging local authorities to consider the lessons learned from Sure Start local programmes (and other Sure Start disadvantaged area programmes) and see how they can be 'mainstreamed' into all their early years services.

- **Sure Start Mainstreaming Pilots**

The Sure Start Unit is currently funding seven mainstreaming pilots, which are exploring mainstreaming of Sure Start type services across their districts. These pilots in Southampton, Manchester, Birmingham, Leicester, Rochdale, North Tyneside and Sunderland are funded until March 2004.

Mainstreaming pilots are considering how strategic planners can use the experience from Sure Start and Early Excellence Centres to adapt mainstream early years, childcare, health and family support services to make them more integrated and responsive to children's and families' needs and provide more preventative services which better meet the needs of children in poverty.

A small piece of research to examine the work of the mainstreaming pilots has recently been commissioned, which should produce findings by September 2004.

- **Local Evaluation of Sure Start Local Programmes**

Sure Start Local Programmes are required to undertake local evaluation of their programme and services in order to generate important evidence to assist them in making changes and improvements to their programme and to provide information to feed back to their stakeholders and to help influence mainstream service providers. Local evaluation is therefore an integral part of programme development and delivery. A range of issues is being examined through these local evaluations, and all programmes have to focus on issues associated with processes, short-term impacts and cost-effectiveness.

- **National Evaluation of Sure Start Local Programmes**

As part of the National Evaluation of Sure Start, a thematic study on maternity services is currently being undertaken. This looks at maternity services provided in Sure Start areas and is due to report summer 2004.

In addition, the Sure Start Unit has in place a framework for assembling and interpreting evidence, intelligence, case study material and other information from internal and external sources; drawing out lessons of practical value to stakeholders and delivery partners; translating this into user-friendly form, and communicating it effectively to practitioners.

The Sure Start website www.surestart.gov.uk offers useful information with links to relevant sites and provides examples of good practice and guidance to those working across the Sure Start programmes, including links to free resources that can be used locally. At present this is undergoing an update with new cases of good practice being sourced in each main policy area of the health team in order to share further best practice.

4 We welcome the interim findings of the Maternity External Working Group, and look forward to seeing the work of the sub-group appointed to examine inequalities and access. The difference for women and families will depend on the identification of effective strategies and the Government ensuring that the implementation of these strategies is achieved. (Paragraph 46)

The Government also welcomes the Maternity External Working Group's (EWG) interim findings published in *Getting the right start: The National Service Framework for Children*, *Young People and Maternity Services* (May 2003). The final NSF will be published later this year.

5 We recommend that the Government investigate the RCM's concerns relating to the recruitment of midwives from minority ethnic communities. Action to promote the recruitment of midwives from ethnic minority communities could include the identification of 'champions' from minority ethnic communities which may help to inspire some younger people from these communities to pursue careers in maternity services. (Paragraph 56)

The HR in the NHS Plan sets out the Government's determination to make sure that each local NHS workforce reflects the make up of its local community. 11% of current NHS midwives already have an ethnic minority background and in 2002/03 13% of applications were from people who identified themselves as from an ethnic background. The Department of Health is working with the Royal College of Midwives to develop a 6 point Recruitment, Retention and Return action plan which will include the need to identify role models amongst ethnic minority midwives who can act as recruitment champions.

6 Any support system for asylum seekers should provide specifically for the needs of pregnant asylum seekers, new mothers and their babies. We recommend that the Government take steps to ensure that pregnant women and new mothers should not be detained for any prolonged period, and that accommodation centres should provide a gateway to maternity services for pregnant asylum seekers. (Paragraph 65)

See recommendation 8

7 Better communication between maternity and child health services and accommodation providers during dispersal is needed to ensure that members of maternity care teams are forewarned of the arrival of asylum seekers who will need their services and that their test results and notes are forwarded. (Paragraph 66)

See recommendation 8

8 In considering asylum seekers for dispersal special attention should be paid to the support needs of pregnant women and new mothers since separating them from any support network at this time could be especially detrimental to families. (Paragraph 67)

Accommodation centres are not the same as removal centres. Residents in accommodation centres will be subject to residence and reporting requirements, but will not be detained. It is expected that residents will remain in accommodation centres for a maximum of 6 months (which may be extended to 9 months in certain circumstances), during which time it is also expected that the processing of the asylum application and any appeals will be completed.

Primary healthcare services will be provided on-site for residents who will have access to the same range of services as the general public and supported asylum applicants in dispersed accommodation. It is the intention to provide specific care for expectant and nursing mothers with young children that will include links with local maternity services.

Generally speaking expectant mothers are only detained for a very short period of time whilst their removal is arranged and would not be detained in the later stages of pregnancy.

Expectant mothers who are supported by the National Asylum Support Service (NASS) are encouraged to travel to their dispersal accommodation before the birth in order that they may familiarise themselves with local support mechanisms and to enable them to take advantage of self-catering accommodation. We understand there is a policy of hand held antenatal records that we hope will assist in the dispersal process. As the expected delivery date approaches, each case for travel is given individual consideration and any representations from the applicant's general practitioner, midwife or obstetrician are taken into account. New mothers are not expected to travel to their dispersal accommodation until two weeks after the birth.

Once a person has been dispersed NASS sends a notification of their details to the local PCT. It is at the request of the Department of Health that this takes place after the arrival in the dispersal area. The information that NASS passes to the PCT is taken directly from the details that are supplied by the asylum seeker. We do not have access to any other information and have to rely on the asylum seeker themselves to supply appropriate details. In addition, when an asylum seeker arrives at the dispersal address accommodation providers and one-stop services are funded to provide advice and to help applicants access local services, including medical facilities.

In relation to the material needs of expectant and new mothers, accommodation providers, under their contract agreement, are obliged to provide appropriate sterilising equipment, cot, highchair and safety equipment such as stair gates and window restraints. Mothers may also apply for a maternity payment of £300 to meet the cost of additional needs other than the standard issue items already mentioned. This can be applied for up to one month before the expected delivery date and up to two weeks after the birth. An additional payment of £3 a week has also been introduced to enable expectant mothers to supplement their diet. When NASS have received the new baby's birth certificate the support rate is recalculated to include an additional £38.50 for the new child and also a further £5 with which the mother may purchase baby milk.

9 Given the high incidence of domestic violence in pregnancy, relying on relatives to interpret for women can be extremely dangerous. All maternity services should ensure that the use of relatives as interpreters does not deny women the opportunity that maternity care provides to report domestic violence or to discuss other concerns such as mental health. (Paragraph 77)

The Government supports this recommendation. Health professionals have been given clear guidance on how to respond effectively to domestic violence cases. *A Resource Manual for Health Professionals published* in March 2000 by the Department of Health established the principles to guide practice. This document highlighted the need for interpreters. Some women may need someone else to be present (preferably of the same gender) either as an interpreter (for different spoken languages, or as sign language interpreters), or as advocates (particularly if the person has a learning disability), or for moral support. The person who is used as an interpreter should be independent and a professional interpreter; it is unacceptable to use family members or friends in this role, or to use staff who happen to have these skills but are not employed (or trained) to use them. The resource manual is available on the Department of Health website at www.doh.gov.uk/domestic.htm

10 Interpreting and advocacy services are a vital component of appropriate maternity care for women who do not speak English as their first language. However, we are concerned that local service planners do not recognise this in their budgets, and in particular that there is so little provision for need in the community and out-of-hours in hospital-based units. We recommend that local maternity services take steps to ensure the development of on-site out-of-hours interpreting and advocacy services and that better use is made of telephone interpreting services. We further recommend that staff running antenatal classes and undertaking postnatal visits should have access to advocacy and interpreting services. (Paragraph 78)

The Government supports this recommendation. It is for local service planners to understand the profile of the community they serve and to make provision for interpreting and advocacy services where necessary. The NSF is looking at the issues around appropriate use of interpreters and advocates.

11 Ideally, interpreting services should be provided, in the community and in the hospital, by specialist interpreters and advocates, rather than by family members, friends, or by other staff. However, we endorse the attempts made by maternity care staff to find interpreters when specialist services are not available. Bilingual and multilingual staff working in PCTs and acute trusts should have the opportunity to develop their interpreting skills. We recommend that the Department commission work to develop appropriate training courses and qualifications in interpreting for non-specialist staff. (Paragraph 79)

The Government agrees that it is not appropriate for family members to be used as interpreters and recognises the valuable role bilingual and multilingual PCT and acute trust staff play in providing these services. If these staff members wish to further develop their interpreting skills then this should be offered as part of their training and development needs. However it should be recognised that this should be up to the individual staff member and they should not feel pressure to undertake the role of interpreter simply because they speak more than one language.

12 We were also concerned to hear of individual social workers giving mothers the general impression that it would be easier to take a baby away and care for him or her, rather than work with the family to keep them together. We recognise that in extreme cases social workers do have to recommend that babies are taken away from parents but this experience suggests that more needs to be done to ensure that social workers are trained to understand and respect the sensitivities of homeless and disadvantaged families so that it is clear that families will be kept together where this is possible. (Paragraph 90)

The Government supports this recommendation. Social workers should work closely with families and offer as much support as they are able to keep families together. However it must also be recognised that the safety of the baby is paramount and in some cases it is not possible to keep some families together.

13 Those responsible for rehousing pregnant women and women with young babies should be able to pass information on to maternity and health visitor services where women wish for these services to be provided. Currently methods of passing on information are inadequate and the situation needs to be improved. We recommend that the Department should assess the difficulties faced by low-income families who have to spend long periods visiting their babies in Special Care Baby Units and that the Department should then take steps to ensure that sufficient financial support is provided so that these families can meet travel and other costs. (Paragraph 92)

The Government supports this recommendation. Those responsible for rehousing pregnant women and those with young babies, should pass information quickly to midwives and health visitors, with the woman's consent, so that she receives appropriate support and advice.

The Hospital Travel Costs Scheme currently does not cover families visiting their babies in special care baby units. Low-income parents can seek help in a number of ways if they are finding it difficult to meet travel costs. They can speak to the trust to see if they have any local schemes (which could include schemes set up by charities) or they can apply for a Department of Work and Pensions Social Fund grant, which is available from their local Jobcentre Plus Office. Following the recommendations of the Social Exclusion Unit's report *Making Connections* the Hospital Travel Costs Scheme is now under review.

14 We believe that domestic violence is substantially under-reported and that the true scale of the problem remains unknown. We endorse the RCOG's call for further research into the prevalence of domestic violence, and into effective models of intervention. All maternity services need to have access to support services, to which they can refer those who are suffering from domestic violence. All women should have ready access women's refuges so that maternity services can protect women who disclose domestic violence from further abuse. (Paragraph 99)

The Government recognises that the health service has an important role to play in identifying and responding to domestic violence which has a considerable impact on individual's health and well-being and that of any children. The Department of Health is focusing activities on developing early and effective interventions for domestic violence. Research has shown that there is a link between pregnancy and domestic violence with 30% of abuse beginning in pregnancy. The Department is funding a pilot project looking at prevalence and routine questioning on domestic violence during the antenatal period as an effective intervention. Outcomes of the pilot will be fully evaluated and will help to inform work programmes around children and maternity, for example, the National Service Framework for Children.

Health professionals have been given clear guidance on how to respond effectively to domestic violence cases. *A Resource Manual for Health Professionals published* in March 2000 established the principles to guide practice.

We are also using the policy research programme to strengthen the evidence base on effective interventions. We have commissioned research from Professor Gene Feder on health interventions to reduce violence against women to inform policy development on prevention and management of domestic violence.

15 All trusts should ensure that maternity and mental health services work together to provide proper support for women during pregnancy and the postnatal period. We believe that the Department should give high priority to addressing the problem of inadequate provision of mother and baby units in some parts of the country. Mental health trusts should appoint lead practitioners to ensure that care for these women is properly co-ordinated. (Paragraph 105)

The implementation guidance for the Women's Mental Health Strategy, 'Mainstreaming Gender and Women's Mental Health' (September 2002) outlines a way forward to encourage maternity and mental health services to work together to provide proper support for women during pregnancy and the postnatal period. In addition to this, the Specialist Commissioning Group chaired by the National Director for Mental Health, Louis Appleby, is working to produce information that will help to support the commissioning of mother and baby units.

16 Information that is provided to expectant parents should be made fully accessible to all groups of people with disabilities, including those with physical or sensory impairments, people with learning difficulties or long-term illnesses and people with mental health problems. (Paragraph 116)

The Government supports this recommendation. We recognise that women need information that is appropriate in order to make informed choices about their maternity care. The Children's NSF is likely to stress the importance of women having access to appropriate information and methods of communication to meet their individual needs in a format that is easy to understand. Women need a variety of information throughout pregnancy, labour and postnatal care. The Government recognises that the information needs of a woman vary according to their individual circumstances and the NSF is examining the different and innovative ways information can be provided at this important time.

The Department of Health recognises that information needs to be provided for pregnant women in a variety of formats and languages and it needs to be clear and accessible. Currently information provided and produced by the Department of Health is in the form of *The Pregnancy Book*. This is given free to all first time mothers. However we accept that this book is not available in large print, braille or audiotape nor is it available in languages other than English and Welsh. The Department of Health is currently looking into producing *The Pregnancy Book* on audiotape and is examining the feasibility of producing *The Pregnancy Book* and *You're Pregnant* in different languages.

The Government is also aware that that there is a wealth of information produced locally and encourages local services developers to produce information in a format that is useful and accessible to women and their families in their area.

17 Maternity units and services should be made accessible to all groups of people with disabilities. We recommend that the Department set up systems for best practice to be shared so that people with disabilities do not have to struggle to make their views known in every area before improvements are made. For example, the obvious success of height-variable cots in one area should automatically be picked up by other units. We have little confidence that this happens now. (Paragraph 117)

The Government agrees that maternity units and services should be made accessible to people with disabilities. Part III of the Disability Discrimination Act (DDA) 1995 stated that from October 1999, service providers must take reasonable steps to change practices policies, or procedures that make it impossible or unreasonably difficult for disabled people to use a service. From 2004, service providers will have to take reasonable steps to remove, alter, or provide reasonable means of avoiding, physical features that make it impossible or unreasonably difficult for disabled people to use a service. Whilst this act covers the physical obstacles to access it does not tackle other obstacles such as communication difficulties. All women should have opportunity to make their views known and give feedback on the care they have received. This will enable those designing the local maternity service to use this comments as a means to improve the service and make it more responsive to women and their families.

18 User involvement is vital to the effective planning of services and monitoring of access to care. We recommend that the Department should ensure the continuation of MSLCs in the context of NHS reforms. The role of MSLCs in relation to the Patient Advice and Liaison Service (PALS) and in relation to new patient forums and other mechanisms to involve the public in health service provision needs to be clarified. The expertise of the Commission for Public and Patient Involvement in Health should also be used to support MSLCs. (Paragraph 128)

See recommendation 19.

19 MSLCs can be a powerful way of involving users in planning and developing maternity services but it is important that MSLC membership reflects the ethnic and social diversity of the local population as far as possible so that the needs of disadvantaged groups are accommodated. Lay members of MSLCs should at least be reimbursed for the child care and travel costs incurred when they attend meetings. (Paragraph 133)

The Government agrees that user involvement is essential in the planning of maternity services that are effective and accessible to all. One of the sub groups working on the development of the maternity module of the Children's NSF was dedicated specifically to the issue of user involvement. The Government recognises the importance of the work of groups like MSLCs. The User Involvement Sub Group looked at updating and clarify the MSLC guidance taking into account NHS reforms and bodies established that could help support the work of MSLCs. In addition they looked at developing a website to enable MSLCs members exchange practice and project examples. The Commission for Public and Patient Involvement in Health have been involved with the work of the User Involvement Sub Group.

The Government agrees that any user group membership should be diverse and reflect the make up of the local population in order to ensure all groups needs are met.

20 We were encouraged by the work of service providers who actively sought the views of women and families from disadvantaged groups by becoming involved in forums established by minority communities, and we are keen to ascertain whether this work could be replicated in other areas. We recommend that the Health Development Agency should gather and disseminate evidence of best practice in this area. (Paragraph 134)

See recommendation 26.

21 Because of the particular sensitivity and importance of maternity services we recommend that trusts should ensure that maternity care staff and PALS officers have access to sufficient opportunities for training with particular reference to the problems of mothers with disabilities or mental health problems, those from minority ethnic communities, those who live in poverty, and those from other disadvantaged groups. If there were to be a 'specialist' in maternity units to help such mothers, service users might not suffer from the ignorance and prejudices of some staff that were reported to the Committee. (Paragraph 141)

The Government agrees with this recommendation. All staff who are involved in the provision of maternity care should be aware of the difficulties particular groups in society have in accessing maternity services and should be aware that their attitudes or prejudices could deter some women from receiving appropriate care in subsequent pregnancies.

22 We recommend that local health services should liaise with local authorities and other agencies to update information about traveller sites within their areas. User representatives from local travelling communities should be involved in planning any special measures for service provision. We further recommend that PCTs should identify a co-ordinator for travellers, to facilitate transfer of health records, especially maternity records and notification of health professionals. (Paragraph 149)

The Government acknowledges the need for user representatives from travelling communities to be involved in the planning of maternity services.

Health services need to target travelling communities effectively to enable them to gain optimum advantage from the health and social care system, and to become and remain healthy. PCTs have an important role in improving the health of their communities- they work closely with other organisations, drawing on existing public health and health promotion skills to provide positive responses to community health problems – this should include the arrangement of services for travellers. The development of the NSF has taken into account the particular health needs of travelling communities.

The Emerging Findings of the Children's NSF Getting the Right Start highlights the need for providing flexible services and for considering innovative approaches for women who have difficulty accessing services.

The Government also acknowledges the excellent work of charities in this area. The Department of Health is funding the Maternity Alliance (2003-2004 £23,700 2004-2005 £16,000) to undertake a project on service take up. The project will work with gypsy and traveller groups, consult with women and with health professionals and produce guidance on service delivery and information materials to encourage these women to make better use of the maternity services.

The Department of Health has also provided funding for the organisation Action on Pre-Eclampsia (APEC) for the Pre-Eclampsia Advice for Travellers and Gypsies Project. This project will provide an easy to understand leaflet aimed at travellers and gypsies together with a pamphlet designed for use by community health workers and support groups involved in their welfare. The leaflet will provide information on the signs and symptoms of the condition and where help can be sought.

23 As part of its work on domestic violence the Government should ensure that the Department of Health addresses the issue in the context of maternity services across the country. For women who have been abused and raped, there may be particular issues which need to be addressed in maternity services. We recommend that the Department should take steps to ensure that special training programmes are made available to all maternity staff across the country so that women subject to rape and domestic violence receive appropriate care. (Paragraph 153)

Thirty percent of domestic violence starts in pregnancy, existing violence often escalates during it. That is why a key focus for the development of early and effective healthcare interventions for domestic violence has been in the context of maternity care. A programme for midwives to train and support them in implementing systems for routine antenatal questioning for domestic violence is being piloted at North Bristol NHS Trust. Outcomes of the Department of Health funded pilot project will inform the developing Children's NSF and produce domestic violence training materials for midwives. The Department of Health will consider wider dissemination of the training materials once evaluation complete. Recently published antenatal care guidelines from the National Institute of Clinical Excellence (22 October 2003) also recommend that healthcare professionals be alert to the signs and symptoms of domestic violence and that women are given the opportunity to disclose domestic violence.

24 We recommend that all maternity services should consider recruiting healthcare assistants from minority ethnic communities, and developing training programmes so that these assistants can provide advocacy support for women and families. (Paragraph 159)

The NHS Plan sets out that the local NHS workforce needs to reflect the make up of the local community. Local employers are encouraged to recruit staff from the local area, including healthcare assistants, so that NHS staff can understand the different backgrounds and cultural issues of the people they care for.

25 All health professionals, including PALS officers, who become involved with a disabled mother who is either planning to become pregnant, receiving fertility treatment or who is already pregnant, should know how and where to obtain specialised information about the problems with pregnancy, delivery and baby care associated with particular impairments. (Paragraph 163)

The Government agrees that all health care professionals involved in the care of a disabled woman should know where or who to approach for advice in dealing with the woman and how her condition will affect the pregnancy. Care should be taken to take on board the views and wishes of the woman herself.

The NSF is looking to meet the individual needs of all women as well as those with disabilities.

26 In order to provide an appropriate level of care for disadvantaged women and families, health professionals should have ready access to expert information, and to sources of further support. We recommend that the Health Development Agency should collate available research and evidence on work with disadvantaged groups, and create a central database of voluntary organisations working at local and national level. (Paragraph 164)

The Health Development Agency (HDA) would welcome the opportunity to prepare an Evidence Review on access to and utilisation and experience of maternity services by disadvantaged groups in the community as part of its 2004 delivery plan. This would fit with their portfolio of work on health inequalities. As part of the National NGO Public Health Forum's work for 2004, information on voluntary organisations working at local and national level in this field could be made available via the HDA's interactive Health Action website.

The Department of Health will include these two suggested areas of work in its discussions with the HAD for its next three year delivery plan 2004-2007.

27 We recommend that local maternity services should appoint a lead health professional to ensure that women and families who have needs specific to physical or mental health, or social circumstances are provided with appropriate services. The role should involve liaison within a multi-disciplinary health and social care team, provision of care for individual women, advice on plans and policies within units, co-ordination of advocacy and interpreting services, including British Sign Language, and training and support for colleagues. (Paragraph 173)

The Government recognises the importance of having a lead professional to ensure the needs of women and their families using maternity services are met. It is for local service providers to assess and meet their communities needs.

28 Maternity teams which have developed community-based continuity of carer schemes for women from disadvantaged groups, have been successful in improving access to maternity care and in achieving positive health outcomes for mothers and babies. We recommend that providing continuity of carer schemes for women from disadvantaged backgrounds should be a particular priority for maternity services. (Paragraph 178)

The Government acknowledges the success of these community based continuity of carer schemes in improving the health outcomes of women from vulnerable groups and agrees with this recommendation that local policy developers should bear these types of schemes in mind when designing services for their communities.

29 Although the use of woman-held notes does not address the problem of identifying and reaching those women who do not make any contact with maternity services, they are a valuable way of passing on information which may be crucial to the provision of appropriate care for women from transient populations and for women who see a variety of health professionals during their maternity care. Given the concerns expressed by witnesses during our first inquiry in relation to maternity care records, and to the Electronic Patient Record (EPR) in particular, we recommend that the Department should clarify whether the EPR will affect the use of woman-held notes and how it will be adapted to facilitate provision of appropriate services for disadvantaged women and their babies. (Paragraph 182)

The commitment to move towards a personally held maternal record will begin to meet this recommendation. The benefits to disadvantaged women and their babies will be realised through the National Programme for Information Technology as records are made electronically available at the point of care in a variety of healthcare settings.

30 Provision of support for smoking cessation and for breastfeeding represent two interventions which can improve a woman's experience of maternity care, and the long-term health outcomes for women and babies. Women from disadvantaged groups may need specialist support in these areas. We recommend that health visitors and midwives undertake training, and that they work closely with peer groups and volunteers, to provide this support. We further recommend that the Health Development Agency issue guidance to PCTs on best practice in smoking cessation and breast feeding support for women from disadvantaged groups. There should be a flexible approach to the transition to care provided by health visitors, to allow mothers to work with whichever health professional they feel is best placed to support them. (Paragraph 191)

Midwives and health visitors are in an ideal position to provide information and support in areas such as parenting, breastfeeding, smoking cessation and early detection and referral for women experiencing domestic violence or post natal depression. Peer groups and volunteers can also provide valuable support to women.

The NHS Priorities and Planning Framework target to increase breastfeeding initiation by 2% a year between 2003 and 2006, focussing on disadvantaged groups, coupled with the Commission for Healthcare Audit and Inspection (CHAI) infant health indicator will enable maternity services to focus on increasing breastfeeding rates amongst low income groups.

To help them with this task the Department of Health is putting together guidance outlining best practice, innovation and top tips. This will be launched in the spring and includes some of the learning from the evaluation of the 79 best practice projects undertaken as part of the Breastfeeding Initiative. The evaluation is due to be published by Department of Health shortly.

The Department of Health supports the annual National Breastfeeding Awareness Week, which takes place in May. This year it will be during the week of 12th May and will concentrate on breastfeeding initiation.

In 2001/02 and 2002/03 some £6m was allocated to the NHS Stop Smoking Service for the specific provision of champions to co-ordinate specialist support for smoking in pregnancy services. The intention of the allocation was to pump prime the provision of such support, for example by ensuring that all midwives are appropriately trained to provide brief interventions about smoking; and by promoting referral to the NHS Stop Smoking Services. These services are now available across the country, provided by trained advisors who undertake advice and counselling, including support in using cessation aids where appropriate.

The Department has set specific targets and initiatives for the reduction of smoking in pregnancy. The Priorities and Planning Guidance, issued in December 2002 to the NHS covering the next three years, had the specific target:

> Deliver a one percentage point reduction per year in the proportion of women continuing to smoke throughout pregnancy, focussing especially on smokers from disadvantaged groups as a contribution to the national target to reduce by at least 10% the gap in mortality between "routine and manual" groups and the population as a whole by 2010, starting with children under one year.

The Health Development Agency has issued recommendations to providers of NHS Stop Smoking Services, which includes specific advice on the provision of stop smoking services for pregnant smokers. The recommendations have been issued to primary care trusts and can be found on the Department of Health's website.

The Department is running a specific media campaign to tackle smoking in pregnancy. The "partners" campaign has been running since 2000 and is based on evidence that the majority of pregnant smokers have a partner who also smokes. The aim is to target partners for the sake of the mother, baby and the whole family.

The Department is also running a media campaign to raise awareness of the dangers of Secondhand Smoke to children and the dangers of Secondhand Smoke in Pregnancy.

The Department of Health funds a NHS Pregnancy Smoking Helpline (0800 169 9 169) to support pregnant smokers. This service provides confidential support from specially trained advisers who can offer advice and guidance to pregnant smokers. The Helpline advisers can also refer pregnant smokers to their local NHS Stop Smoking Service.

31 We recognise the potential of midwives, and of maternity services, to play an expanded role in promoting public health. However, maternity care staff must have access to appropriate levels of training and support if they are to be effective in this role. We recommend that the Department should facilitate the implementation of the proposals in Making a Difference by making a detailed assessment of the training and support needs of staff who provide maternity care. (Paragraph 197)

Midwives play a key role in public health, as part of the multidisciplinary team providing pregnancy care. Midwives are taking a lead role in targeting care and support to women and their families who experience inequality of access to NHS maternity care and inequality in health outcomes.

Delivering the Best – the midwives contribution to the NHS plan was published in May 2003 and provides many excellent examples of midwives working to improve public health across the country. Copies of the Executive summary are available from Catherine McCormick, Midwife Advisor at the Department of health. The full text can be accessed at the Department of health web-site at www.doh.gov.uk/deliveringthebest/index.htm.

The Nurses and Midwives Council have acknowledged the need for education in public health in their proficiencies for pre registration midwifery programmes.

Select Committee on Health Ninth Report of session 2002-03 Choice in Maternity Services Detailed Response to the Committee's Recommendations

1 For most women, giving birth is a normal physiological process, not an illness. It is not clear to us that the usual methods the Department employs to measure the effectiveness of services (which must inevitably focus on clinical outcomes) are necessarily the most appropriate for maternity services. We also note the surprising paucity of evidence in this area, given that over half a million births are recorded by the NHS each year. So we would welcome the Department commissioning some more research on the fundamental needs, wishes and concerns of women in this area to gain a better picture of what women think about maternity care but also to see how they would respond to different lead carers and different birth settings. (Paragraph 18)

The Government agrees that for the majority of women pregnancy and childbirth are normal life events not illnesses. The Government welcomes women's views. The Department of Health is funding a research project (£200K), which will be undertaken by Southampton and Portsmouth NHS Trusts and will look at what influences women when they make decisions about place of birth and their lead carer. As well as research being commissioned by the Department of Health it is important that PCTs and trusts regularly gauge the views of women and their families in order to provide services that are relevant to their communities.

2 We note the Leeds University research which suggested that high levels of intervention in care had militated against better psychological outcomes being achieved as a consequence of greater choice. The Department needs to ensure that women are given a genuine and informed choice, and not the illusion of choice that some of our witnesses suggested was currently the case. (Paragraph 25)

The Department of Health is committed to providing choice in maternity services for all women. Organisations and individual views were taken during the recent choice consultation, which led to the publication of *Building on the Best – Choice, Responsiveness and Equity in the NHS* (December 2003). The maternity guides *You're Pregnant* equip women with valuable health information and services available in their area. The NSF will advocate the provision of information to allow women to make real choices about their maternity care.

3 We were concerned to hear that some women found it hard to access maternity care without a referral from a GP. We advised the Minister that even NHS Direct was not giving correct advice to callers on how to access maternity services suggesting that the only route was via a GP. We would expect this advice to be updated. (Paragraph 28)

NHS Direct sites that have access to the A – Z chapters of health have correct advice for callers on how to access maternity services. However, the advice offered by NHS Direct on access to maternity services is inconsistent as not all sites have access to the A – Z Chapters of health. NHS Direct has taken on board the comment raised by the Health Select Committee and have agreed with NHS Direct Online as a priority to update and standardise the information. NHS Direct will undertake a series of "Mystery Shopper" exercises to ensure NHS Direct is providing correct information on how to access maternity services.

4 For our part, we do think it appropriate that women should be encouraged to contact midwives as their first port of call and to at least be aware of their right to have a home birth without seeking "the GP's permission". This could be done by ensuring all GP receptionists and hospital units know of the appropriate midwife to refer women to, by notices in GP practices advising women on how to contact midwifery services directly and by local telephone directories having a contact for midwifery services. (Paragraph 31)

A woman can already go direct to a midwife rather than her GP when she finds out she is pregnant. However for lot of women this option would not occur to them. The Government recognises this issue that is why it was included in *Building on the Best Choice*, *Responsiveness and Equity in the NHS* (December 2003). For many women seeing their GP first is unnecessary and can delay access to specialist advice. This document asks local services to publicise contact details for midwives so all women know they have the option of direct access. The way local services publicise this information is for them to decide – notices in GP practices and details in local telephone directories would be an effective way of getting the message across. A woman would then be able to discuss all her birthing options, including the possibility of having a home birth direct with the midwife early in her pregnancy. The forthcoming NSF for children is also likely to support the principle of direct access to a midwife.

5 We therefore recommend that, as part of the Children's NSF, the NHS should ensure that each pregnant woman has at least one initial 'booking appointment' with a community midwife who has in-depth knowledge of local services, and who has received special training to help newly pregnant women with this type of decision-making. Women whose first contact is with their GP should be referred automatically to a community midwife. (Paragraph 37)

The Government accepts this recommendation. The Children's NSF is looking carefully at recommendations around booking and will emphasise the importance of early access to a midwife who will be able to provide women with information on local services. The recently launched *You're Pregnant* local maternity guides will be a valuable tool in informing women of the options open to them.

6 We recommend that the Government uses the opportunity presented by its forthcoming NSF as an opportunity to recast maternity services to the advantage of both women and their carers. We feel that the current delivery of maternity services, which is generally led by acute general hospitals, over-medicalises birth. Through the NSF, PCTs should be given a lead role in ensuring there is choice and community-led services for women, wherever they live. (Paragraph 42)

The Children's NSF is likely to emphasise the objective of modern maternity care – to place every woman and her baby at the centre of services that are acceptable, designed around the needs of women and their families and provide flexible and equal access to high quality clinical and supportive care. The NSF will acknowledge that for the majority of women pregnancy and childbirth are normal life events facilitated by health care and other professionals during which medical interventions should only be recommended if they are of benefit to the mother and/or child.

7 We accept that local configuration of services is a matter for local determination but given that pregnant women are not able to travel long journeys to give birth, if midwife led units are not available local choice is severely constrained. (Paragraph 48)

It is for local service developers to design services to meet the needs of their local population taking fully into account their views. The Government accepts that where a midwife led unit is a fair distance from the woman's home this can have an impact on choice. Choice should be informed by the locally available options for pre-birth, birth and post natal care and an understanding of clinical risks. Some midwife led units are underused that is why the Department of Health is funding the research as detailed in the answer to recommendation 1.

Even when services are close in proximity to a woman's home, some women particularly those from vulnerable groups in society find it difficult to access, or maintain access with maternity services.

8 In costing proposed closures the Department should ensure that local health services take into account the full and long term costs and benefits of the services being considered, including the likely impact on the recruitment and retention of midwives, on breastfeeding rates, postnatal depression rates and reduced intervention and caesarean rates which these units tend to achieve. We believe, as did our predecessor committee, that there should be a presumption against closure of smaller maternity units because without them the shift in attitude which they wanted and we want to see will be very much harder to deliver. (Paragraph 49)

In February 2003, *Keeping the NHS Local – A New Direction of Travel* was published. This provided new guidance on service change that builds on the new arrangements for patient and public involvement in health that came into force on 1 January 2003. It challenges the view that 'biggest is best', and explores some innovative ways of keeping high quality locally accessible services within the bounds of patient safety. These service models are presented for consultation.

The guidance sets out that when considering service expansion and redesign, there are 3 core principles to be followed:

- developing options for change *with* people, not for them, starting from the patient experience and our commitment to improve choice, and working with staff to develop new ways of delivering services;

- focus on *redesign* not *relocate*. Redesign can offer a high quality alternative to relocating services, extending the range of options for developing new configurations that meet local needs and expectations;

- taking a *whole systems* view: the NHS needs to exploit the contributions of different hospitals, primary, intermediate and social care providers within a whole systems approach. These providers can expand the range of options available to meet centralising pressures by working in partnership, with genuine integration and joint planning of services.

Wherever change is being considered, local health organisations, working with their partners, will need to satisfy themselves that their plans are in line with the core principles set out here.

9 We believe that our recommendations above, calling for a shift towards midwife bookings, greater autonomy for midwives in delivering services and sufficient priority given by trusts to maternity issues would reverse the worrying medicalisation of birth reported to us. (Paragraph 50)

The Government agrees that measures promoting direct access to midwives and greater autonomy for midwives will help to increase the normality of the birthing process. We are in favour of reducing unnecessary intervention however it is important to realise that some women and babies have had their lives saved by medical intervention. Those women who have undergone interventions should be supported and not be made to feel that they have failed in any way.

10 We support the Secretary of State's policy goal of making home birth more widely available but are disappointed that nothing has been done directly by the Department to achieve this over the two years since his statement. It may be that it is expected that the NSF will achieve this and if so we would welcome that but we believe action could have been taken on this independently of the NSF. (Paragraph 52)

The NSF has been the main vehicle to develop policy in maternity services. The final NSF will be published later this year and is likely to address the issue of homebirths.

11 We regard this treatment of women [the introduction of barriers against home birth] particularly at such an important stage of their pregnancy as wholly unacceptable. If trusts have staff shortages they should call on the services of agency staff and independent midwives so that women in hospital and at home do not have to face the prospect of not being properly supported in labour. The Department should ensure that via a fast-track complaint or other procedure women experiencing any pressure like this should have an immediate source of help for the situation to be resolved without delay. (Paragraph 60)

The Government believes that all women should have the option to have a home birth if they wish. We have already outlined the action we are taking to recruit and retain midwives. It is a matter for the trust whether to take up the use of agency staff and independent midwives when planning their services.

12 Rather than perceiving home births as a potential drain on scarce resources we see them as a gateway to promoting normal birth and a spur towards midwife recruitment and retention. We endorse AIMS' recommendation that all trainee midwives should be obliged to attend a minimum of three home births as an essential part of their training. We believe that this would help tackle prejudice against home births amongst health professionals, But we also believe it would be very beneficial if GPs and consultant obstetricians attended a similar number of home births to give them insights into the process and to provide for a more informed and rational debate. (Paragraph 64)

See recommendation 13

13 Home births, we believe, would be far better supported if there was a general principal of continuity of carer, an issue we raised in our first report but reiterate here. (Paragraph 65)

The Government is committed to the principles of good quality, woman-centred maternity care. Women should receive clear, unbiased advice and information so that they can make informed choices about their care, including where the birth takes place. The NHS has a legal duty to provide a maternity service however there is not a similar legal duty to provide a home birth service to every woman that requests it. It is for local service providers to decide on the pattern of service provision taking into account the needs of local people. All health care professionals involved with home births should receive appropriate training.

14 There may be scope for creating the post of maternity assistant to help deliver services in the community. Such a person could also assist in the role of educating and informing pregnant women and in neonatal and postnatal support in areas such as breast feeding as happens in Hythe, Hampshire and Lymington. (Paragraph 66)

The Government welcomes the development of local innovative approaches to use maternity assistants to deliver the services women want within their communities. The NSF is looking into the potential future use of maternity support workers.

15 If a woman wants or needs to be cared for in an acute hospital setting, she should also be offered a choice of different acute units where this is practical. As our previous inquiry has shown, the type of care a woman is likely to receive can vary significantly from hospital to hospital, and even between different consultants in the same unit. That inquiry recommended that individual consultant data on, for example, the caesarean rates of different consultants, together with national and local comparisons, should be given to all users. (Paragraph 68)

See recommendation 16

16 Professor Dunlop, for the RCOG, thought there would be "no problem at all" with such a recommendation provided that the data took account of the different case mix of units, and we accept that this is an important requirement. (Paragraph 69)

The Government has no plans to make available individual consultant data regarding the number of caesarean sections performed.

17 The NCT also told us that miscarriage rates following invasive testing are also reported to vary significantly. Echo, the fetal heart charity, also pointed to an inequality in the detection rates of congenital heart disease through ultrasound screening from 3% to 68%. The Department should investigate and take action if there is such a variation. (Paragraph 78)

The UK National Screening Committee will be reviewing ultrasound screening for structural anomalies and will consider any available evidence.

18 We do not believe that simply making tests available is in itself an extension of choice. Testing and screening sometimes inhibit rational choice and sometimes encourage higher levels of intervention. We recognise that many women will want to have the tests available and support them in that choice but women do need to be fully informed of the purpose and consequence of all tests, so that tests are not treated simply as a routine part of the process of being pregnant. We recommend that the NSF should specify the minimum screening services that should be available in all areas of the country. (Paragraph 82)

The Government agrees that women should be fully informed of the purpose and consequence of all tests in order to make an informed choice. Some women will feel that their pregnancy is being over medicalised and they are able to refuse more tests. However there is a high uptake of antenatal screening and on balance most women prefer to be tested.

The Department of Health has published guidance on Down's syndrome screening based on advice from the UK National Screening Committee (NSC). It complements and supports the NICE guidelines on antenatal care. The guidance provides a framework for women to receive a high standard of antenatal screening, to be well informed during pregnancy and to be supported to make an informed choice by health professionals. This is part of the Department's overall programme to improve the quality of all antenatal screening programmes. The work includes developing training programmes across the country for clinicians and screening co-ordinators. Improved communications and counselling will ensure that the nature and purpose of the screening programme is made clear to all those choosing to take part. Counselling and support will also be available to those who decide not to have screening. The NSC's programme is intended to ensure that women across the country receive a high standard of antenatal screening and consequently reduce the variations in the provision and quality of services.

19 The NCT reported to us that the evidence-based guidelines on the induction of labour published by the RCOG and NICE in 2001 were being interpreted in very different ways across the country. The guidelines stated that 'women with uncomplicated pregnancies should be offered induction of labour beyond 41 weeks'. The guideline also said that 'women must be able to make informed choices'. The NCT reported that many women were not being supported to make decisions that they felt were right for them and that professionals were not respecting women's right to refuse unwanted treatment. (Paragraph 83)

The Government notes this recommendation. The NSF has examined the whole issue of information and it is likely that the NSF will support women in making informed choices.

20 We recommend that women should receive evidence-based information on the balance of risks and benefits of induction of labour at different times, so that those whose pregnancy continues beyond term can make informed decisions about whether to accept the offer of a medical induction at around 41 weeks or at any stage thereafter. Where women refuse treatment their decision should be respected. (Paragraph 84)

The Government agrees with this recommendation. Women should be given timely information to make informed decisions and their decisions should be respected.

21 If the arguments of the NCT and AIMS are soundly based, and hundreds of thousands of women are being asked to give birth in wholly inappropriately designed rooms, this would be a matter of very great concern. We are not the appropriate body to judge on such clinical matters but we suggest that the National Institute for Clinical Excellence should be able to investigate this important issue as a matter of priority. (Paragraph 88)

NHS Estates, along with an expert group, is currently updating Health Building Note (HBN) 21 'Facilities for maternity care', to give planning and design advice on all types of unit from stand-alone midwife-led centres in the community to tertiary consultant units and it will take on board the findings of the recent NCT report, 'Creating a better birth environment'. A representative from the NCT has been involved in this work.

The main principle that has emerged from the scoping process is that regardless of the setting, "normality" is key. LDRP (labour, delivery, recovery and post-partum) rooms, which most women will occupy for the entire period of their stay, must ensure access to all facilities needed for intervention appropriate to the type of care provided. However, whatever the setting and the type of care that the woman is receiving, the environment should be as normal as possible with a comfortable hotel-style ambience and should enable self-management in privacy whenever possible. The social needs of higher risk groups should not be overlooked – more medical units need to include some of the elements seen in birth centres in the community, in order to create an environment that is less clinical and threatening.

The HBN will reflect the need for choice by recommending the availability of single rooms for women who do not wish to remain in the same room following recovery and bays for women who wish to be in the company of other women.

The guidance is intended for designing a maternity unit in a new building, however the principles outlined are equally valid for upgrading and adapting existing buildings. Units without a major refurbishment programme can also make a difference to what is available in terms of cleanliness, furnishing and décor without a lot of capital expenditure.

The first draft will be circulated widely for consultation shortly and NHS Estates aim to publish the document on their web site by the end of March 2004.

22 While we acknowledge that there may be problems of space and security which might limit the overall number of partners who can be present we do not think that it is reasonable that women should be limited to a single birth partner in any circumstances. Such an attitude suggests birth is being managed for the convenience of the unit rather than the mother. We look to the Department to support the view that women should not be limited to a single birth partner. (Paragraph 93)

The Government supports the view that trusts should welcome fathers and/or birthing partners. The decision to allow more than one birthing partner to support the woman during labour should be made by the unit taking into consideration available space and the privacy of other women and of course the wishes of both the woman herself and other women/families in the unit.

23 We believe that if maternity units have pools, as most now do, a woman giving birth should have a reasonable expectation that the pool will be available for her use except in cases where demand is abnormally high. Efforts should be made to ensure that maintenance is organized so as to restrict as little as possible the hours which the pool may be accessed. We think it is unacceptable that midwives should be uncomfortable in dealing with mothers using birth pools: this is a matter that should be addressed in training and through professional development. We agree that it should not be acceptable for midwives to be unable or unwilling fully to support women using birth pools. (Paragraph 97)

The Government agrees that where a unit has a pool it should be maintained in accordance with safety regulations and made available to those women who wish to use it. Midwives should be trained to feel confident in handling a water birth.

24 We hope that the NSF will include choice for women on the length of time they can stay in hospital or in a midwife-led unit after birth and allow for flexible support in the community for up to eight weeks from midwives and health visitors working as a team. (Paragraph 106)

The Children's NSF is likely to set standards for postnatal care that will ensure that a woman's individual physical and psychological health and social needs will be met and that a multi- disciplinary team will assess, taking on board the views of the woman and her family, when she is ready to leave the maternity unit and the levels of support she will need in the months following the birth.

25 The consultation paper [Making Amends] does not explicitly address the issue of defensive medicine, and we are not convinced that on their own these reforms will have a significant impact on the more defensive clinical practices that have become entrenched in maternity care in recent years. It will take time to establish whether such a scheme can engender a true 'no-blame' culture in the NHS, or whether admission of responsibility for a clinical error or misjudgement would still go hand in hand with individual clinicians being singled out or stigmatised, an approach which may still be perceived as being implicitly punitive. A system of collective, team-based responsibility might be more likely to succeed in building clinicians' confidence to report adverse incidents. Our concern is that the defensive approach to medicine may particularly undermine giving women choice in maternity services and we urge the Government to implement and monitor any changes with this in mind. (Paragraph 110)

The Chief Medical Officer has made a series of recommendations to reform the way in which clinical negligence claims are handled within the NHS. Under the subject of defensive medicine, the reforms directly address criticisms of the present system where 'harm' caused by healthcare has to be litigated in court where lengthy, adversarial legal proceeding can be seen to add to a climate of blame in health organisations. This undermines the doctor-patient relationship and damages the morale of clinicians and clinical teams and may encourage professionals to practise defensive medicine – a problem at its most extreme in the United States of America. As part of the work to further develop policy in this area, research will be commissioned to provide more information about the practice of defensive medicine in the UK, a subject area that has been under-researched to date. Findings will help formulate final policy details.

The recommendations include the introduction of a 'duty of candour' and protection from disclosure of information in court to encourage the reporting of adversarial events without the fear of litigation. They will assist with investigations of and learning from events, complaints and claims. It is often not the fault of one particular individual but a failure of a system or series of events. By promoting openness and reporting 'near misses', the NHS will be able to resolve these issues and continually improve the quality of service rather than experiencing accidents where blame is often linked to an individual.

Of direct relevance to maternity services and defensive medicine, the reforms include a redress scheme that offers a package of care and compensation for severely neurologically impaired babies in defined circumstances, including those with severe cerebral palsy if the impairment was birth-related.

26 We therefore would urge the Government to consider allocating some one-off resources to maternity units wanting to make changes to their practise so that they could carry out this work. Unlike the £100m allocation the Government announced in 2001 for maternity services this one-off allocation might be used more to support staff than building improvements. This might be done in the form of a team of people who local units could ask to be brought in to support a service either by releasing local staff to do the work themselves and/or by helping them make changes. Independent midwives may be a particularly useful source of staffing for a part of these teams. (Paragraph 115)

The Department of Health will explore with the Modernisation Agency their role in supporting this recommendation.

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