



House of Commons  
Committee of Public Accounts

---

# Maternity services in England

---

**Fortieth Report of Session 2013–14**

*Report, together with formal minutes, oral  
and written evidence*

*Ordered by the House of Commons  
to be printed 20 January 2014*

**HC 776**  
Published on 31 January 2014  
by authority of the House of Commons  
London: The Stationery Office Limited  
£12.00

## Committee of Public Accounts

The Committee of Public Accounts is appointed by the House of Commons to examine "the accounts showing the appropriation of the sums granted by Parliament to meet the public expenditure, and of such other accounts laid before Parliament as the committee may think fit" (Standing Order No 148).

### Current membership

Rt Hon Margaret Hodge (Labour, Barking) (Chair)  
Mr Richard Bacon (Conservative, South Norfolk)  
Stephen Barclay (Conservative, North East Cambridgeshire)  
Guto Bebb (Conservative, Aberconwy)  
Jackie Doyle-Price (Conservative, Thurrock)  
Chris Heaton-Harris (Conservative, Daventry)  
Meg Hillier (Labour, Hackney South and Shoreditch)  
Mr Stewart Jackson (Conservative, Peterborough)  
Fiona Mactaggart (Labour, Slough)  
Austin Mitchell (Labour, Great Grimsby)  
Nicky Morgan (Conservative, Loughborough)  
Nick Smith (Labour, Blaenau Gwent)  
Ian Swales (Liberal Democrats, Redcar)  
Justin Tomlinson (Conservative, North Swindon)

### Powers

Powers of the Committee of Public Accounts are set out in House of Commons Standing Orders, principally in SO No 148. These are available on the Internet via [www.parliament.uk](http://www.parliament.uk).

### Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the internet at [www.parliament.uk/pac](http://www.parliament.uk/pac). A list of Reports of the Committee in the present Parliament is at the back of this volume. Additional written evidence may be published on the internet only.

### Committee staff

The current staff of the Committee is Sarah Petit (Clerk), Claire Cozens (Committee Specialist), James McQuade (Senior Committee Assistant), Ian Blair (Committee Assistant) and Janet Coull Trisic (Media Officer).

### Contacts

All correspondence should be addressed to the Clerk, Committee of Public Accounts, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general enquiries is 020 7219 5708; the Committee's email address is [pubaccom@parliament.uk](mailto:pubaccom@parliament.uk)

# Contents

---

<b>Report</b>	<i>Page</i>
<b>Summary</b>	<b>3</b>
<b>Conclusions and recommendations</b>	<b>5</b>
<b>1 The management of maternity services</b>	<b>9</b>
<b>2 Women’s experience of maternity care</b>	<b>12</b>
<b>Formal Minutes</b>	<b>15</b>
<b>Witnesses</b>	<b>16</b>
<b>List of printed written evidence</b>	<b>16</b>
<b>List of Reports from the Committee during the current Parliament</b>	<b>17</b>

## Summary

---

The vast majority of women have good outcomes from NHS maternity services and most rate the care they receive as excellent or very good. However, performance and outcomes could be much better. The rate of stillbirths and babies dying within seven days of birth is higher in England than in the other UK nations, there is significant variability in the quality of care between trusts, and there are persistent inequalities in the experiences of different groups of women. When NHS maternity care goes wrong, the impact can be devastating for those affected and costly for the taxpayer. Nearly a fifth of spending on maternity services is for clinical negligence cover. The Department of Health (the Department) published *Maternity Matters*, its strategy for maternity services, in 2007 and yet still has little grip in key areas and little assurance about performance.

## Conclusions and recommendations

---

1. Having a baby is the most common reason for admission to hospital in England. In 2012, there were nearly 700,000 live births, a number that has risen by almost a quarter in the last decade. There has also been an increase in the proportion of 'complex' births, such as multiple births or those involving women over 40. Maternity care cost the NHS around £2.6 billion in 2012-13. The Department is ultimately responsible for securing value for money for this spending. Since April 2013, maternity services have been commissioned by clinical commissioning groups, which are overseen by NHS England. Maternity care is provided by NHS trusts and NHS foundation trusts.
2. **There is confusion around the Department's policy for maternity services, what it wants to achieve and who is accountable for delivery.** Having clear objectives and accountabilities is crucial in a devolved delivery chain like the NHS. Stakeholders told us they were confused as to the current policy objectives and whether Maternity Matters removed the policy framework. In addition, some of the Department's main objectives for maternity services, such as continuity of care for women by midwives, are described only as aspirations not objectives. The Department and NHS England struggled to articulate to us who is accountable for even the most fundamental areas of maternity care, such as ensuring the NHS has enough midwives. At local level, it is unclear how commissioners are ensuring maternity services meet the Department's policy objectives, or how they are holding trusts to account. Over a quarter of trusts lacked a simple written service specification with their commissioner last year.

**Recommendation:** *The Department should set out clearly its objectives for maternity care, explicitly stating who is accountable for their implementation and how success against its objectives will be measured.*

3. **The Department has not demonstrated whether its policy objectives for maternity services are affordable.** There is evidence from stakeholders that many maternity services are running at a loss, or at best breaking even, and that the available funding may be insufficient for trusts to employ enough midwives and consultants to provide high quality, safe care. The Department has recently introduced a new payment framework for maternity care. However, the evidence we received suggests that the Department had only limited assurance that the new tariff payments would provide sufficient income to providers to deliver the Department's objectives. Stakeholders believed more could be delivered for less money with better outcomes if there were more midwife-led birth centres available. The payment framework was one factor inhibiting the increase in such birth centres. Although there has been a welcome increase in midwives there is still a national shortage of some 2,300 midwives required to meet current birth rates. Pressure on staff leads to low morale and nearly one third of midwives with less than 10 years' work experience are intending to leave the profession within a year. Over half of obstetric units do not employ enough consultants to ensure appropriate cover at all times. Evidence suggests quality of care is less good at weekends.

**Recommendation:** *The Department should assess, through a detailed costing exercise, the affordability of meeting its policy objectives, and work with NHS England and Monitor to review whether the current tariffs for maternity care are set at the right level. The department should ensure the financial incentives enable the best and most appropriate services to be developed at the lowest cost.*

4. **The clinical negligence bill for maternity services is too high.** Clearly victims of poor care need to be properly compensated, but clinical negligence costs have spiralled and reduce the money available for frontline care. Maternity cases account for a third of total clinical negligence payments and the number of maternity claims has risen by 80% over the last five years. The rate of babies who are stillborn or die within seven days of birth in England compares poorly with the other UK nations and some European countries. Some £480 million, nearly a fifth of trusts' spending on maternity services, is for clinical negligence cover, equivalent to £700 per birth. The NHS Litigation Authority has recently produced helpful research on the causes of maternity claims, such as mistakes in the management of labour.

**Recommendation:** *The Department and NHS England should build on recent research to address the main causes of maternity clinical negligence claims and to stop so many claims coming forward. They should also investigate the variations in performance between trusts to see how services can be improved so that fewer tragic mistakes occur.*

5. **Women want more choice about where to give birth.** The number of midwifery-led units, where midwives take primary responsibility for care, increased from 87 in 2007 to 152 in 2013, but only 11% of women gave birth in these units in 2012. Research by the National Federation of Women's Institutes and the NCT suggests that only a quarter of women want to give birth in a hospital obstetric unit, with care led by consultants. However, 87% of women still gave birth in this setting in 2012. Women who have a low risk pregnancy should be able to choose where to give birth and such a large disparity between what women want and what women receive in terms of choice of place of birth is unlikely to be driven by clinical need alone. Over a quarter of maternity units had to close to admissions for half a day or more between April and September 2012. While such short-term closures of maternity units can safeguard the quality and safety of care when demand might outstrip capacity, they further restrict the level of choice available to women.

**Recommendation:** *NHS England should build on recent research to investigate the factors that affect women's choice of place of birth, including closures of maternity units, and what inhibits women from exercising choice in practice.*

6. **The NHS has failed to address persistent inequalities in maternity care.** The NHS has had a specific objective to promote public health with a focus on reducing inequalities in maternity care since 2007. However, the latest available data (from 2010) on women's experiences showed black and minority ethnic mothers were less positive about the care they received during labour and birth than white mothers. They were also significantly more likely to report shortfalls in choice and continuity of care. The Department intended to address inequalities through improved early access to maternity care, but data also show regional and demographic inequalities in

the proportion of women receiving an antenatal appointment within 12 weeks of conception.

**Recommendation:** *NHS England should set out what it intends to do to reduce inequalities, take the appropriate action as a matter of urgency, and report annually on progress.*

7. **Local maternity networks are an important way of sharing good practice and reducing variation, but they are not obligatory and those that do exist tend to be less well developed than other NHS networks.** Maternity networks bring together commissioners, providers and other stakeholders (including users of maternity services) in a local area with the aim of achieving the best possible outcomes for women and babies and tackling variations in outcomes. Despite recommending the creation of maternity networks in its 2007 maternity strategy, the Department has not made it compulsory for commissioners and providers to create them and a quarter of trusts are still not part of a network. In addition, less than 40% of trusts are part of a maternity network with a paid coordinator, compared with 90% for neonatal networks.

**Recommendation:** *NHS England should actively manage the development of maternity networks across the NHS, and set out what arrangements it will put in place to ensure the sharing of good practice between, as well as within, networks to improve quality and eradicate unacceptable variations across the country.*

8. **The Department lacks the data needed to oversee and inform policy decisions on maternity services.** The Department's main source of data for assessing performance against its strategy is the Care Quality Commission's survey of women's experiences carried out once every three years. The Department seemed to be unaware of other relevant research, for example from the National Federation of Women's Institutes and the National Childbirth Trust, that it could be using to supplement its understanding of the performance of maternity services. The NHS is in the process of implementing a new 'dataset', comprising over 100 data items covering all the maternity care received by every woman. But collection of this data will only be mandated from 1 April 2014, almost five years later than planned and there are no minimum requirements for the IT systems that will support collection of the data.
9. **Recommendation:** *The Department and NHS England should make better use of existing and emerging data, and of research, to monitor progress against its policy objectives and to inform decisions.*



# 1 The management of maternity services

---

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health (the Department) and NHS England about maternity services in England. We also took evidence from the National Childbirth Trust (NCT), the Royal College of Midwives, and a consultant obstetrician.<sup>1</sup>

2. Maternity is a unique area of the NHS as the services support predominantly healthy people through a natural life event that does not always require doctor-led intervention. Having a baby is the most common reason for admission to hospital in England and, in 2012, there were almost 700,000 live births. The number of births has increased by almost a quarter in the last decade, placing increasing demands on NHS maternity services. Over recent years there has also been an increase in the proportion of ‘complex’ births, such as multiple births and those involving women over 40 or women with obesity or pre-existing medical conditions, meaning care often requires greater clinical involvement.<sup>2</sup>

3. Maternity care cost the NHS around £2.6 billion in 2012-13. The Department has devolved the commissioning, provision and regulation of maternity services, but it remains ultimately accountable for securing sufficient resources for healthcare from the Treasury and for achieving value for money for this spending. Since April 2013, maternity services have been commissioned by clinical commissioning groups which are overseen by NHS England. Prior to this, services were commissioned by primary care trusts. NHS trusts and NHS foundation trusts provide maternity care to women.<sup>3</sup>

4. In 2007, the Department set out its policy for maternity services in its strategy document *Maternity Matters*. Its aims include to improve performance against quality and safety indicators and to promote public health with a focus on reducing inequalities. The Department intended to achieve its aims by: offering women choice in where and how they have their baby; providing continuity of care from midwives; and ensuring an integrated national service through networks and agreed pathways of care.<sup>4</sup>

5. Stakeholders told us they were confused about whether *Maternity Matters* was still the current policy. During our hearing, the Department confirmed that *Maternity Matters*, and subsequent ministerial commitments such as the ‘named midwife’ guarantee, remain government policy. However, we note that a number of the individual objectives, such as continuity of care, have been expressed by the Department in aspirational terms, with a lack of clarity about what they mean in practice and how they will be achieved. Additionally, it is not clear who we should hold to account for important aspects of maternity care. For example, the Department and NHS England struggled to articulate to us who is accountable for ensuring the NHS has enough midwives.<sup>5</sup>

---

1 C&AG’s report, Maternity services in England Session 2013-14, HC 794, 8 November 2013

2 Qq 90, 167, 267, C&AG’s Report, paras 1, 3, 4

3 Qq 27, 30-31, C&AG’s Report, paras 2, 7-9

4 Qq 2-3, C&AG’s Report, paras 11, 12

5 Qq 22, 33-34, 53-61, 65, Memorandum to the Committee from the Royal College of Midwives, November 2013

6. To achieve its policy objectives, and to hold trusts to account, the Department expects local commissioners of maternity services to guarantee national policy commitments through contractual service specifications with trusts. However, over a quarter of trusts did not have a written service specification with their commissioner in 2012-13. NHS England told us that it is mandatory for clinical commissioning groups to have a service specification for maternity services in 2013-14 and that every group would have a service specification in place by the end of the financial year.<sup>6</sup>

7. The Department funds most maternity care delivered by the NHS through the ‘payment by results’ framework. Under this system, commissioners pay providers fixed prices for each unit of care. We heard from the Foundation Trust Network that funding is inadequate to cover costs. As a result, many maternity services run at a loss, or at best break even, and are cross-subsidised by other services within trusts. The Department and NHS England did not know whether this was the case and did not seem aware of the Foundation Trust Network’s research.<sup>7</sup>

8. In April 2013, the Department introduced a new payment system for maternity care. Rather than paying for each individual activity undertaken, the Department has aggregated the funding to create ‘tariffs’ for the three sections of the maternity care pathway—antenatal, birth and postnatal. However, the Department implemented these new pathway tariffs with only limited assurance on whether they provide sufficient income to providers to deliver the Department’s policy objectives. NHS England told us that it would change the pathway approach if it did not work as intended.<sup>8</sup>

9. We explored whether trusts have sufficient funds to employ the recommended levels of midwives and consultants to provide high quality, safe care. The National Audit Office noted that there were around 21,000 midwives in 2012 and that the number of long-term vacancies reported by maternity units at September 2012 was around 700. However, a calculation based on a widely recognised benchmark for midwife staffing levels suggested a total shortfall of some 2,300 midwives. Following our hearing, we received evidence from the Royal College of Midwives, suggesting that the benchmarks for midwife staffing levels may be financially unachievable under existing funding frameworks. The Royal College noted that the pathway tariffs do not reflect a fully staffed system, because they are based on the average cost of providing services two years previously when, as now, the system was short of midwives.<sup>9</sup>

10. There is also a shortage of consultants, with only 47% of hospital trusts achieving recommended standards in consultancy presence. Standards of care and outcomes vary across the country, and the evidence we heard suggested poorer levels of care at weekends leading to higher levels of complications occurring.<sup>10</sup>

---

6 Qq 61-62, 146-149

7 Qq 23-27, 35-44, 79, C&AG’s Report, para 2.8, Email to the Committee from the Foundation Trust Network, November 2013

8 Qq 44, 196, C&AG’s Report, para 2.14

9 Qq 29, 32, 35-37, 42-44, 66, 125, 133-34; C&AG’s Report, para 1.31, Memorandum to the Committee from the Royal College of Midwives, November 2013; Email to the Committee from the Foundation Trust Network, November 2013

10 Qq 19, 124, 125, 132; C&AG’s Report, paras 1.13 and 1.22

11. The Department's main source of data on the performance of maternity services is the Care Quality Commission's survey. This survey seeks views from a large sample of over 25,000 mothers, but covers just one month in every three years. NHS England noted that trusts have also recently started using the 'friends and family' test to assess people's experience and understanding of the services they receive.<sup>11</sup>

12. From April 2014, trusts will be required to record over 100 data items for every woman receiving maternity care, covering demographic information and details of all the care received.<sup>12</sup> These items will be brought together into a national maternity 'dataset'.<sup>13</sup> This dataset was supposed to be introduced almost five years ago in 2009.<sup>14</sup> The Department explained that the delay had been caused by concerns about the burden that collecting data would place on NHS staff as the original proposal had been for a dataset of more than 1,000 items.<sup>15</sup>

13. The Department told us that it expected electronic data systems would facilitate the collection of the new maternity dataset.<sup>16</sup> However, the National Audit Office found that local data systems are often poor and in 2013 almost one in five maternity units did not have an information system linked to its patient administration system.<sup>17</sup> Although collection of the new dataset will be mandated from 1 April 2014, the Department told us that there are no minimum requirements for the IT systems that would support it.<sup>18</sup> It is not clear to us what assurance the Department has that trusts will purchase IT systems that support connectivity with other parts of the system.<sup>19</sup>

---

11 Q 67, 69; C&AG's Report, para 2.7

12 Qq 70-71, 75

13 Ibid

14 Qq 69, 73, 108; C&AG's Report, para 2.7

15 Qq 76, 108

16 Q 76

17 Qq 76, 103; C&AG's Report, para 2.7

18 Q 103

19 Q 103-114

## 2 Women's experience of maternity care

---

14. For the vast majority of women NHS maternity services provide good outcomes. In addition, most women rate the care they receive—during pregnancy, during labour and birth, and after the birth—as excellent or very good.<sup>20</sup>

15. However, when maternity care goes wrong the consequences can be devastating. Maternity cases account for a third of total clinical negligence payments and maternity clinical negligence claims have risen by 80% over the last five years. Nearly a fifth of trusts' spending on maternity services (some £480 million in total, equivalent to £700 per birth) is for clinical negligence cover. The NHS Litigation Authority has recently produced helpful research on the causes of maternity claims, looking at data from the last ten years. The most common reasons for maternity claims have been mistakes in the management of labour and relating to caesarean sections, and errors resulting in cerebral palsy.<sup>21</sup>

16. The Department told us that it was seeking to reduce the legal costs associated with clinical negligence claims. The Department admitted that there had been no financial penalties for trusts that had higher litigation costs as the amount trusts paid for maternity clinical negligence cover had been based on an assessment of their maternity care processes, rather than their outcomes. However, in future the amount individual trusts pay for maternity clinical negligence cover would be linked to their litigation costs.<sup>22</sup>

17. In 2011, 5,183 babies were stillborn or died within seven days of birth in England, equivalent to 1 in 133, a rate that was higher than in the other UK nations and some European countries. The Department and NHS England referred to work in the West Midlands to detect babies at risk of being growth-restricted, which form one of the greatest proportions of stillborn babies. The stillbirth rate in the West Midlands had come down to below the national average in the past three years, although there was still wide variation between the rates for the region's individual clinical commissioning groups. There is also wide variation between individual trusts in the quality of care provided, as indicated by rates of complication (such as rates of emergency readmission for mothers and babies) and medical intervention (such as emergency caesarean section rates).<sup>23</sup>

18. We questioned the Department about the persistent inequalities in the reported experience and levels of care received by different groups of women. The latest available data, from 2010, show that black and minority ethnic women were less positive about the care they received during labour and birth. They were also significantly more likely to report shortfalls in choice and continuity of care and were less likely to see a midwife as often as they wanted after birth. NHS England recognised that this was a problem noting that the women concerned were often in more deprived communities and that sometimes there were also language or cultural barriers. The Department told us it intended to address inequalities through improved early access to maternity care, but data from the National

---

20 C&AG's Report, para 27

21 Qq 79, 81, 85, 95, C&AG's Report, para 14, 1.15

22 Qq 79, 97-100

23 Qq 69, 151-154, C&AG's Report, paras 14, 1.9

Audit Office show regional and demographic inequalities in the proportion of women receiving an antenatal appointment within 12 weeks of conception.<sup>24</sup>

19. We also asked about the inequalities in the quality of care women receive at weekends compared with weekdays. Rates of maternal infection, infection to the baby and injury to the baby are all higher at the weekend. Although there have been substantial improvements in levels of consultant presence on labour wards in recent years, over half of obstetric units were still not meeting the levels recommended by the Royal College of Obstetricians and Gynaecologists at September 2012. The Department acknowledged that a proper 24/7 service was needed across all parts of the NHS, and that it needed to work out how to achieve this in terms of employment contracts and affordability.<sup>25</sup>

20. The witnesses highlighted the important role maternity networks can play in improving the quality of care by spreading good practice and reducing variation. To achieve the best possible outcomes for women and babies, the Department intended to bring together commissioners, providers and other stakeholders (including users of maternity services) in a local area to form maternity networks. Despite recommending the creation of maternity networks in its 2007 strategy, the Department has not made it compulsory for commissioners and providers to create them and a quarter of trusts are still not part of a network. In contrast, nearly all trusts are part of a neonatal network. Less than 40% of trusts are part of a maternity network with a paid coordinator, compared with 90% for neonatal networks.<sup>26</sup>

21. Choice is central to the Department's strategy for improving maternity services. Women who have a low-risk pregnancy should be able to choose where to give birth, in terms of setting (that is obstetric unit, midwifery-led unit or home birth) and provider. Women may need to be transferred to an obstetric unit if complications occur. However, the Department and NHS England seemed unaware of recent joint research by the National Federation of Women's Institutes and the NCT which shows that there is a significant disparity between what women want and what women receive in terms of choice of place of birth. According to this research, only a quarter of women want to give birth in a hospital obstetric unit, with care led by consultants, but 87% of women still gave birth in this setting in 2012.<sup>27</sup> Not only are women not able to exercise choice as to where their baby is born, but stakeholders considered the costs to the NHS are much higher for births that take place in a hospital setting.

22. The Department pointed to the significant increase in the number of midwifery-led units, which has risen from 87 in 2007 to 152 in 2013. The research by the National Federation of Women's Institutes and the NCT found that more than half of women want to give birth in a midwifery-led unit, where midwives take primary responsibility for care, yet currently only 11% of women do so.<sup>28</sup>

---

24 C&AG's Report, paras 1.5-1.6

25 Qq 37, 124, 132-133

26 Qq 15, 17, 118-120, C&AG's Report, para 2.18 and Figure 11

27 Qq 175-180, 215, The National Federation of Women's Institutes and the NCT, *Support overdue: women's experience of maternity services*, May 2013

28 Qq 175, 180, 215, C&AG's Report, paras 9, 1.42

23. The level of choice available to women in practice is restricted when maternity units have to be closed for short periods to safeguard the quality and safety of care when demand might outstrip capacity. Over a quarter of maternity units had to close to admissions for half a day or more between April and September 2012. The main reported reason for these closures was a lack of either physical capacity or midwives.<sup>29</sup>

# Formal Minutes

---

**Monday 20 January 2014**

Members present:

Mrs Margaret Hodge, in the Chair

Richard Bacon  
Jackie Doyle-Price  
Meg Hillier  
Stewart Jackson

Fiona Mactaggart  
Austin Mitchell  
Nicky Morgan  
Justin Tomlinson

Draft Report (*Maternity services in England*), proposed by the Chair, brought up and read.

*Ordered*, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 23 read and agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

*Resolved*, That the Report be the Fortieth Report of the Committee to the House.

*Ordered*, That the Chair make the Report to the House.

*Ordered*, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report.

[Adjourned till Wednesday 22 January at 2.00 pm]

## Witnesses

---

### Monday 18 November 2013

Page

**Professor Susan Bewley**, Consultant Obstetrician and Senior Honourary Lecturer, King's College, **Belinda Phipps**, Chief Executive, National Childbirth Trust and **Professor Cathy Warwick**, Chief Executive, Royal College of Midwives

Ev 1

**Una O'Brien**, Permanent Secretary, Department of Health, **Sir David Nicholson KCB CBE**, Chief Executive, NHS England, **Professor Juliet Beale**, Director of Nursing, NHS England and **Dr Catherine Calderwood**, Clinical Director, Women's Services, NHS England

Ev 5

## List of printed written evidence

---

1	Professor Susan Bewley	Ev 27
2	Royal College of Midwives	Ev 27
3	Department of Health and NHS England	Ev 28
4	Royal College of Obstetricians and Gynaecologists	Ev 32

# List of Reports from the Committee during the current Parliament

---

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

## Session 2013–14

First Report	Ministry of Defence: Equipment Plan 2012-2022 and Major Projects Report 2012	HC 53
Second Report	Early Action: landscape review	HC 133
Third Report	Department for Communities and Local Government: Financial sustainability of local authorities	HC 134
Fourth Report	HM Revenue & Customs: tax credits error and fraud	HC 135
Fifth Report	Department for Work and Pensions: Responding to change in jobcentres	HC 136
Sixth Report	Cabinet Office: Improving government procurement and the impact of government's ICT savings initiative	HC 137
Seventh Report	Charity Commission: the Cup Trust and tax avoidance	HC 138
Eighth Report	Regulating Consumer Credit	HC 165
Ninth Report	Tax Avoidance – Google	HC 112
Tenth Report	Serious Fraud Office – redundancy and severance arrangements	HC 360
Eleventh Report	Department of Health: managing hospital consultants	HC 358
Twelfth Report	Department for Education: Capital funding for new school places	HC 359
Thirteenth Report	Civil Service Reform	HC 473
Fourteenth Report	Integration across government and Whole-Place Community Budgets	HC 472
Fifteenth Report	The provision of the out-of-hours GP service in Cornwall	HC 471
Sixteenth Report	FiRe Control	HC 110
Seventeenth Report	Administering the Equitable Life Payment Scheme	HC 111
Eighteenth Report	Carrier Strike: the 2012 reversion decision	HC 113
Nineteenth Report	The dismantled National Programme for IT in the NHS	HC 294
Twentieth Report	The BBC's move to Salford	HC 293
Twenty-first Report	Police Procurement	HC 115
Twenty-second Report	High Speed 2: a review of early programme preparation	HC 478
Twenty-third Report	HM Revenue & Customs: Progress in tackling tobacco smuggling	HC 297
Twenty-fourth Report	The rural broadband programme	HC 474
Twenty-fifth Report	The Duchy of Cornwall	HC 475
Twenty-sixth Report	Progress in delivering the Thameslink programme	HC 296
Twenty-seventh Report	Charges for customer telephone lines	HC 617
Twenty-eighth Report	The fight against Malaria	HC 618

Twenty-ninth Report	The New Homes Bonus	HC 114
Thirtieth Report	Universal Credit: early progress	HC 619
Thirty-first Report	The Border Force: securing the border	HC 663
Thirty-second Report	Whole of Government Accounts 2011-12	HC 667
Thirty-third Report	BBC severance packages	HC 476
Thirty-fourth Report	HMRC Tax Collection: Annual Report & Accounts 2012-13	HC 666
Thirty-fifth Report	Access to clinical trial information and the Stockpiling of Tamiflu	HC 295
Thirty-sixth Report	Confidentiality clauses and special severance payments	HC 477
Thirty-seventh Report	Supporting UK exporters overseas	HC 709
Thirty-eighth Report	Improving access to finance from small and medium-sized enterprises	HC 665
Thirty-ninth Report	The Sovereign Grant	HC 775

# Oral evidence

## Taken before the Committee of Public Accounts

on Monday 18 November 2013

Members present:

Margaret Hodge (Chair)

Mr Richard Bacon  
Stephen Barclay  
Chris Heaton-Harris  
Meg Hillier  
Mr Stewart Jackson

Fiona Mactaggart  
Austin Mitchell  
Nick Smith  
Justin Tomlinson

**Amyas Morse**, Comptroller and Auditor General, **Gabrielle Cohen**, Assistant Auditor General, **Laura Brackwell**, Director, National Audit Office, and **Marius Gallaher**, Alternate Treasury Officer of Accounts, were in attendance.

### REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

#### Maternity services in England (HC 794)

##### Examination of Witnesses

*Witnesses:* **Professor Susan Bewley**, Consultant Obstetrician and Senior Honorary Lecturer, King's College, **Belinda Phipps**, Chief Executive, National Childbirth Trust, and **Professor Cathy Warwick**, Chief Executive, Royal College of Midwives, gave evidence.

**Q1 Chair:** Welcome. My apologies for being 20 minutes late. I am really sorry, but we do quite a lot of work and there were one or two issues that we needed to talk about.

Golly, who do we start with? I will start with Sue Saxey.

**Belinda Phipps:** Sue's not here today.

**Chair:** You're from NCT?

**Belinda Phipps:** Yes, that's right.

**Q2 Chair:** I am going to go to you, because you represent the consumers—the mums. When I was preparing for today, one of the things that struck me was the quality of what we offer. Most mums go home. Most births are completely straightforward and everyone goes home completely happy with a bundle of joy—it is one of the nice bits of a hospital. But if you look at our performance in relation to the rest of the UK and the rest of Europe, we are not doing very well. We are not doing well either on maternal mortality, or on child damage and child mortality. From your perspective of dealing with mums, why is that?

**Belinda Phipps:** Cutting it all down to one common factor, the one thing we could do that would make an enormous difference would be to ensure that every woman is able to meet and get to know a midwife, and have that midwife—or that midwife as one of a small team—look after the mother in her pregnancy and be there for her birth. That is called, in the jargon, continuity of carer, so it is having somebody you know supporting you right through this life episode. The evidence on that is building. It has an effect on reducing pregnancy loss before 24 weeks, and on the birth itself—it has an effect on all sorts of things. If you look at the Sands reports on baby deaths, one of

the things that women report—nearly half of women who lose a baby say this—is that they knew that there was something wrong, but nobody believed them. If we pulled it all together with continuity of carer, a lot of the good things the health service does would be more focused, and made better, by a woman having somebody with whom she has a relationship during this life transition. If we were able to do that, satisfaction levels for women would go up enormously. Continuity of carer—that type of care—is the most satisfying care.

**Chair:** I should say that this first half hour, which we stick to, is really for you to tell us where we should be focusing the questions when we are holding the accounting officers to account.

**Q3 Meg Hillier:** You talked about a small group or an individual. An individual is quite expensive, so what sort of size of group would you say would be ideal for achieving outcomes like that?

**Belinda Phipps:** Can I just correct “an individual is quite expensive”? In order to run a proper continuity of carer service, you need about one midwife to 28 women. A full-time midwife can cope with a case load of about 28 women, so it is no more expensive than properly staffing our health service now. However, to make it realistic for a midwife to live their life around it, they quite often work in pairs, or a team of four or perhaps six. The essence is that it is mostly the same midwife who the woman would see. Women aren't unrealistic. They know that people get sick and have children to consider—they know they might have to see somebody else—but at the moment we have a chopped up system. It is like a Ford motor car going through a factory with a different person at every stage. If you are a woman who has suffered

domestic violence or sexual abuse, or if there is something you have to disclose that is painful to talk about, you often have sequentially to disclose it. That is really difficult for women. It is much better if they can build a relationship, and that is where you can get an enormous difference, and then the woman who perhaps has never disclosed these things will disclose them. If she is worried about her pregnancy, or whatever, she will disclose it.

It also gives you an opportunity to deal with two of the big risk factors, because if you meet your midwife early in pregnancy—at about seven to 10 weeks—that is a good time, if smoking and weight have not been dealt with, for that midwife to talk to you about smoking and weight, and to stand a chance of doing something about it, to bring down mortality at or around birth. It is no more expensive than the way we do it now. You do not need any more midwives than you do to run the existing service, and it would increase satisfaction, and likely reduce mortality and morbidity in both mother and baby. There is already evidence to suggest that it should be done. Why aren't we doing it? Because the health service is not organised to deliver like that. It is a monolithic organisation that is organised to care for people who are sick, and chopped up care works reasonably well there; it just does not work very well for maternity.

Continuity of carer means that you do not have shifts in the way you have in a hospital. The midwife weaves her life around caring for her caseload, and it is not the way the bureaucracy thinks. In addition, health service financial systems are not fit for delivering that sort of service. They work for a factory service, but not this sort of service.

**Q4 Chair:** The financial systems, you say. Go on.

**Belinda Phipps:** Gosh, where shall I start? The new payment by results system, although better than the original one, which was payment by activity—or, rather, more payment for more activity, or more payment for more intervention—is now a payment by risk system. The payment by activity system drives hospitals that have high fixed-costs systems to do more to raise their income to cover their fixed costs. Also, there is the capital charge. The way they pay for their space drives them to want to do things in a building, whereas the evidence suggests that if you are a low-risk woman, your baby is equally safe whether you have that baby in a consultant unit, an alongside birth centre, or in a stand-alone birth centre. If you are a second-time mum at home, your baby is equally safe and you will suffer less intervention.

If you have your baby at home and you are low risk, you are four times less likely to have a caesarean section, even if you transfer into hospital. If you have it in a stand-alone maternity unit, you are three times less likely to have a caesarean section, even if you transfer, and you are half as likely in an alongside unit, but health service systems draw people into a central building, and the incentives work against normality. They incentivise you to do things, whereas in maternity—for most women—watchful waiting is actually safer. For a few women, you do need to do things with experts, but for 50% or 60% of women—

maybe more—you need to do less in the community with somebody you know.

**Q5 Chair:** Cathy Warwick, you represent the midwives. Explain to us why we are doing badly—we are doing well for most women, and for most women it is absolutely brilliant, but we are a relatively poor performer.

**Professor Warwick:** Part of the problem is not having enough midwives.

**Q6 Chair:** Why haven't we got enough? There are 1,300 more.

**Professor Warwick:** This Government is doing very well, and you are absolutely right that we have more midwives than we have ever had before, but the problem is that we have had a rising birth rate for the last decade, and, throughout that time, the number of midwives has not been increasing in proportion to the increased birth rate.

**Q7 Chair:** Why not?

**Professor Warwick:** Because we were not training enough midwives and we were not employing enough midwives. We are now in the position where we are training enough midwives. If we carry on training those midwives and get them into employment, we will end up catching up with the birth rate, because that is now levelling off. However, we need to keep training and employing midwives at the kind of rate we have seen for the last three to four years if we are not to have a shortage. It is not just about the birth rate. The other side of this is that births are becoming much more complex, so there is much more for the professionals to do, but I think one of the underpinning problems is a sheer numbers problem.

The other problem is the way we have our services organised. We are not providing services in a way that assures the best outcomes, according to the evidence. At the moment, the vast majority of women give birth in our big obstetric units, which are ideally designed for the very highest risk women. But the evidence indicates that for lower risk women, giving birth in midwifery-led units is better both in terms of outcomes and satisfaction.

**Q8 Chair:** And cheaper.

**Professor Warwick:** And it is cheaper.

On a point that Belinda made, if you keep lower-risk women lower risk and normal, you can employ fewer midwives per head than if those women are turned into high-risk women. For every low-risk woman, the ratio can be 1:35. If we provided for more normal births in midwifery-led services, the chances are that, in the long run, we would manage to deliver the same for less.

**Q9 Chair:** And Professor Bewley.

**Professor Bewley:** I echo both my colleagues. The best measure of maternity services is the traditional one of maternal mortality, to which you rightly draw attention. For more than 150 years it has been a combination of professionalism, evidence, measuring and feedback with a learning culture that has improved the safety and quality of those services. The

---

18 November 2013 King's College, National Childbirth Trust and Royal College of Midwives

---

data in the Report show that people are doing an extremely good job. They should have a big pat on the back because, despite a 10% shortage in the number of midwives and despite the number and complexity of births going up, satisfaction has also gone up. The report even says that international comparisons are difficult to make, so I do not think you should make them.

**Q10 Chair:** Why do you think I shouldn't make them?

**Professor Bewley:** Because I don't think they are robust. We can look to other people for other ideas—

**Q11 Chair:** What is not robust about death rates per thousand?

**Professor Bewley:** Maternal mortality is rising in a number of western countries with different populations.

The other thing I was going to say about maternal mortality is that it tells you about two things: the public health of women before they become pregnant; and everything that puts maternal mortality up is rising, such as age, obesity, inequalities, multiple pregnancies, previous caesareans, previous obstetric history and previous gynae history. The health of women coming into the services is not improving—apart from smoking—and that is a public health issue before they get to us.

**Q12 Chair:** The same would be true in Spain. which has half the rate.

**Professor Bewley:** That is child mortality; I was talking about maternal mortality.

Maternity services tell you about the public health of women, the context in which they get pregnant, a society that makes it easy or difficult to do so, and the health of children becoming adolescents, the young and now, increasingly, older women. It also tells you about the robustness of the health service. We are facing a shortage of midwives on the one hand and more demands on the doctors on the other. If morbidity was rising threefold and maternal mortality was rising only twofold, that would be an increase in productivity, so I don't think you should look simply at just the headline rate. You need to understand what the pressure is, and this report is showing that maternity services—the people delivering them on the ground—are doing very well.

**Q13 Mr Jackson:** May I plug a very old campaign that I have been fighting for? The fortification of basic foodstuffs with folic acid would reduce the tragedy of spina bifida and hydrocephalus, which are neural tube defects about which I have been battling for eight or nine years. Any help you can give to support that would be welcome, because it would reduce the incidence of about 400 cases of live births with those conditions. However, that is not what I will ask you about.

Professor Warwick, I think the Report is generally very positive and that on most criteria we are heading in the right direction, but one thing that is slightly worrying in respect of the Government's ambitions is the recruitment of midwives. Why do you think there

is growing trend for midwifery students to drop out of their courses, and how can the Government improve the situation so that the attrition rate is reduced, because that is obviously having a big effect on established posts in obstetrics units across the country?

**Professor Warwick:** One of the problems is that many students entering midwifery programmes are women with young families and they find being on the course financially difficult. The other reason is that midwives go into midwifery training wanting to do midwifery. At least 50% of their training is clinical practice, but their experience out in the maternity service is sometimes not what they are learning in the classroom, so there is a bit of a theory-practice gap. They are learning about how to support women, how to give them one-to-one care and how to build relationships with them, and some of them unfortunately go out into maternity services that are incredibly busy and big, and they are not seeing that kind of care. So I think it is a sort of chicken and egg situation. The more we could build our services based on the evidence as to what provides high quality, the more our students would learn in the environments that they are hearing are the best, and the more they would stay.

We were quite surprised at those attrition figures in the Royal College of Midwives, because our own are not quite so high. We would be interested in an exploration as to where those figures come from. What happens is that quite a lot of students get pregnant, and they leave, but they do come back again. There is a slight concern on our part about the figures.

**Q14 Chair:** Laura, do you want to help on that?

**Laura Brackwell:** The figures are from the Department of Health. They were given in an answer by Dan Poulter in June. We took our figures from the Department.

**Q15 Mr Jackson:** Looking at page 35 of the report, about trust participation in networks, in your professional experience, is there a close correlation between the participation of commissioning trusts in the maternity networks and better outcomes? To me, it is quite disturbing to see that 26% of trusts are still not part of maternity networks. I guess the bigger question is: how do you get them into a network, where presumably they are going to be absorbing best practice?

**Professor Warwick:** We are certainly very lucky now that we are part of the specialist networks that are funded through NHS England. There are the maternity and children's networks.

It is certainly the experience of the Royal College of Midwives that under the old system, when networks tended to sit at SHA level, if trusts were participating in those networks, you certainly had a real opportunity to reduce variation and to try to ensure that the outcomes were as good across the patch, particularly in relation to things such as intervention. For example, networks played an enormous part in ensuring that there was less variation in caesarean section rates. I certainly think that it will be important that the

maternity and children's networks take on that role. Every effort should be made to ensure that all trusts participate in those networks. It is hard to understand why they wouldn't.

**Q16 Chair:** What is a network, in this context?

**Professor Warwick:** The maternity and children's networks will sit within the new health service system in the NHS in England. They will, I believe, help the local clinical commissioning groups to ensure that they are delivering the best possible care.

**Q17 Chair:** It brings together whom?

**Professor Warwick:** It brings together the midwives, the obstetricians, the anaesthetists and the paediatricians—all the health professionals—across a network. It also includes user representatives and commissioner representatives. You essentially have a body of all involved people working together to try to ensure that, in their area of England, they are achieving the best possible outcomes for women and children.

**Q18 Mr Jackson:** Do you have charities as well, such as Bliss?

**Professor Warwick:** There is no reason, I understand, why they could not be involved.

**Belinda Phipps:** We tend not to be that much involved at the moment, because it is much more of a clinical process. Organisations such as NCT and Bliss tend to sit on the maternity services liaison committees. There is usually one of those for each NHS trust maternity unit.

Just on networks, there sometimes is a bit of confusion about what is what. Yes, it would be a good idea if all providers and all commissioners were involved in networks. What that tends to do is to grade up best practice, so people are more likely to follow NICE guidelines and to spread good practice across the system. We would like to see networks there.

Why are people not involved with them? I am afraid that it comes back to money. The networks are a "nice to have". They are people talking to each other to improve clinical practice. In reality, however, the person who calls the shots is the finance director of the trust. I have been witness to several discussions in a network when the network has agreed that it might be better to do this, that, or the other, such as increasing or reducing a service, or changing it in a particular foundation trust, but the foundation trust has vetoed it because it does not work for its finances. Yes, there should be networks. Yes, we need to find a way to make them operate more. Yes, users should be involved—and should be required to be involved. We also need to ensure that when those networks come up with good things that need to be done, foundation trusts cannot stand in the way because of their own individual organisational interests.

**Professor Bewley:** I have some experience in trying to set up networks in London, which was officially referred to by someone very high up as the "basket case" of maternity services, which I did not find terribly helpful some five years ago. The key thing for a network is information, and there are two types of information. There is the hard data, and, through the

whole of this Report, you are hearing about the quality of coding and the burden of putting data in, which people on the front line do, but not getting information back. I remember talking to Yvette Cooper about the problem of computers and coding in maternity services many years ago at the Health Committee and the problem is similar. The quality of data and the feedback and the transparency are not there on the ground, and that is one problem.

The second problem is with intelligence about what is going on, and about who is in charge and able to make something happen. Very often in a maternity unit, when things go wrong due to human factors in systems at three in the morning, it is because we have a relentless 24-hour service. The only other 24-hour services with no circadian rhythm are intensive care and neonatal intensive care. Working relentlessly through the night is not a popular thing, so mistakes happen. They often happen due to human errors in weak systems in dysfunctional units in dysfunctional hospitals and in places where the big issues are around finance, as was just said, and the concept of the financially viable unit are difficult. We set up the networks and we were then reorganised, but the clinicians are still going to do it. However, paid co-ordinators, such as those for gynae-cancer networks and for neonatal networks, are the key to helping those professionals on the ground to do it with evidence. They are crying out for information and evidence.

**Chair:** Data is an issue that we will take up.

**Q19 Chris Heaton-Harris:** My question is for Professor Bewley. You are right to say that this is a good Report—it is certainly worth a pat on the back—but I think you are wrong to dismiss international comparisons. I have done a lot of work with different stillbirth campaigns, and an article in *The Lancet* not so long ago said that the UK had one of the worst stillbirth records among similarly high-income nations. That journal ranked us 33rd out of 35 countries, with only France and Austria scoring worse; more important, it found that best practice elsewhere had improved the chances of babies coming through the birth period, with Norway and the Netherlands improving their stillbirth rates exponentially over the past 20 years—by 50% and 40% respectively. Where things go well, things go really well and everyone is very happy, but where things go badly, there is still a lot for us to learn and not enough research is being done.

My question is about out-of-hours births, women having their baby at weekends or overnight—a conversation that you briefly skipped over. A study in the *British Medical Journal* in 2010 by Pasupathy, Wood, Pell, Fleming and Smith called "Time of birth and risk of neonatal death at term: retrospective cohort study" suggested that there was a 45% increased risk of neonatal death due to oxygen starvation during births at such times. Surely there are pressure points that we can identify and work on.

**Professor Bewley:** I agree. I want to confirm that I was talking about the maternal mortality rate, which is rising and which I have reported in *The Lancet*. That is the international comparison that I was

---

18 November 2013 King's College, National Childbirth Trust and Royal College of Midwives

---

particularly drawing attention to. I agree with you about the other.

On the second thing about nights, the Report talks about birth injuries at the weekends. Obviously, if you do not get birth injuries or scalpel injuries which you do not see at caesarean sections that only take place on weekdays, that will change the comparison. There is always a problem in the measurement. In the Royal College's view, we have to have properly trained people—we have to ensure that the obstetricians of the future are trained and skilled up—and if you want those people there 24 hours a day and want to get rid of the variation, there is a need to concentrate, because three doctors are needed to make it safe: the obstetrician, the paediatrician and the anaesthetist. They have a different model of providing for those predictable emergencies—we are utterly an emergency service, but it is entirely predictable that women will give birth after they have got pregnant—but that has to be done in a different style of unit, which is compatible but different from what we are doing presently. I think we can do better at days and nights, but we have problems with the skills in obstetrics as well.

**Q20 Mr Bacon:** When you say that there are problems, do you mean that there are not enough good people, or that the people who are doing it are dangerous, or what? What do you mean?

**Professor Bewley:** We have problems in terms of the skills that we are developing with a shorter working week and a shorter length of training, and the confidence of the people coming out at the end of the system. Whether it is a massive haemorrhage or a complicated vaginal delivery, we need supervision while we are training and we need help and support also even when we are coming out of training.

**Q21 Mr Bacon:** When you talk about a shorter working week, that is to do with the working time directive and consultants, registrars and the people who are training not getting the exposure and the number of hours that they would have done. Is that what you mean?

**Professor Bewley:** Yes. And if you look at the GMC reports on unhappiness in different staff specialties, it is an unhappy specialty. There are morale problems.

**Q22 Chair:** We are running late, but are there any issues that we have not covered that you think we should cover with the accounting officers?

**Professor Warwick:** We were very interested in the policy on maternity services. It appears that the National Audit Office has been advised that the current maternity policy in England is "Maternity Matters". The Royal College of Midwives certainly got a slightly different impression—not from the present group of Ministers, but from a previous Health Minister, who in a parliamentary question suggested that "Maternity Matters" was not the current policy. We would be very interested in having it confirmed that "Maternity Matters" is the current England policy.

**Belinda Phipps:** The thing I wanted to raise was the joined-upness issue. We have talked about several different things that need to be done, but it all needs to be seen as a coherent whole. We have a fantastic evidence base in maternity that points to what needs to be done. If you think about low-risk women, it points very clearly to more care in the community and to continuity.

In a separate set of thinking, we have the financial rules which do not bear any relation to the type of evidence that we are trying to follow and, separate from that, there is the CNST, which is not brought alongside all those things. We need to bring those things together, to ensure that the financial systems work in the same direction as the evidence and that the CNST—the insurance system—works in the same direction as the evidence. Cathy has the problem of midwives going through midwifery training to build relationships with women and coming out of that to discover that they are in a factory system. We want to keep those midwives.

For me, it is about joined-upness. It is about there being one set of strategic oversight to make all the different parts work together. Women want a safe birth—they want to come out safe, whole and healthy with a safe, whole and healthy baby—but they also want a positive experience. Giving birth is as much about getting the women to a place where she will fall in love with that baby and be its advocate for the rest of its life as it is about actually having a live mother and baby. We forget the second.

**Chair:** Thank you very much indeed.

---

### Examination of Witnesses

*Witnesses:* **Una O'Brien**, Permanent Secretary, Department of Health, **Sir David Nicholson KCB CBE**, Chief Executive, NHS England, **Professor Juliet Beal**, Director of Nursing, NHS England, and **Dr Catherine Calderwood**, Clinical Director, Women's Services, NHS England, gave evidence.

**Q23 Chair:** Welcome. I will start with you, Una, because I think you have the responsibility for the budget and ensuring that there is sufficient money here. I had an e-mail this morning from the Foundation Trust Network, which is not a mad organisation. It says: "Most maternity services have run at a deficit or break even at best and are cross-subsidised from other services." Is that true?

**Una O'Brien:** Obviously I have not seen the e-mail and I have not seen the data, so I would not be able to say whether it is true or otherwise.

**Q24 Chair:** You would have seen the data; you would know about your own services. You would know how much money was going in, and you would know whether it is true that "Most maternity services"—I do not think they were trying to catch

---

18 November 2013 NHS England

---

you out in any way—“run at a deficit or break even at best and are cross-subsidised from other services.”

**Una O'Brien:** It is a matter for individual providers to organise the running of their entire organisation in the way that they judge best—

**Chair:** I understand that.

**Una O'Brien:** Sorry. Obviously I have not seen the data that they have supplied to you—

**Chair:** I am not asking about—

**Q25 Stephen Barclay:** We are not asking about the message; we are asking about the way in which the finances work.

**Una O'Brien:** This is not something that has been raised with me directly as an issue.

**Q26 Chair:** I am asking about the money, Una. From the Report, it looks to me, and I think our witnesses said the same, as though we have an improving service—I think we all accept that around the table—but it is pretty clear how you could make it even better and put it at the top of European and UK standards rather than where it is at present. It is therefore very worrying to be told by the Foundation Trust Network that there is not enough money, and that they all “run at a deficit or break even at best and are cross-subsidised”. You must know that, because you distribute the money.

**Una O'Brien:** We distribute the money en bloc to NHS England. We do not carve it up by individual services from the Department.

**Q27 Chair:** But you have in your distribution tariffs around—I do not know what you call them nowadays. This is a Department of Health question in terms of accountability. You have to account to us to enable the foundation trusts to realise that they do not have to subsidise maternity services from across other services, because I think the problems arise from that.

**Una O'Brien:** My responsibility in the Department of Health is to secure the resources overall and then to make a disbursement between public health, social care and the NHS. The NHS, under NHS England, is the commissioning organisation, which is responding to the mandates set by Government.

**Q28 Chair:** That is from April this year, isn't it?

**Una O'Brien:** Yes.

**Q29 Chair:** What we are looking at here is pre-April 2013.

**Laura Brackwell:** Most of the data relate to that.

**Chair:** Okay, most of the data relate to that. We have a picture of a growing number of midwives but too few, and not enough consultants. We have a picture here of mums being put into the wrong area for delivery—too many mums in the consultant-led unit rather than the midwife-led unit. And then we hear this information from the trusts that they are running this at a deficit. The moment you hear that, you think, “No wonder there are not enough midwives or there are not enough consultants if that is true.” You set the tariff—or you certainly did till April this year. It then moves to David in his new job, but you set the tariff;

you are accountable, and that is really worrying if it is true.

**Una O'Brien:** I am very happy to comment on the question, but I want to be absolutely clear as to the respective accounting officer responsibilities between myself and David, both pre-April and currently. As I think we have talked about in this Committee before—I think it is important to invite David to comment on this, as he has offered to do—he has been, throughout that period, the additional accounting officer with the direct responsibility for the disbursement of NHS funds. I think that has been a very clear division, for both my predecessor and David and for David himself, and I think it is perfectly legitimate. The carve-up of money to individual commissioners is not something the permanent secretary has had the responsibility for.

**Q30 Mr Bacon:** Ms O'Brien, you said you were responsible for securing the funds.

**Una O'Brien:** Yes.

**Q31 Mr Bacon:** How do you know how much to secure?

**Una O'Brien:** That is set out in a series of negotiations on estimates of the cost of the entire system at the point of the spending review, taking information and working together with the accompanying accounting officer for the NHS. That is how the proposition is put forward to the Treasury at the time of the spending review.

**Q32 Chair:** The other thing to say, which Steve has just drawn to my attention, is that if you look at paragraph 2.13, it states: “In some cases commissioners have also made block payments to support general maternity services that would otherwise have not been financially viable”, so in those cases you have a view about how much should be paid and you do it.

**Una O'Brien:** Yes, but in some cases that is completely acceptable, and we have said even under the new system—

**Q33 Chair:** Who is accountable in this world if there are not enough midwives? You?

**Una O'Brien:** We are responsible for the design of the system in terms of—

**Q34 Chair:** Who is accountable?

**Una O'Brien:** Right now, the accounting officer for the system as a whole is myself, and David is the accounting officer for the NHS and the disbursement of the money in relation to the NHS.

**Q35 Stephen Barclay:** Ms O'Brien, could we just go back to the first question, because I wasn't clear on your answer? Are some maternity units run at a loss?

**Una O'Brien:** That is not something that I am aware of. You are quoting to me information that you have in an e-mail. That has not been put to me directly, but I think David can help with this—

---

18 November 2013 NHS England

---

**Q36 Stephen Barclay:** Just in terms of your understanding, you would not be briefed on whether any maternity units were running at a loss, particularly if, say, there was a stand-alone maternity unit, such as in Liverpool.

**Una O'Brien:** I am not—that has not been raised with me directly as a current issue.

**Fiona Mactaggart:** Actually, it is not just an e-mail. I am looking at a report dated May 2011 from the Foundation Trust Network, which shows a funding gap in all cases other than straightforward delivery cases—we know that that is quite a high proportion of cases—that is quite substantial. It says that only three of the 16 participants covered or exceeded their total costs, based on the data provided. I am surprised that you do not know about this, because this is a publicly available briefing from the Foundation Trust Network, and I can't imagine that it is enormously different from any other part of the health service.

**Q37 Stephen Barclay:** What the Committee is trying to establish is this, Ms O'Brien. This is the most common reason for admission into hospital, and if a unit is being run at a loss, that goes to the heart of whether it can run the recommended consultant staffing levels—that is dealt with on page 20 of the Report, which shows that 53% of obstetric units are not achieving the recommended consultant presence—so their ability to get to a safe level is going to be compromised, which may be in part what is driving the high litigation bill, or they are going to close their doors, which obviously impacts on consumer choice. Surely, in terms of understanding whether the tariffs and charges are right, you need to know whether they are being cross-subsidised from other parts of the hospital or whether they are being paid enough.

**Una O'Brien:** Obviously, the setting of the tariff is a very complicated matter. We know that the overall arrangement up until now has been that some of the activity in maternity care has been under tariff and some of it, because it is based in community services, has been under block contract. Part of the reason for changing the system is so that we can get a much better designed payment system, which more accurately reflects the costs that are incurred.

**Chair:** I do not want to go to the future, because what we are trying to do here is build accountability—

**Q38 Stephen Barclay:** We have just had evidence from the chief executive of the NCT, whose members are the consumers in this, that one of the key impediments blocking the improvements that the mothers are seeking is the financial arrangements for which you are responsible.

**Una O'Brien:** Well, I say again, it is the responsibility of commissioners working with providers to commission the service clearly and make sure that the resources are there to meet that demand.

**Q39 Stephen Barclay:** But they are commissioning under your rules—the rules that you set.

**Una O'Brien:** We have made changes in the way the tariff has developed, very much in the direction of what the previous witness was describing, precisely to

get away from this item-of-service approach to provide a much clearer incentive for a payment that reflects the care of the whole person.

**Q40 Chair:** Una, I think the thing we are saying to you is you should know how much money is going into maternity services. You have set a departmental objective around maternity services. We will come back to whether it is your existing policy or not. You set it. It is therefore down to you as the accountable officer—if we can't get this established we are going nowhere in this Committee—to ensure that income is sufficient to meet the demand set on the policy that you set. What the stakeholders have told us is that they do not have enough money to meet the demand on the policy you have set. That is you.

**Una O'Brien:** In the setting of the mandate and the budget that goes with it, we do not carve up the money by individual service at the centre.

**Q41 Chair:** No, but you set it.

**Una O'Brien:** We set the overall envelope.

**Chair:** It is like a local authority gets the flexibility then to spend, but the central Department will set what they get for roads and for doing this and that activity. You set it. At the moment what we are being told by the stakeholders, by the people who write to us, is that it is not enough.

**Q42 Mr Bacon:** To be clear, they were saying they think they should do more for less. To be strictly accurate they were saying that your rules mean that more money is being spent for poorer outcomes than could be the case. I don't think they were saying, which you are now denying because it is true, "It's that Una O'Brien who carves it up." I think they were saying that you have a set of rules which mean that the money is sub-optimally spent and produces poorer outcomes for bigger expenditure than could be the case. Sir David is bobbing up and down. He is dying to get in. We should probably let him at some point.

**Sir David Nicholson:** Can I try to help with all of this? The tariff is set on the basis of reference costs. It is set on actual costs three years ago. So we set the tariff for maternity services based on what they actually cost during that period. *[Interruption.]* Sorry, I am clearly getting too sensitive, if that is possible. The reference costs are based on actual costs. Whatever it cost two years ago is what is put in the tariff, so there is the possibility of a lag and that we are not doing it quickly enough. About five years ago, we concluded that we were not spending enough on maternity. We thought it needed about another £300 million, so we included that in the PCT general allocations. You can see in the expenditure profile that we had a leap in the amount of expenditure in maternity services two or three years ago. We were trying to balance the amount of money available for maternity and what was required. That is the way the tariff is set and that is the way it was operated.

**Q43 Chair:** Are you aware that most maternity services run at a deficit?

---

 18 November 2013 NHS England
 

---

**Sir David Nicholson:** What they do is they have service level costing. We know that in the NAO Report there is a massive variation in costs—

**Q44 Chair:** That is a different issue.

**Sir David Nicholson:** Yes, but it is not necessarily that people are running at a loss because they are not getting enough money; it may be that their costs are in the wrong place. The tariff is set on the average across the whole of the country.

Secondly, a few years ago we did the tariff in little bits across antenatal, post-natal and all the rest of it. We have now put it into a pathway, and that should— theoretically—make it easier. I understand the criticism of the pathway that we have done, but it was done with a lot of consultation with lots of clinicians and users. From what we hear, it did not quite get it right. We are committed to changing that pathway if that is not the right way to allocate resources.

**Q45 Chris Heaton-Harris:** In the back of the Report in appendix 3, there is reference to the 2007 Report of this Committee about neonatal care, which touches on this point of tariffs. We recommended that tariffs for neonatal care should reflect the full costs of meeting staffing standards, but care is commissioned on a local level based on outdated standards. We knew there was a lag then, in 2007, and there is obviously still this lag in 2013. It would surely be much easier to commission services if they knew what the tariff was going to be and it reflected what the spend on these things would be.

**Sir David Nicholson:** I agree and this year we are going to put out a tariff for two years to give people the opportunity.

**Q46 Meg Hillier:** I want to explore the pathway issue. Many women prefer to have care at primary care level. We have now seen a new regime with CCGs. Some GPs were getting money from previous commissioning bodies, the PCTs, for locally enhanced services and providing their maternity service partly with that money, but with the CCGs in place, it is not certain that that money will continue. What is in the basic GP contract for providing antenatal care to women?

**Sir David Nicholson:** I would have to give you a note on that; I do not have the details.

**Q47 Meg Hillier:** I'm sorry that is perhaps an unfair question. Would you expect, Sir David, that GPs would be able to provide it, and perhaps not at a set time. If you are a woman, you are often told that you come along at 2 o'clock on a Monday afternoon and you will see the midwife, and that is your lot. Frankly, if you are a working woman, you still have a life to lead—you are not sick, just pregnant—and that is really annoying, as is sitting in a hospital for three hours waiting because you all have the same time for an appointment.

Seeing your own GP who knows you, and perhaps knows your previous births, is quite a positive experience; so is having your own midwife, seeing somebody you know. At the moment some GPs are funded extra for providing that. With the new

commissioning regime I am not clear—I am not sure how widespread this is—whether GPs will have that money, the enhanced local services money, taken away, and will therefore reduce their maternity services.

**Sir David Nicholson:** No, the locally enhanced services are commissioned by CCGs.

**Q48 Meg Hillier:** Yes, but would that be expected to cover things like that?

**Sir David Nicholson:** Yes.

**Q49 Meg Hillier:** So if they took that money away, it would stop GPs offering a one-to-one 8 o'clock in the morning appointment to somebody.

**Sir David Nicholson:** The enhanced service, yes.

**Q50 Meg Hillier:** So there is a risk that, with CCGs individually commissioning under managing their own budget, there will be even more variation in what women can get, even in neighbouring London boroughs, for instance.

**Una O'Brien:** I think we have to look at the evidence of what is actually happening. Do not forget that CCGs are principally led by GPs themselves, who are in daily contact with women and other members of the public.

**Chair:** We want a national service and national entitlements, for goodness' sake.

**Una O'Brien:** Yes, and they know what people want. I do not yet have any evidence that those services are being withdrawn because of CCGs. It is just as likely that CCGs would be commissioning more of that as a locally enhanced service.

**Q51 Meg Hillier:** If that is the case, we then have the interesting situation where CCGs, groups of GPs, are deciding what money to spend on themselves to commission from themselves. That is a bit of a problem with CCGs generally. If there is a current contract in place and it is altered, that could be to the benefit of GP practices.

**Una O'Brien:** There are clear rules in place to handle such adverse behaviour, were it to happen. The purpose of the role of CCGs is to serve the whole of their population. If they can best do that through a primary care service, then that is a completely legitimate and proper thing to do.

**Q52 Meg Hillier:** At the moment hospitals get money for the tariff, for this pathway, Sir David. So they are provided that money on the pathway. They are effectively being funded for that midwifery-led care, maybe in the community or the hospital. Obviously, some women will choose and are able to go to their GP. Who pays for that is a bit of a blur, isn't it? Hospitals could in effect be losing out if GPs stop providing that service and it all lands on the midwifery-led service, which could have a big impact on the viability of service that they are running from the hospital. Is that fair comment?

**Sir David Nicholson:** It is possible.

---

18 November 2013 NHS England

---

**Q53 Chair:** I am going to bring Fiona in. I don't want us to get off this issue. Who is responsible and accountable for there being enough midwives and for the funding of them? You?

**Una O'Brien:** The training of midwives—

**Q54 Chair:** Who is responsible and accountable for enough midwives in the community, serving pregnant mothers, and for the funding of those? Who is responsible?

**Una O'Brien:** The training is the responsibility of Health Education England and they are funded to do that. Subsequently, the responsibility for employing midwives is that of the individual provider, and they are responding, in the service that they are developing, to the requirements of commissioners.

**Q55 Chair:** Who funds them?

**Una O'Brien:** The commissioners are funded all through NHS England.

**Q56 Chair:** So in all this, who is responsible for ensuring that the Government's objective—whether or not it is the right one, but let us stick to that at the moment—of having 1:28 is a national offer wherever you live, whether in the East Midlands, which at the moment appears to be badly served, or in London, which appears to be badly served, or anywhere? Who is responsible?

**Una O'Brien:** The responsibility for commissioning an effective maternity service is NHS England's.

**Q57 Chair:** So are you responsible, Sir David? Do we hold you to account?

**Sir David Nicholson:** The first thing to say is that the Government does not have a policy of 28 births per midwife.

**Q58 Mr Bacon:** Does maternity matter or does it no longer matter? We are trying to establish that. I meant it slightly facetiously, but is the policy *Maternity Matters* extant? Yes or no.

**Una O'Brien:** Yes.<sup>1</sup>

**Mr Bacon:** Right.

**Q59 Chris Heaton-Harris:** Does that include the policy that Andrew Lansley talked about on 16 May 2012, when he was Secretary of State for Health: "We have listened to the concerns of women about their experiences of maternity care, which is why we are putting in place a named midwife policy, to ensure consistency of care"?

**Sir David Nicholson:** All of that, but I am saying—

**Q60 Chair:** All of that—is that policy?

**Mr Bacon:** We do not question policy. We just want to know what it is.

**Una O'Brien:** It is.

**Q61 Chair:** And who is responsible for that?

**Chris Heaton-Harris:** I ask because I am fascinated by this area—apologies, because I have done some research for this one. I am reading from a big report from the Women's Institute, who have sent this huge report round to everybody. They have been trying to work out who is responsible for making sure that the right amount of midwives are around. Only four trust boards said specifically that they had a policy on assigning women to a team of midwives, so it is not getting down to trust level yet, and it is not getting down to the commissioners properly. So where is the emphasis on delivering said policy?

**Sir David Nicholson:** Take to one side the argument about whether there should be 28, 23, 33 or whatever, as far as we are concerned, the objective is team midwifery and getting named midwives. We would expect commissioners to put that in their specifications and their commissioning guidance, to use the NICE clinical standards to enforce and make that happen, and to use the tariff to incentivise it, the CQIN, and all the rest of it. That is what we would expect to happen and that is the way we would discharge our responsibility to do that—

**Q62 Fiona Mactaggart:** What would you do if it does not? I am sorry to interrupt. That is what we would expect. I am asking what you would do if what you expect does not happen.

**Sir David Nicholson:** Okay.

**Amyas Morse:** If you know whether it is happening or not.

**Chair:** Amyas, you will have to speak up. I missed what you said.

**Amyas Morse:** I was asking, only as a supplementary to Fiona's comment, do you actually know whether it is happening or not?

**Sir David Nicholson:** We know that only a third of CCGs have proper specifications out, but we also know that they all use the national contract, which says, "You have a contractual responsibility to deliver it," so we know that is the case. We have recently, as you know, established 211 CCGs. We are currently putting together an assurance system, which will test quarterly whether they are delivering all these sorts of things; we will make assessments of their performance as we go through; and we will intervene when we need. That is the way this system—

**Q63 Chair:** We?

**Sir David Nicholson:** NHS England, as the oversight body for that. But that will not necessarily drive a particular number of midwives.

**Chair:** So Chris's WI survey, which showed that—

**Q64 Stephen Barclay:** The point that came out of Ms Phipps' evidence was not the ratio—in fact, the evidence was that the ratio could go higher—but the continuity of care, as opposed to a team approach. The key question for me is by what date are we going to move to a point where a mum has interaction with a pair of midwives, so there is continuity of care, instead of what my wife had, which was seven visits from midwives after the birth of our child and on every single occasion it was a different midwife?

---

<sup>1</sup> *Maternity Matters* (April 2007) was the previous administration's policy for maternity choice. The current administration set out its commitment to extend maternity choice in the White Paper, "Equality and Excellence: Liberating the NHS" July 2010

---

 18 November 2013 NHS England
 

---

**Chair:** She was lucky to get seven visits.

**Stephen Barclay:** We had seven visits and seven different midwives—I don't know why, but that was the experience. In the session before we heard evidence about continuity of care, so by what date are we going to move to that new model?

**Sir David Nicholson:** There is no date.

**Q65 Stephen Barclay:** But you are commissioning. The evidence we had before from the NCT on behalf of mums—you were in the room so you heard—was that they would like continuity of care, and that the financial model was getting in the way of that. You are the person commissioning. Are you saying that you are not going to meet that expectation from the NCT?

**Sir David Nicholson:** No. It is an aspiration, an ambition that we all have. It is not absolutely clear yet how we would deliver it. We have to work with the clinical networks and the commissioners to work out how best to deliver that, so we will be working with them to make that a reality. If the financial arrangements stand in the way of doing that, we will either change those financial arrangements or we will provide people with more flexibility locally to design financial arrangements that suit the way they deliver their care.

**Q66 Stephen Barclay:** But if their unit is running at a loss they are not going to have much flexibility.

**Sir David Nicholson:** I absolutely understand the point. All I would say on that is that we resource maternity units on the basis of the money that they spend—the average across the country—and if they do not control their costs or have a cost structure that doesn't deal with that, they are going to have to deal with that themselves. In broad terms, however, I would say that there is enough money going into the system to deliver what we need to deliver.

**Q67 Stephen Barclay:** Are you going to gather data, Sir David, to track progress against the aspiration?

**Sir David Nicholson:** There is a whole set of other issues around the maternity dataset and how we do that, but the most immediate data that we will get—and we will get it in the next few weeks—is the CQC's triennial review of women's experience.

**Una O'Brien:** That will be 12<sup>th</sup> December.

**Sir David Nicholson:** So we will be able to measure that, and, as you know, from 1 October all organisations are using the friends and family test to test people's experience and understanding of the service they get.

**Q68 Stephen Barclay:** You say, "We are testing it," but we have just had evidence from the NCT about the fact that there is clear desire for this. Are you saying that you don't accept that and therefore you want to do friends and family tests and others? Surely it is clear that this is what people want?

**Sir David Nicholson:** No. We want to measure progress.

**Q69 Meg Hillier:** On the triennial data collection, you are polling a big sample, but over one month in every three years. What about the data collected by clinicians about emergency admissions, caesareans, complications and all the rest of it? Thank goodness the NAO has done the Report, because it seems that there are not good data to inform you centrally about what is going on. It seems to be very haphazard. Is that fair?

**Sir David Nicholson:** It is true that it has taken us a long time to get our maternity dataset right. Catherine is leading that work now so she can tell us.

**Chair:** It's always the future.

**Meg Hillier:** Perhaps Dr Calderwood could tell us.

**Q70 Chair:** No, I'd like the accounting officers to account. They are always passing it. Let us have the two accounting officers. Why the hell haven't we got the data and when are you going to get it by?

**Sir David Nicholson:** There is quite a lot of data already, so we can test all of that. But the minimum dataset starts now and this year is going to be the annual—

**Q71 Meg Hillier:** Can you just explain what the minimum dataset involves, to be clear about that?

**Dr Calderwood:** It is a dataset that has been drawn up with a lot of stakeholder involvement. It collects 109 data items about demographics, mode of delivery and so on for women passing through the whole pathway from antenatal care to intrapartum and postnatal.

**Q72 Meg Hillier:** For every woman?

**Dr Calderwood:** For every woman. We have never had the complete set of data.

**Q73 Chair:** What data do we need?

**Laura Brackwell:** The dataset that was supposed to be introduced in 2009, so it is four years late. It has taken some time.

**Q74 Chair:** Is it in now?

**Laura Brackwell:** No.

**Dr Calderwood:** In units where they have an electronic—

**Q75 Chair:** When will it be in? I am so fed up with these explanations. It was supposed to be in by 2009, but it is not in; when we will have these national datasets so we can stop depending on NAO Reports every now and again to get the data out?

**Dr Calderwood:** It is collected from 1 April this year and becomes mandatory from 1 April next year.

**Q76 Meg Hillier:** My experience now is a bit out of date—my youngest is four—but I always carried paper notes with me from A to B. In fact, when I have had subsequent children, sometimes I have seen the paper notes from my previous births, which is great—I have a good old read through—but most of the people I met did not have a good look through the notes. My hospital, the Homerton, does a lot of very good work on electronic data collection and is moving to be only electronic very soon across all services, but that is not the norm for most hospitals. Are we relying

18 November 2013 NHS England

on hospitals to be electronically savvy before this really works, or will there be some manual override?

**Dr Calderwood:** One of the reasons for the delay of the dataset was that it was originally thought to be placing too much burden on staff, who were collecting lots and lots of data items that had to be collected from individual women's patient notes. Each individual note had to be looked through and that data item found and recorded somewhere else. That was felt to be unacceptable. The electronic record allows that data to be entered once and then you can take whatever you want out of that.

Interestingly, what is happening is that the two are driving each other, so the dataset becoming mandatory means the hospitals have to invest in electronic data systems that are fit for recording maternity services. In tandem, they are both going to push the collection forward, without adding burden to staff, because this was put in mostly by clinical staff—mostly by midwives, actually—which of course is taking them away from direct clinical care, so we wanted to minimise that as much as possible.

**Q77 Mr Bacon:** Sir David, I am reading in Professor Beal's CV that she is responsible for the implementation of "Compassion in Practice", the new vision and strategy for nurses, midwives and care staff that was launched by the chief nursing officer. I am also looking at this document *Maternity Matters*. Who is responsible for the implementation of *Maternity Matters*? Is there a named person, in the same way as Professor Beal is responsible for implementing *Compassion in Practice*?

**Sir David Nicholson:** The Department of Health is responsible.

**Q78 Mr Bacon:** The Department of Health. There is not a named person responsible for implementing *Maternity Matters* in the same way as there is for *Compassion in Practice*?

**Sir David Nicholson:** No.

**Mr Bacon:** I just wanted to check. Thank you.

**Q79 Fiona Mactaggart:** I was referring earlier to the report by the Foundation Trust Network, which showed that the funding for maternity and obstetric units was inadequate to cover their costs. One of the reasons for that—it is referred to in paragraph 1.17 in the NAO Report—is the enormous costs of the clinical negligence scheme for trusts. For normal deliveries, according to the Foundation Trust Network, it represents 49.4% of the costs of each delivery, and the NAO Report suggests that it is about 30% on average. What is happening to drive that down? One thing we heard from our earlier witnesses was that if you get the right kind of care for second-time mums, safe births and so on, which is less costly, the odds are that you will have less of the kind of intervention that leads to clinical negligence claims. I am wondering what your plan is.

**Una O'Brien:** Perhaps I can start on that. I am not going to project myself as an expert on those precise clinical issues, but I can talk generally about what we found from the NHSLA. As the NAO Report points

out, the NHSLA has very helpfully undertaken a 10-year review of the causes behind maternity claims. It is a very thorough piece of work, and it is built with a lot of expert evidence, so it is something that we can rely on. We have in addition been talking to the NHSLA about what steps can be taken to drive down the cost.

One particular area that has really shocked me has been the amount of money tied up in legal costs in all this. While we think we have been pretty successful at driving down the costs incurred by the NHSLA itself, the claimant's legal costs can be four or five times the scale of the defence costs. One of the actions we are working on with the NHSLA and the Ministry of Justice currently is what steps we can take to reduce the legal fees, which are driven by a number of different things, such as no win, no fee. Recent legislation in Parliament is going to stop solicitors recovering a success fee on all their costs, which I think is scandalous, and it is good to know that we will be able to bear down on that.

Secondly, more can be done to introduce a fixed cost regime in the future. That is not the whole story—obviously there are clinical issues to be dealt with—but, because it concerns a significant amount of money, we need to bear down on legal fees.

**Q80 Stephen Barclay:** We went through this matter not at the previous Whole of Government accounts hearing but the one before that—18 months ago—and that was one of the key findings. Before the previous general election, work was done in Scotland on a review, so I am a little surprised that you say you are shocked by it.

**Una O'Brien:** When you actually look at the figures, thankfully the Government have taken steps. The Legal Aid, Sentencing and Punishment of Offenders Act will stop solicitors recovering a success fee on their costs. It is interesting that it came into effect in April 2013. Who knows whether that was partly why there was a surge in claims lodged before April, but obviously any claim lodged after that date does not qualify for the success fee. No win, no fee and success fees are part of the story that is driving this issue, and we seek to bear down on them.

I did want to say—forgive me for not saying this at the outset—that where negligence is proven it is absolutely right that mistakes should be acknowledged and apologies should be given, and negligence must be compensated for. Nothing I am saying should take away from that for a single moment.

**Q81 Chair:** In this area there has been an 80% increase in claims in the past five years. It is not rocket science. The whole Report is full of it. It is because there are not enough midwives or consultants. You are in a vicious circle where of all this money that is spent on maternity, 20%—Fiona is saying more—goes on litigation in one form or another or compensation claims, and none of the trusts have the money to employ midwives or consultants at the right time. It is just nonsense, and somebody has got to take responsibility—I don't care who. None of us cares who sorts it out, but they should not just pass the buck. Health is the worst offender; it happens every

---

 18 November 2013 NHS England
 

---

time. Somebody needs to say, “This is a real problem. Let’s sort it out.”

**Una O’Brien:** I just want to be absolutely clear that we recognise that more can and should be done to bring down the harm that happens in very rare circumstances. There are specific things that we are looking to do.

**Q82 Chair:** More midwives and consultants.

**Una O’Brien:** It is not necessarily a direct relationship to the proportion of staff. It would be very helpful to have Catherine’s detailed explanation of this, because she could really help the Committee on this complex area. It is something that we all care about very deeply. Nobody wants to see a mother or a baby harmed through the process of labour and birth. We take that extremely seriously.

**Q83 Fiona Mactaggart:** You will have noticed that I have been asking a number of questions about legal costs in the NHS generally. In my view, the amount of taxpayers’ money we put into the National Health Service that ends up being paid in legal fees is slightly shocking, whether it is the recent ridiculous example of paying deal lawyers for looking at whether hospitals can merge or not—that particularly provoking me—but also in this matter, which the Committee has raised before. It would be helpful if we could have a note of how much of the NHS budget ends up being spent on legal advice and legal costs, because it is a matter that we might want to pursue in general.

**Chair:** We’ve got that. It is £20 billion.

**Q84 Chris Heaton-Harris:** I just wanted to follow up on something you said, Ms O’Brien. The default position of the NHS Litigation Authority appears to be to deny and fight claims. I have been corresponding with one of the ladies who runs the Campaign for Safer Births. In her case, and in other cases I have seen, even though the hospital admitted negligence and offered an unreserved apology and causation was shown in an MRI scan, the legal case still took two years, with massive legal costs on either side. I completely understand trying to chase out the ambulance-chasing solicitors and whatever. However, when you have gone through the process—you have either had a problem birth with a child who needs extra help, or, worse than that, you have lost your child—an apology has been offered and the hospital has acknowledged what has gone on, surely that is the time to save the taxpayer a huge amount of money by making the NHS Litigation Authority sort itself out and settle? That would help parents as well.

**Una O’Brien:** Of course. I am sure you are right about that. In the cases where a very large amount of money is involved—some of these cases cost between £6 million and £10 million—having a court order is actually quite useful and helpful because the payments are structured over a lifetime. It is obviously difficult for me to comment on the individual case. I am pleased to hear that the trust acknowledged that incident; we need more openness and candour from organisations when things go wrong.

We reviewed the NHS Litigation Authority and its conduct two years ago. The evidence I have is that they are addressing these issues—they are bringing down the time it takes to resolve the claim. We evaluated them against how an insurance company would operate on a similar basis, and the independent review gave the NHSLA quite a strong endorsement for the way it is undertaking its work. So I do see an organisation that recognises these issues, but obviously on individual claims it may be necessary to have a court order in order for it to be in the interest of the family concerned.

**Q85 Chris Heaton-Harris:** I understand that, but the sum is £482 million, which is the best part of £700 per birth, I think. That is a rather large sum, and it is not a true insurance policy, is it?

**Una O’Brien:** That is correct.

**Q86 Chris Heaton-Harris:** I do not pretend to understand how that works, but surely your Department must sit there and think, “Blimey, that’s a lot.” What can you do about it?

**Una O’Brien:** The amount gathered in through the charge on trusts is significant, but it is also true to say that an obstetrician operating entirely in the private sector, for example, would pay a premium something close to £200,000 a year by way of protection for this field of work. That is just to demonstrate that it is—

**Q87 Chris Heaton-Harris:** Yes, but not many consultant obstetricians live impoverished lives and are short of money. Their £200,000 probably equates to a lot less than they are charging. It would certainly not be a fifth of their turnover.

**Una O’Brien:** Yes, but a £200,000 premium on an individual obstetrician just goes to demonstrate that outside of the NHS system it is also regarded as risky business.

**Q88 Chris Heaton-Harris:** We know that NHS England has not been in existence for long enough, but has the Department seen what best practice is being done overseas in this field? I know that there is not an NHS overseas to enable you to compare like with like, but there are comparators across many European countries, and although I would not choose America, you can go to Canada and see a system that provides a certain level of insurance for most and that seems to be, on the face of it, a lot cheaper and give better value for money than the system we operate.

**Una O’Brien:** We are obviously extremely open to whatever we can learn from other countries. I am not complacent for a second about the amount of—

**Q89 Chris Heaton-Harris:** But we haven’t done any work on that, have we?

**Una O’Brien:** I think the NHSLA have done some work. I do not have it available to me today, but I can write to you about it. The other point I want to make is that if you look at the claims that were actually paid out in 2012–13, the amount paid out covered payments to do with 17 different years, so this is part of the difficulty.

---

 18 November 2013 NHS England
 

---

**Q90 Chris Heaton-Harris:** So it is a growing amount.

**Chair:** But it is worse, because claims are up.

**Una O'Brien:** No, hang on a minute. Also, you do not see the effect of the changes and improvements that we have been making for some considerable time, either. For example, of the claims that came through in 2012–13 that were actually logged for 2012–13, fewer than 20% relate to events that took place in 2012–13, so it is quite a long time until you see the effect of what is actually happening each year.

Catherine Calderwood commented on what is happening on the clinical side in terms of what steps we are taking to address the underlying clinical causes of these negligence cases.

**Dr Calderwood:** I suppose I would not like us to think that the NHS would be running its service based on whether you have a good lawyer. The successful claims are a tiny proportion of the number of labours managed. There are 700,000 deliveries a year in England. In any one year, there will be 70 successful claims for mismanagement of labour, so it is a tiny proportion, but it is very important, as Una O'Brien has said, that those families are compensated when there is negligent care.

**Q91 Chair:** But it is an 80% increase on where we were five years ago. As Chris has pointed out, it takes 20% of the budget that we have on maternity, so that is why it is important.

**Dr Calderwood:** But the NHS has seen a rise of 88% across all specialties. It has risen less in obstetrics than it has in the other specialties. In fact, we were responsible for almost 40% of the payouts, and it is now down to 30%.

**Q92 Mr Bacon:** You are getting worse less slowly than some of the others. That is what you have just said. That is not really something to be proud of.

**Dr Calderwood:** No, the amount of money paid out has also increased, as it rightly should have done, because the way that the compensation is worked out has changed recently.

**Q93 Chair:** No, this is an 80% increase in claims, not in money.

**Dr Calderwood:** And the rest of the NHS has an 88% increase in claims.

**Chair:** It is absolutely shocking.

**Q94 Mr Jackson:** There does seem to be a discrepancy. I might be sympathetic to Ms O'Brien's point here. No one is contesting the 80%, but we are then told in the Report that the issue is around unnecessary interventions. The degree of increase in unnecessary interventions is nowhere near 80%, so why the discrepancy there? For instance, elective caesareans have only gone from 9.5% to 10.2%; induction only from 20.3% to 22.1%; and instrumental births with forceps and so on from 11.5% to 13% in the same time period, and yet there is an 80% rise in claims. Why the discrepancy?

**Dr Calderwood:** I wish I could take you to a labour ward. First, on unnecessary intervention and the definition of that—in fact, what we can find is that intervention might rescue a situation in which a baby was going to be damaged, so the emergency caesarean section that follows abnormal foetal monitoring can prevent a claim.

On the unnecessary intervention we are talking about, I did not get to make the point that I was trying to make, which was that we would like women to have safe care. Whether the lawyers make big amounts of money is not relevant in the NHS, because of course there are claims that are not successful and there are people who do not ever make a claim. What we should be running is an NHS that is safe for our mothers and our babies. In the new outcome-focused NHS where I work, perhaps an intervention gives you a better outcome, so that is the right intervention.

**Q95 Mr Jackson:** I think you are slightly going off the subject, if I may say so. The point is that it is an objective of the Department to reduce unnecessary interventions on the basis that they lead to higher claims for inappropriate or negligent treatment. I am saying there is a discrepancy between the numbers of claims. I am asking why the number of claims overall in maternity services is increasing, but the number of unnecessary interventions is not increasing at the same rate.

**Dr Calderwood:** We would need to look at the individuals and the way that claims are looked at. There is management of labour; cerebral palsy, which is, of course, an outcome rather than a cause; and misinterpretation of the foetal monitoring. Those are the three most common causes of claims, and they cost the most in compensation. When you are talking about interventions, those are part of a pathway of care and different parts of that may be found to have been negligent. You would not expect to see a rise of caesarean sections as you saw a rise of mismanagement of labour claims, necessarily. They do not follow each other in parallel.

**Q96 Stephen Barclay:** Can I just clarify whether the litigation cost is picked up centrally or cross-charged to the trust responsible?

**Sir David Nicholson:** It is part of the tariff. The tariffs are all set out with litigation costs in, and that income then goes into the individual trust.

**Q97 Stephen Barclay:** Sure. So is there a financial penalty to a trust that has a higher litigation cost?

**Sir David Nicholson:** Yes, there is.

**Q98 Stephen Barclay:** Do you break it down between midwifery-led units compared with obstetric-led units?

**Una O'Brien:** There is a distinction between the midwifery premium, if we call it that, and the non-midwifery. I think you are asking whether there is a distinction between the premium for a midwifery-led unit and that for an obstetric-led unit, and I am not aware that there is. That would be a point that I could check and write to you about.

18 November 2013 NHS England

**Q99 Stephen Barclay:** It would be helpful to have a note. Logically, the midwifery-led would be lower risk, but if there is a higher proportion of claims—sorry, Laura, do you want to come in on that?

**Laura Brackwell:** I did not think that under the old system there had been a penalty for trusts through the cost of cover, because they were assessed at different levels depending on their processes rather than their outcomes. I know it is changing, but I did not think that up to now that had been the case.

**Una O'Brien:** It depends on whether you define not having a discount as a penalty.

**Laura Brackwell:** But the discount was based on their processes rather than their outcomes.

**Una O'Brien:** Yes, but the system coming in now will.

**Laura Brackwell:** Yes, it is changing.

**Una O'Brien:** Exactly.

**Amyas Morse:** So it used not to matter.

**Q100 Stephen Barclay:** So it used not to matter, which is the heart of the question, because it does not exactly drive the right behaviours.

**Una O'Brien:** That is why we have changed it.

**Q101 Stephen Barclay:** Yes, but in terms of understanding why the liability went up £10 billion in five years, which is what the evidence was 18 months ago. What is the up-to-date figure?

**Una O'Brien:** Of the total liability? The provisions are £23 billion, currently.

**Q102 Stephen Barclay:** For midwifery? I meant for the NHS as a whole.

**Una O'Brien:** That is the figure I have got for the NHS as a whole.

**Q103 Stephen Barclay:** Okay. I wanted to come on to data. The Report says on page 32, paragraph 2.7: “local data systems are often poor”. Sir David, are you mandating IT requirements in respect of maternity services?

**Sir David Nicholson:** We are mandating the minimum data set. We are not mandating the kind of IT that they need in order to collect it.

**Q104 Stephen Barclay:** So you mandate the data but not the systems.

**Sir David Nicholson:** Yes.

**Q105 Stephen Barclay:** So different hospitals can go and buy different IT systems. How do we ensure compliance in terms of systems speaking to each other?

**Sir David Nicholson:** Well, they have to. That is part of what they have to do.

**Q106 Stephen Barclay:** Your last answer was that you were mandating the data, not the systems.

**Dr Calderwood:** They speak to the information at the centre. Each of the hospital systems must be able to speak to the centre so that the national data set can be collected.

**Q107 Stephen Barclay:** Right. Must they be able to speak to each other?

**Dr Calderwood:** Would they need to?

**Stephen Barclay:** Potentially. If you go to a walk-in centre because, for example, your child has an ear infection shortly after birth, you might want the hospital data to be available in the walk-in centre. I would have thought that that was a common thing. If the swab has been done in one, they need to be able to see the culture. You need your IT systems to be able to speak to each other in a national health service, do you not?

**Mr Bacon:** They did try that, Stephen, but it cost £12 billion and it did not work.

**Meg Hillier:** Women do transfer hospitals during pregnancy.

**Q108 Stephen Barclay:** What I am interested in is the compliance around the minimum IT standards. Dr Calderwood, if you could address that.

**Amyas Morse:** Going back to the question of why it took four years to implement this, you were saying that it is onerous for the staff to manually enter it. I genuinely do not know the answer to this, and I am just curious to know. What has changed now is that you are going to mandate it, right? You could have applied mandation at any point in time. Why did it need to wait until now before you mandated it? Is there a real reason why you haven't implemented it for the last four years, or is there a cause or reason why you could not implement it earlier?

**Dr Calderwood:** It started with more than 1,000 data items and it has been a long process to get to the 109 that were thought to be the key data items. Part of the delay was all of that, and stakeholder engagement to get those absolutely correct.

**Amyas Morse:** So it takes roughly four years to implement something like that in the NHS. Is that fair? I think we have had this conversation before.

**Sir David Nicholson:** In these circumstances it did but, as I said, the majority of the conversation around it is refining and consulting with people about getting absolutely the right thing rather than any feeling that we could leave it for longer.

**Amyas Morse:** I wasn't trying to say something discreditable.

**Sir David Nicholson:** It is not only four because there will be a year of running it in and a year of mandation, so it will take slightly longer than that.

The Health and Social Care Information Centre is taking responsibility for taking forward the residual part of the national programme—the connector bit—and is driving the “all systems need to be able to talk to each other” bit. As part of this consultation, it will be doing that.

**Q109 Stephen Barclay:** So if someone in a hospital trust goes out tomorrow and buys an IT system that does not allow that to happen, who is accountable for that?

**Sir David Nicholson:** The organisation that bought it.

---

18 November 2013 NHS England

---

**Q110 Stephen Barclay:** Okay. Who in the Department of Health is checking compliance to try to mitigate that risk?

**Una O'Brien:** Sorry—checking compliance on the data set, or the purchase?

**Q111 Stephen Barclay:** About the risk that Sir David has just alluded to.

**Una O'Brien:** That is a good question. I don't have an immediate answer. Compliance with the purchase of an individual provider system—

**Q112 Stephen Barclay:** As Richard Bacon knows, and as we have debated before, a lot of money has been spent on IT, and the whole business case was about connectivity. That was the whole rationale for spending however many billions. After a four-year delay, we are now moved to ask you for 10% of the data from 1,000 down to 100 or so. That is the data, but what that doesn't do is say that trusts are going out to buy.

The Report says: "In 2013, almost one in five maternity units did not have an information system linked to its patient administration system". That is in the Report. So before people go out and buy new IT systems locally, who at the centre is setting minimum requirements to ensure that there is connectivity?

**Una O'Brien:** I will write to you on that. I am absolutely sure that someone is, because plainly it would be irresponsible if any trust purchased a system incapable of communicating with anything outside it.

**Q113 Stephen Barclay:** Do you think the Committee has repeatedly had reports when people have done exactly that during this Parliament?

**Chair:** We have. Loads.

**Stephen Barclay:** Potentially, Ms O'Brien, the sums of money are significant, and we are then into issues of people without expertise being bamboozled by IT suppliers who often over-spec what is required or sell something at a higher rate than another hospital is paying so there is then price variance between hospital trusts, which again is a common issue that the Committee has looked at.

I would have thought that, as a minimum, the Department should be looking at some sort of minimum spec mandation and having some sort of compliance to ensure that hospitals are not going off on a frolic of their own. I am staggered that you are not aware of the issue. **Una O'Brien:** It would definitely concern me greatly if I thought that hospitals were going off and purchasing systems that were completely incapable of participating in a national exchange of data.

**Q114 Stephen Barclay:** It would never be completely incapable; the question is whether it is sub-optimal.

**Una O'Brien:** It would be sub-optimal were they to do that.

**Chair:** I am going to move the discussion on, but we wait with interest, because all we see in health is systems that do not speak to each other. That is what Richard has focused on.

**Mr Bacon:** That is a bit unfair. I was focusing on systems that simply did not work at all. Whether it is worse to have systems that do not talk to each other or to have the Department of Health at the centre forcing hospitals to buy systems that do not work is a moot point.

**Q115 Austin Mitchell:** I was surprised by the fact that the experience of black mothers seems to be less happy than that of white mothers. Paragraph 1.5 states that they rated care during labour and birth not as highly as white mothers. They were "more likely to report shortfalls in choice and continuity of care" and were less likely to see "a midwife as often as they wanted after birth".

Paragraph 1.6 states that "available data also indicate that black and minority ethnic women were significantly less likely to have early access to services compared with white women." Why is that? Is it because they are in underprivileged areas where the service is less effective? Is it because those communities have greater health problems initially? What is the explanation for that difference in experience?

**Dr Calderwood:** I think your points are probably correct. They are often in more deprived communities. Sometimes, there are language or cultural barriers. We recognise that that is a problem. There is a real drive now to try to reduce those inequalities. We have had them before in local areas where good work is being done with local communities. When it is recognised as a problem, we can then start to try to fix it.

**Q116 Austin Mitchell:** What are you doing?

**Dr Calderwood:** One issue is bringing in early access to antenatal care, which of course is for all women. That work will try to find out how we can better bring women in and whether perhaps community midwifery services are better visiting women in their homes if they find it difficult to come to GP practices or to see the midwives. There are aims that are for all women, but we will target some of these access problems.

**Fiona Mactaggart:** Dr Calderwood, paragraph 1.6 points out that ethnic minority women are much less likely to have early access, so saying, "We want early access," seems to be advantaging a group that already gets early access. What specifically are you doing to target ethnic minority women?

**Q117 Austin Mitchell:** Is it because they are likely to rely more on family and community folklore, as it were, rather than turning to maternity services?

**Dr Calderwood:** I suppose that there is not necessarily the concept that being pregnant means that you need to see anybody. It is a physiological process. Your question about us knowing that means that we are looking to work with the communities. Specific areas of London have large black and ethnic minority communities and they are trying to reach the targets and to push up the number of women who access earlier.

---

 18 November 2013 NHS England
 

---

**Q118 Fiona Mactaggart:** You really cannot say that it is their fault, because the Report shows that they are much more dissatisfied.

**Dr Calderwood:** Of course not. It is our fault.

**Sir David Nicholson:** It is absolutely true that this is a problem for us. The NAO Report highlights it in a way that has not been done before. There are places that do it fantastically well. The Homerton hospital is a good example. What happens in those circumstances to get that satisfaction is that they have to change completely how they operate and work much more as a community organisation that is much more engaged with the community. The problem we have had is with how to share that and to ensure that everybody does it in the same way and starts to think in that way. That is why we—you mentioned it earlier—put so much effort into networks, because that is best way. We do not want to be saying, “You must,” from the centre. We want people to learn from each other. That is why, in the past, networks have grown through people working together; not in a haphazard way, but nevertheless—

**Chair:** Let’s stick to the question, Sir David.

**Sir David Nicholson:** I am saying that that is one of the mechanisms by which we can make sure that the—

**Q119 Fiona Mactaggart:** How do you know that every network has a Homerton? It is a serious question. How do you know that every network includes a good-quality experience, or an institution capable of giving a good-quality experience to an ethnic minority mum?

**Dr Calderwood:** The networks are just getting started, really. They have been—

**Q120 Fiona Mactaggart:** So what are you going to do?

**Dr Calderwood:** They are going to speak to each other. They have set themselves a list of priorities, of which this is one, so that if there is a Homerton, the other parts of the country where there isn’t one can hear about the experience somewhere there is good practice. Rather than reinvent the wheel every time all over the country, the idea is to bring obstetricians, midwives and all the other health care professionals involved together for face-to-face meetings and monthly WebExes to share all the good practice.

**Q121 Austin Mitchell:** Will you try to use black and ethnic midwives with black and ethnic mothers?

**Dr Calderwood:** I do not know whether that has been—

**Q122 Chair:** What is the ethnic breakdown of the midwife work force?

**Meg Hillier:** One in 10 African women in the UK is a nurse, but I do not know if that is—

**Chair:** What is it on midwives?

**Professor Beal:** I will need to give you a note, but I was the head of midwifery at Newham, where the midwifery population was 98% from ethnic minority groups, whereas the population delivering was 60%. They are not always from the same ethnic minority

groups. We try hard to look at recruiting from our local population, for example, to help that balance, but that is not always possible.

**Meg Hillier:** There are two important things. One is that there is a range of other people in the hospital as well as midwives, appointed as volunteer helpers and so on, for mums giving birth. Secondly, Homerton hospital runs all community services; it won the contract from the PCT to do that. That means that its reach into the community is even more than what the hospital would normally provide, so it is out there all the time.

**Chair:** Austin, have you finished?

**Q123 Austin Mitchell:** Nearly. I have always nearly finished. Does this difference in experience and reaction mean that there is also a difference in terms of complications, caesareans and induced labour? Are they higher among the black and ethnic community than among the white community?

**Dr Calderwood:** The outcomes are poorer for maternal mortality and for perinatal mortality, yes, in black and minority ethnic women.

**Q124 Austin Mitchell:** There is a further point. I see from the NAO Report that there is some evidence to suggest that outcomes are slightly worse—it says “slightly poorer”—at weekends than on weekdays across three of the six indicators of complications, which I suppose are inducement of labour, instrument delivery and so on. It used to be said of the Grimsby maternity hospital—I have heard it said of other hospitals—that induction of labour and caesareans would often be performed because the consultants wanted to spend a weekend on the golf course and were not prepared to come in. That is a type of folklore, but it would mean that the induction of labour or the caesarean was performed before the weekend. Why are the problems worse for people who come in at the weekend?

**Laura Brackwell:** Can I just clarify? The areas where the complications were statistically different at the weekends were maternal infection, infection to the baby and injury to the baby.

**Q125 Chair:** Right. So on weekends, less consultancy. Who is going to deal with that one? Who will sort it out? Who is accountable for that little bit of the jigsaw?

**Dr Calderwood:** If you look at our consultant availability on labour wards, there has been a sea change since 2007. The 60 hours a week cover was at 7%, and now it is at 73%.

**Q126 Chris Heaton-Harris:** This isn’t on the end of a phone, is it?

**Dr Calderwood:** No. This is consultant availability. I use the term carefully.

**Q127 Chair:** But 85% of negligence claims originate from a time of day when there is no consultant on site.

**Dr Calderwood:** The concept used to be that the senior doctors in training ran the labour ward, and the consultant was in the gynaecology clinic or the

---

18 November 2013 NHS England

---

gynaecology theatre and was supervising nominally, as it were. So the senior trainee was running the labour ward, making the decisions and carrying out the procedures. Really, that has changed completely. With our speciality now, consultants have dedicated time. This is what I mean by availability: you are not doing something else and on the end of a phone, or concentrating on something else, and we are then there training and performing the procedures as well. On the hours that you see, there is a true, complete difference—perhaps the golf course was another place to be available from.

**Q128 Chair:** Is it your job to ensure greater coverage, back again to this link with negligence? It is true that you are more likely to end up getting things wrong if you do not have a consultant on site, and if it is true that you get a worse service at the weekends because consultants are not around, who is tackling that, and how?

**Dr Calderwood:** What we need is the evidence about consultant availability versus the consultant being resident—living in the hospital or physically having to be there. We do not have the evidence that that improves outcomes so, back to our outcome-focused NHS England, we need to be clearer about exactly what the balance of consultant, midwife and skill mix—

**Q129 Chair:** I am quoting 2012 research from foundation trusts. Again, 85% of negligence claims originate from a time of day when there is no consultant on site. That was 2012 research.

**Dr Calderwood:** I would need to know—

**Chair:** It is not my research. You will have seen it; you are the expert. It is 2012 research, and I have got it down here as foundation trust research.

**Dr Calderwood:** I would need to understand that. As we have discussed already, there are very many complexities—

**Q130 Chair:** You said there is no evidence. All I am saying is that these are the foundation trusts.

**Una O'Brien:** I would really like to see what the Foundation Trust Network has—

**Q131 Chair:** I have spent three or four hours preparing for this. It ought to be bread and butter to you guys. This is not some great thing that comes to me; you should have the knowledge about this stuff.

**Una O'Brien:** The reason I am commenting is that my reading of the NHSLA's report—a big report that looked back over claims over 10 years—is that it was not drawing out great associations. I was expecting to see a really big association with out of hours and claims, but it was not as strong in that report as I thought it would be.

**Q132 Chair:** There are two bits of evidence. One is this, which you say you have not seen, although I cannot understand why I can see it in three hours but you guys don't know about it. The other bit is what Austin Mitchell alluded to, which is in the Report: at weekends, when the consultants aren't around, there

is more likelihood of there being danger to children and things going wrong. I don't think this is rocket science.

**Una O'Brien:** As a principle, we have made it absolutely clear that across all areas of the NHS we recognise that we need a proper 24/7 service—evenings and weekends—and I think that has been acknowledged across the piece. I think Sir Bruce Keogh has led the charge on this. He has been absolutely clear that this is what we need to see and it is something where we back him up completely.

We have now got to work out how to do it. We have to work out how to do it in terms of employment contracts and affordability, but it is clearly the direction we need to go in for all areas of the NHS. It is not acceptable that you should get a lower standard of care because of the random chance that you come into hospital at a weekend. I think we have absolutely acknowledged that.

**Q133 Mr Jackson:** The top of page 20 says: "Fifty-three per cent of obstetric units (including all of the largest units) were not achieving the levels of consultant presence"—going back to this point that Dr Calderwood mentioned earlier. Further down, it is intimated that the trusts are effectively saying that it is unaffordable. Is it the case that you have demonstrable, empirical evidence that this will have an impact on clinical negligence, for example, and that you are insisting on it, or have you not yet got enough data and so you concur with the trusts that are saying, "It is nice to have, but we can't do it and we can't afford it anyway"?

**Dr Calderwood:** To talk about consultant availability and not being tied up doing something else, there is not evidence that outcomes are improved with 24/7 resident consultants. There will always be, in an obstetric unit, a consultant on call 24/7, 365 days a year. More and more time is available, without doing other duties, but the evidence for this person needing to be actually resident in the hospital is not there.

**Q134 Mr Jackson:** Even though the Litigation Authority and the Royal College are both insistent that this is an important aspect of the regime.

**Dr Calderwood:** I looked into this quite carefully before coming here. It needs a clear statement by the Royal College of Obstetricians, of which I am a member. The original primary evidence quoted in its working party report does not justify this resident on call. I can quote it to you here—one of the papers has 32 patients in it. We know about this change in decision makers' availability, but this 24/7 is of course very expensive, and we would need to be sure that we were spending our money wisely, because it might be that different numbers of midwives or a different skill mix would make our outcomes better, rather than needing the consultants to be resident, particularly depending on the size of unit. I think that there are moves—certainly in at least two units in England—to 24/7 cover simply for practicality, because there is no point in being available at home when you are in the hospital all the time and to-ing and fro-ing. In the smaller units, however, you might have times when a

18 November 2013 NHS England

very expensive consultant being paid to be resident is not necessarily going to make the outcomes better—we do not know yet.

**Laura Brackwell:** I think the Royal College is only recommending 24/7 for 5,000-plus births, so it is only for the biggest units, of which there are 26—so it is a relatively small number.

**Sir David Nicholson:** But it has been used as an argument for centralising more and more maternity services, which we do not think is necessary.

**Q135 Mr Jackson:** Another question that occurs to me: who has accountability and responsibility for the language proficiency of clinicians?

**Dr Calderwood:** The GMC.

**Q136 Mr Jackson:** Okay. Is that a factor in any of these issues around poor clinical care and negligence? Is it a growing factor? Are you satisfied—I guess this is my question—that language proficiency is at the optimum level to ensure that the risk of these catastrophic events is reduced to the absolute minimum?

**Dr Calderwood:** I do not think that we have the data, I am afraid.

**Professor Beal:** To give an example for nurses and midwives, all midwives and nurses are expected to pass proficiency in maths and English prior to commencing training to ensure that they are competent.

**Q137 Mr Bacon:** What about midwives from overseas who come qualified?

**Professor Beal:** That is up to the organisation and—

**Q138 Mr Bacon:** Sorry, which organisation?

**Professor Beal:** The organisation that employs them.

**Q139 Mr Bacon:** When my first son was born, I tried to keep count of the number of nationalities of the different midwives who were attending to us, and I simply could not keep count, because there were so many. I have to say that English was not a problem, but you are saying that it is down to the trust involved to make sure that its midwives have adequate—

**Professor Beal:** If they come from overseas, but normally if midwives come from overseas, they will have done at least part of their training to validate themselves to be on the midwifery register, and therefore will have had to pass as competent in English.

**Q140 Mr Jackson:** Did you say “normally”? Does that mean all midwives?

**Professor Beal:** If they come from a country where they can practise—

**Q141 Stephen Barclay:** Within the EU.

**Professor Beal:** Yes, within the EU. If they come from a country where they can practise, the provider organisation will need to make sure of the competence.

**Q142 Stephen Barclay:** But we know that that has failed, as the case of Dr Ubani and my constituent David Gray illustrated. That is still under consultation in terms of doctors. It is still the case that midwives can come in from the EU but not speak English.

**Professor Beal:** It is, but the provider organisations I have worked with test for competency in English.

**Q143 Mr Bacon:** Can you just be clear about what you mean by “provider organisations”? Do you mean agencies supplying midwives, or the trusts employing them?

**Professor Beal:** Trusts employing them.

**Q144 Mr Bacon:** Employers.

**Professor Beal:** Employers, yes.

**Q145 Stephen Barclay:** Was it the same governance arrangement at the time of Dr Ubani?

**Professor Beal:** I cannot comment on a doctor.

**Stephen Barclay:** Okay, but that goes to the heart of Stewart’s question.

**Q146 Mr Jackson:** This is a very positive Report generally—it bears repetition to say that—but one of the most striking parts is on page 34 in the section about “Commissioning arrangements”, which states: “Twenty-eight per cent of trusts did not have a written service specification for maternity services with their primary care trust in 2012–13, almost double the level in 2007”. Further on, we are talking about block payments and some of the inconsistencies around in-patient and out-patient provision, but it does seem to me worrying that getting on for a third are paying taxpayers’ money and don’t know what they should be getting for that. I just wonder what comments you have on that issue and how you aim to address it. That’s for either of you.

**Sir David Nicholson:** The numbers speak for themselves. As you know, we were working through a process whereby all these organisations, first of all, were being abolished—the PCTs were being abolished—and new CCGs were being set up, but I would say that it was already in the national contract. It is within the national contract itself that they have to take account of the guidance that is available, *Maternity Matters*. But in 2014, it is mandatory that all CCGs have a proper specification.

**Q147 Mr Jackson:** So you think that, by the end of the 2014–15 financial year, there will be 100% coverage of—

**Sir David Nicholson:** 2013–14—this year.

**Mr Jackson:** Yes, 2013–14. There will be 100% coverage of service specification.

**Sir David Nicholson:** They will all have a specification, yes.

**Q148 Mr Jackson:** A slightly higher proportion of trusts were not expecting to have a written service specification in place with their clinical commissioning group by the time the groups assumed responsibility for commissioning in April 2013. You are saying within a year.

---

 18 November 2013 NHS England
 

---

*Sir David Nicholson:* A year, yes.

**Q149 Mr Jackson:** You are absolutely certain of that.

*Sir David Nicholson:* Yes.

**Q150 Mr Jackson:** Okay. If your successor or the permanent secretary comes back in a year—

*Sir David Nicholson:* I'm sure you'll bring me back.

**Mr Jackson:** We always love to see you, Sir David.

**Q151 Chris Heaton-Harris:** I shall ask a couple of questions about stillbirth, if I may. The latest figures are that, every day, 11 babies are stillborn—that is after 24 weeks' gestation—and six babies die within 28 days of birth, in the neonatal period. We are, as *The Lancet* report that I referred to earlier showed, going backwards in many ways when it comes to stillbirth.

The charities that campaign in this area—Sands and Bliss—are always asking for extra research to be done, because we don't seem to do any research in this country on this particular matter. Could you talk about the research aspect? Also, part of this is about identifying risks earlier. Dr Calderwood talked about identifying risk categories of people. The medical profession does tend to know roughly where they are, and I know that there is a segment of stillbirths that will always happen, but given the massive regional variation that we have in the UK, let alone the fact that we are 33rd out of 35 among advanced nations in this, what can we do to improve and where can we get research from?

*Una O'Brien:* By way of introduction, the first thing I would say is that every stillbirth is a tragedy and a very difficult thing for a woman and her family to come to terms with. We absolutely get that—we feel that—and we all know that more can and should be done to try to reduce the stillbirth rate. We have been working with Sands on this and will continue to do so. A lot of research is under way in respect of this. The difficult thing is to come to terms with the fact that a significant number of stillbirths occur in women who were originally identified as low risk. So the question is: how can we take the right action and the best action that helps to identify the women most at risk of stillbirth early on?

One particular part of the country—the west midlands—has managed to bring the stillbirth rate below the national average over the past three years. I was very struck that the actions taken there show that you have to go at this in a very focused and systematic way. Even after bringing the stillbirth rate down for the region as a whole, there are still huge discrepancies among its 23 different CCGs. The rate is 1.6 per 1,000 births in the best performing area and 7.8 per 1,000 births in the worst performing area.

There are wider factors that are affecting this as well. We are very alive to this issue and NHS England needs to take some really important decisions. There is new guidance from the Royal College of Obstetricians and Gynaecologists, which came out in spring this year, and Catherine can perhaps talk more about that. That guidance will push us further towards

having a more systematic assessment of women who could be at risk of stillbirth, but who would not, up to now, have been identified as such.

**Q152 Chris Heaton-Harris:** The one thing that strikes me is that the NHS has done remarkably badly on spreading best practice in this field. You have identified a region and areas within that region where best practice is being evolved. It is such a cheap option. Considering how much money goes on this area, how will you spread that best practice?

*Dr Calderwood:* I was looking forward to meeting you because, like me, you want to try to reduce the stillbirth rate. What I have done is spoken about some of these things at all the strategic clinical network events across the country that I have been going to with my colleague, who is a paediatrician. For women and children's strategic clinical networks, reduction of stillbirth is their No. 1 priority. We are looking at some of these public health issues along with the Department of Health, and we are looking at raising awareness of the risks for women, as well as at health care professionals. We are looking at standardised review processes, because we know from other countries, such as the Netherlands, that if we look at what has gone on in the care of women, we can then make improvements to prevent stillbirths happening within those units. That is localised review, and we also have the new process for the national review of perinatal deaths.

As Una O'Brien has alluded to, we are looking at some of the work that the west midlands has done, some of which is on the teaching and training of midwifery staff as a sort of package of care around picking up babies that are at risk of being growth-restricted. The networks have seen the evidence from the west midlands. Yorkshire and Humber has reduced its stillbirth rate, as has the north-east of England. We would hope that the other networks are being made aware of that and take on the work that has been done.

**Q153 Chris Heaton-Harris:** One final point, on litigation. We are one of the countries where, if a stillbirth occurs, we do not call a coroner. A coroner is not allowed to look into a stillbirth. If parents feel that there has been an issue in the process, they have to go to the law and end up instructing lawyers who want to chase that particular ambulance. I wonder whether there is something that we can do to look at that. I know that that does not necessarily relate to your Department, but it seems fairly obvious to bring in a measure that coroners look at stillbirths where they occur. If it can cut out the legal uncertainty at that point and give the parents the closure they need, that could save an awful lot of money and avoid the dire consequences for parents of going through it again in court.

*Sir David Nicholson:* I do not know about the coroner bit in that, because that is for the Government. The national standards and the structured analysis of what has happened will significantly help us to understand it. Hopefully, when it is shared with parents, they will understand better at that time. There will be a proper structured conversation with them as part of this,

---

 18 November 2013 NHS England
 

---

which may or may not need a coroner afterwards, but it will certainly be something.

**Una O'Brien:** If I may, I will take your point away. In a separate policy area, we are working on the introduction of a new system of death certification and the introduction of medical examiners. While there is no plan to change the definition of stillbirth, I recognise the point you are making. The role of the new medical examiner has not come up in discussions yet, but perhaps we could have contact outside the meeting and take that further.

**Q154 Mr Bacon:** This is a follow-up to Chris's point. What is the "it" that you were doing? Una O'Brien talked about more focused work, but what is the "it" that you are doing that produces reduced numbers of stillbirths? You were talking about work being done, but what are the actions that result in a smaller number of stillbirths? I did not quite gather that; I may have missed it.

**Dr Calderwood:** The specific work we are talking about in the west midlands is around the detection of growth-restricted babies, which form one of the greatest proportions of stillborn babies. If we detect them when they are small and struggling and deliver them, they are delivered alive. We know that there is a proportion of women whose babies are more at risk of being small—

**Q155 Mr Bacon:** But they are the higher-risk ones.

**Dr Calderwood:** Yes.

**Q156 Mr Bacon:** You were talking about the significant proportion of ones who were thought to be low risk and turned out to be stillbirths.

**Dr Calderwood:** That is Una's point. One of our difficulties is that the vast majority of stillbirths occur in women who are low risk. There is a study at the University of Cambridge by Professor Gordon Smith, who has done a lot of work in this area, looking at a population of low-risk women to see whether we can develop screening tests so that we would be alerted to interventions that would be needed to prevent stillbirths in that group of women.

**Q157 Meg Hillier:** I have two quick points, first on postnatal care. Again, I commend the WI's report into this; it did some thorough and thoughtful work. What is the standard that you would expect, Sir David, to be provided nationally for postnatal care, or is this now all a matter for the CCGs to decide?

**Sir David Nicholson:** There is a national standard—the NICE standard—which sets out the quality standards that are expected.

**Q158 Meg Hillier:** So why is it so varied up and down the country, and sometimes within regions? I could quote some of the WI figures on the variation, but it is all on record, so I won't take up the Committee's time reading that out. Some people get two visits; some people get no visits. Mr Barclay was saying that his wife got seven visits, which is an all-time record.

**Stephen Barclay:** Each was a different midwife; that was the point.

**Chair:** Some get three visits; some get one. Some in London get none.

**Meg Hillier:** I imagine that there must be some element of risk. When I was a third-time mother, I probably did not need it as much as I did as a first-time mother—I would imagine that was a reasonable assumption. You might have better contact with a GP. I don't think that is the total answer. It is varied. You are looking puzzled, Sir David. Perhaps I am not making myself clear.

**Sir David Nicholson:** No. That was why we created a national standard: so that people could measure themselves against it as part of the audit.

**Q159 Meg Hillier:** Who is going to hold them to account on that other than Parliament? The CCGs?

**Sir David Nicholson:** The commissioners.

**Q160 Meg Hillier:** So locally, if that service is not being delivered, the commissioners will do what?

**Sir David Nicholson:** It depends on the circumstances in which it is not being delivered. It could be local variation or it suits the local population. It could be that that is how they operate and they can justify why they want to do it in that way.

**Q161 Meg Hillier:** Do you think it is good enough at the moment? Obviously not, if you have this standard in place. Do you feel some responsibility at the centre to make sure that there is consistency?

**Sir David Nicholson:** Absolutely. That is why we have created the national dataset. That is why we are having the national audit so that we can then measure everybody against it.

**Q162 Meg Hillier:** That is one of the challenges, isn't it? There are these different sets of professionals involved and no one has been measuring. We look forward to that data.

I just want to touch on the size of units. Paragraph 21 of the Report states: "Twenty-eight per cent of units reported that they closed for half a day or more between April and September 2012... The main reason for closing was a lack of either physical capacity or midwives." Do you take that sort of closure into account when you are looking at choices available? We are seeing a lot of squeeze on some hospitals. Do you look at that in your central planning?

**Sir David Nicholson:** We don't look at it in terms of central planning but we would look at it when a particular group of CCGs were working together to look at the capacity they require across their patch. Most obviously in the different parts of London, that is what has been done recently to identify that. Most of the country is going through some sort of process of capacity planning in all that. They have to set off the debate between efficiency, safety and choice. That trade-off can be different in different parts of the country.

---

 18 November 2013 NHS England
 

---

**Q163 Meg Hillier:** That brings me to a particular example in Bishop Auckland general hospital, whose midwifery-led unit has about 260 births a year, or five births a week. That is quite a small unit compared with the Homerton. A transfer is required to the consultant-led obstetric unit in about 30% of cases—Dr Calderwood is nodding, so that must be about right—but the North East Ambulance Service, which is based next door to the unit, guarantees that it will transfer people to the obstetric unit within 8 minutes only in 71% of cases. Because it is only 71% rather than 100%—it has never been 100%—that unit has been temporarily closed. That brings us to planning. We have had A and Es talked about recently and stroke units in the past. Is a unit the size of that at Bishop Auckland sustainable?

**Professor Beal:** A free-standing maternity unit normally needs up to 600 deliveries a year to be sustainable. Again, it is up to individual providers and trusts to look at their free-standing units and how they make the use of that capacity. But for financial viability, it is about 600 births.

**Q164 Meg Hillier:** In this case, it is interesting—we see this often in this Committee—that one bit of the system is causing viability issues. If the ambulance service could guarantee 100%—I know that that is difficult to guarantee—that might be a sustainable package as a whole. But because it cannot, it causes an issue in an area of the country that is far more rural than the one I represent.

Does anything in the pathway of care look into transfer in emergencies and issues such as that? It is not so difficult in London, because you are close to everything, but in somewhere such as County Durham there are real issues.

**Sir David Nicholson:** This issue about viability and how many cases you need to create an infrastructure to provide a totality of service is what Juliet Beal was talking about with the figure of 600. Explicitly in the guidance for next year, in terms of the tariffs, people can apply to have that altered. If there is a strong argument for a local service like that that requires extra resources, people can apply to get the tariff changed to support that. The cost would have to be taken into account, but that would be possible.

**Meg Hillier:** Thank you; that was very helpful.

**Mr Bacon:** I was struck by the earlier witnesses' suggestion that organising things better could mean that more was done with less. That always interests us in this Committee, and the fact that you put your thumb up like that, Sir David, suggests—

**Sir David Nicholson:** Sorry, I did not mean—

**Mr Bacon:** No, no. We like to see your thumb up. It is good. After all, that is better than the alternative.

**Sir David Nicholson:** That is normally what you do to me.

**Q165 Mr Bacon:** I speak not as a Roman emperor, but merely a humble member of the Committee. Will meeting the objective of having a named midwife or pair of midwives for every patient necessarily cost more money?

**Sir David Nicholson:** That has not been tested, but it is just about to be tested in a significant way. We are going through a planning round with all the clinical commissioning groups for them to set out what their service will look like in five years' time, and also then, in detail, operational plans for year 1 and year 2. Part of that is a capacity plan for their community and part of that is the delivery of seven-day services. That will squeeze out that issue in a very significant way, so, during that process, we will be able to tell whether it is possible to do that—whether people have the ingenuity to make that happen or not.

**Q166 Mr Bacon:** So watch this space, in other words.

**Sir David Nicholson:** Yes.

**Q167 Mr Bacon:** This is probably one for Dr Calderwood: Professor Bewley said earlier that obstetrics is not a happy service; there is a morale problem. Why is that? You are talking about something that ought to be almost the most joyous part of the NHS—it is the nice part, as the Chair said earlier. It is the bit that is really good and fun and usually—dreadful tragedies excepted—results in something really good happening. Surely it ought to be the best bit to work in.

**Dr Calderwood:** I am not aware of data from lots of staff, certainly from obstetricians, saying that it is not a happy service.

**Q168 Mr Bacon:** That is what Professor Bewley said. She is shaking her head now, but I think she is shaking her head because she disagrees with you rather than because she disagrees with me.

**Dr Calderwood:** In my experience lots of people think that it is, as you put it, the happy side of the NHS.

**Q169 Mr Bacon:** Why is there perceived to be a morale problem?

**Dr Calderwood:** I have said to you that I am not sure that I am aware of data showing that there is a morale problem.

**Mr Bacon:** We invite people who take a different view to write to us, and we will include any evidence that we find, if it is written in clear English.

**Q170 Chris Heaton-Harris:** I have a couple of quick questions on tariffs. Sir David, earlier you said that the tariff includes litigation costs. That set off my thought process, because if litigation is going up massively and the tariffs lag behind the current circumstances by a couple of years, that is your financial problem, isn't it?

**Sir David Nicholson:** Do not forget that, although it is absolutely right that people look at each individual service line, people who run an organisation look at the totality of it. Within the total amount of the tariff, unless you are a very specialist hospital—that is a separate issue—there should be the ability to move money around the system to enable you to support things in the short term until you get caught up.

---

 18 November 2013 NHS England
 

---

**Q171 Chris Heaton-Harris:** But the litigation is going up and your tariff has been lagging.

**Sir David Nicholson:** It is a pressure that people have to hold, but that is why we have an efficiency gain in the tariff.

**Q172 Chris Heaton-Harris:** Will you confirm when the two-year tariffs commence?

**Sir David Nicholson:** On 1 April 2014.

**Q173 Chris Heaton-Harris:** Does that include a national tariff for neonatal care?

**Sir David Nicholson:** May I absolutely confirm what it is before I tell you?

**Q174 Chris Heaton-Harris:** Yes, certainly. I have one final question. What work is being done to ensure that tariffs for neonatal care reflect the service specification set by your good selves at NHS England?

**Sir David Nicholson:** What is happening is that, while we do the reference costs and all of that work so that we build up the costs on the basis of what is currently spent, we are doing a series of best-practice tariffs. So we are creating some tariffs for specific services from the bottom up. We have introduced a whole range of those over the past year or so, which is why I am not quite sure whether the neonatal tariff is in that best practice bit or the other bit. I will be able to tell you that.

**Q175 Chair:** I am going to sweep up the things that we haven't done. First, I will go back to the WI report, which found that only 25% wanted to give birth in an obstetrics unit, although currently 87% do so. The report found that more than half wanted to go to a midwifery unit, and currently only 9% do so. What are you doing about that?

**Professor Beal:** There has been a large increase in midwifery-led units over the past couple of years to help promote women's choice. Women who have a normal pathway of care should be able to choose whether to deliver in a midwifery-led unit, and they should be asked when they first meet their midwife to discuss their pathway of care. At any time during that pathway of care, things might become not normal, in which case they may well need to transfer to the obstetrics-led unit.

**Q176 Chair:** I can accept that, on the margin, something might go wrong and you may have to end up in an obstetrics unit when you wanted to have a midwifery unit, but the difference between what women want and what women get is huge. Just saying "should" is not working, so, in an environment in which we are trying to give women choice, what are we going to do about that difference between what women want and what they are actually delivered?

**Professor Beal:** Again, it comes to commissioners setting a specification and ensuring that providers are giving those women that choice.

**Q177 Chair:** But they are not.

**Professor Beal:** There has been a large increase.

**Q178 Chair:** But they are not. That is really frustrating. I am in the grandchildren bit of it now, but I can tell you that women are not getting the choice they want. The stats hit you. These are WI data.

**Sir David Nicholson:** I'm sorry. I haven't seen the WI data. We know that 84% of women say that they have had a choice. We know that we have nearly doubled the number of midwifery—

**Chair:** It doesn't fit with the WI figures.

**Q179 Mr Bacon:** Why do you say that we know that 84% say that they have had a choice?

**Sir David Nicholson:** Isn't it in the Report?

**Meg Hillier:** It is in the NAO Report.

**Q180 Chair:** Once you have had a baby and you are home, you just feel relief. You are relieved that it has got 10 fingers and 10 toes and you feel over the moon. That is very different. In my day, I didn't get the choice I wanted. That was a long time ago. It is very different from these stats. I can get it on the margin. There are obviously some women who would rather go into a birthing pool but end up having to have a caesarean. But the difference is so huge, you can't just say that we expect X to do that, we do this and it doesn't happen. Somebody, somewhere has to take accountability and responsibility for this lot.

**Sir David Nicholson:** I think we have. As I said, 84% of women have said that they have had a choice. It is not the complete choice, I know. We have almost doubled the number of midwifery-led units in the country over the past three or four years.

**Q181 Chair:** It is only 9% who do.

**Sir David Nicholson:** There must be a lag there somewhere, if that is true, if they are still feeling that they are not getting that choice, but we have nearly doubled the number of midwifery-led units. If it was four or five years ago, I could say that the issue is that we need more midwifery-led units, but actually we seem to have increased the number significantly.

**Q182 Chair:** Okay. I have to tell my Committee members that they have to stay behind afterwards for five minutes. We have just had a communication that we need to discuss.

The next thing is on maternity networks. Is there anything in the competition framework that prevents these networks from operating effectively? Having read what was in the papers last week about collaboration and the difficulty of that and competition. Is there anything in there?

**Sir David Nicholson:** No.

**Chair:** Okay, that's good.

**Q183 Austin Mitchell:** Sir David has described the health service as crawling with competition lawyers, I think it was. Does that apply to this area? Is this an area that is going to be profitable for competition?

**Sir David Nicholson:** I have no experience of having any discussions about the use of competition law in this area.

---

18 November 2013 NHS England

---

**Q184 Chair:** The next area is that more than one in 10 women experience post-natal depression or some mental health problem, yet under 30% of trusts have a mental health network. What are you doing about that? We had the tragic case last week in the press.

**Dr Calderwood:** Perinatal mental health is under specialised commissioning in NHS England. There are already networks building on some existing networks for perinatal mental health, and we would expect those under specialist commissioning to increase.

**Q185 Chair:** Increase? So when would you expect all trusts that are responsible for delivering obstetrics, babies and so on, to have links into the mental health services?

**Una O'Brien:** By 2017 we expect there will be specialist staff available for every birthing unit. That was an announcement made by Dr Dan Poulter just last week.

**Q186 Chair:** Linked into the maternity services?

**Una O'Brien:** I am talking about them specifically being in the relevant trusts with a specialist midwife with training in perinatal mental health by 2017. Just to add, we have also commissioned the national perinatal epidemiology unit to develop a perinatal mental health indicator. Our aim is to have that in the public health outcomes framework for 2016. So we will also be prioritising perinatal mental health by having a designated indicator, by which people can track progress.

**Q187 Chair:** There are two other public health things. One is mums who smoke, where there are huge variations. What are you going to do about that? And a third of mums stop breastfeeding within eight weeks. I don't believe in giving them £200 vouchers.

**Dr Calderwood:** The smoking would make a big difference to a lot of outcomes, stillbirth being one. We are working very closely with Public Health England looking at some incentivisations for maternal smoking cessation. Again, there is the dataset—collecting the data better will help—and having women signposted to services that will help them quit smoking.

**Q188 Chair:** So it will just be signposting; it won't be a public health outcome.

**Dr Calderwood:** We are discussing with Public Health England at the moment.

**Una O'Brien:** The most important thing is that this is a moment where not only can a mother-to-be be persuaded to stop smoking, but it has a sustainable impact on the health of the whole family. This is why we have consistently prioritised smoking cessation in the antenatal phase.

**Q189 Chair:** Are you expecting to put an outcome into your public health framework, around smoking and pregnancy?

**Una O'Brien:** I think we have already got one. I am pretty sure that we have, but I will write to you on that.

The two areas of our absolute focus on public health have been the two signalled in the NAO's Report.

**Q190 Chair:** And the other thing about breastfeeding.

**Professor Beal:** Yes, we could do better at breastfeeding. There are a lot more health visitors coming into the system to support women with their breastfeeding. But we do need to do more on working with supporting them through that difficult period.

**Q191 Chair:** Anything specific there, rather than just a general desire to do better?

**Professor Beal:** I would need to give you a note on that.

**Q192 Chair:** A note on that. Okay.

I have one final one, then Steve wants one—everybody wants a go. It is back to the funding framework. The Report tells us that trusts classify outpatient appointments as inpatient admissions, simply because they get more money for it. That is an unintended consequence of your financial framework.

**Sir David Nicholson:** I am sorry. Is that a question?

**Q193 Chair:** On page 33, paragraph 211, it says that trusts overcharge for appointments because they classify them as inpatient admissions, rather than outpatient appointments.

**Sir David Nicholson:** Yes, that is why—

**Q194 Chair:** I am saying that that is an unintended consequence of your financial framework.

**Sir David Nicholson:** It is an unintended consequence that we want to change. We are changing it.

**Q195 Chair:** By?

**Sir David Nicholson:** By the pathway.

**Q196 Chair:** By? Date?

**Sir David Nicholson:** The pathway is available from 1 April last year.

**Una O'Brien:** This is part of the new payment system, whereby we pay for the whole of care, rather than for the individual items and encounters that we were referring to earlier.

**Q197 Chair:** Okay. The very final one—sorry, it is just my totting up—is that nearly a third of midwives are planning to leave, according to the Royal College of Midwives, with 29% of midwives with less than 10 years' experience planning to change profession within the next year. I accept that it is the trade union, but it is nevertheless a big number.

**Professor Beal:** There are a number of midwives who are due to retire.

**Q198 Chair:** No. Sorry, I will read it again. Some 29% of midwives with less than 10 years' experience—they will not be retiring, unless they started late—plan to change profession within the next year.

**Professor Beal:** There is work to do around retaining midwives. Many midwives will also go on to other

---

 18 November 2013 NHS England
 

---

professions within the NHS after a 10-year period, but there is a need to look at the retention of midwives. We are also aware of the turnover of midwives, which is why we have got more than 5,000 midwives in training at the moment.

**Q199 Mr Bacon:** Dr Calderwood said earlier, when I asked if there were a morale problem, that there was not. Dr Calderwood, can you name another profession where there is no morale problem, where nearly a third of people are thinking of leaving in the next 12 months?

**Chair:** And they have been there less than 10 years.

**Chris Heaton-Harris:** Outside the NHS.

**Dr Calderwood:** I said I was not aware. I was talking about obstetricians, I suppose. I am aware of that figure that you have quoted, which is, as you say, from the Royal College of Midwives. It would be important to explore the reasons for that poor morale.

**Q200 Mr Bacon:** It does not sound, from what Professor Beal was saying—if I may say so, Professor Beal—that you have done it yet. You have said there is a need to look at the issue of retention, like it is some aspiration in the future rather than something that is being gripped now.

**Professor Beal:** Under *Compassion in Practice*, one of the work streams is around looking at staff and staff retention. So we have been working closely with NHS employers to look at the retention of all nurses and midwives, and staff experience. We know that, where there is a good staff experience, women will have a good experience of care, and where there is not such a good staff experience, there is not such a good experience of care.

**Q201 Chair:** Can you give specifics about what you are intending to do?

**Professor Beal:** We are looking at a number of health and well-being initiatives with NHS employers. We are looking at having a question to staff similar to the family and friends tests: “Would you recommend this as a place to work?” That should then give providers of care in trusts some really good information to look at for staff and what they would like to see in place for staff. With NHS employers, we have looked at mentorship schemes for midwives, so that they have a good experience when they first come into midwifery and have good support. Those are a number of the things we have been looking at for implementation in *Compassion in Practice*.

**Q202 Stephen Barclay:** May I ask about the protection for whistleblowers, which I have raised repeatedly? It has been reported in the media that a whistleblower who raised concerns about maternity services at the Liverpool women’s hospital has been suspended for talking to the media. Are you aware of that case?

**Una O’Brien:** I am not personally aware of that case, but we have been very clear that people who raise concerns about care must be listened to and treated fairly. I am certainly very concerned by what you have reported to me.

**Q203 Stephen Barclay:** Sir David, are you aware of the case? Dr Tattersall is the doctor concerned.

**Sir David Nicholson:** Liverpool women’s hospital? How recently did this happen?

**Stephen Barclay:** I can check during the next question. But the CQC did a report, I understand, earlier this year and upheld concerns he raised.

**Sir David Nicholson:** Okay. I was not aware he had been suspended.

**Q204 Stephen Barclay:** Are you aware that he raised whistleblowing concerns about patient safety at the Liverpool women’s hospital?

**Sir David Nicholson:** I would have to check. Off hand, I cannot remember.

**Q205 Stephen Barclay:** At one of our previous hearings, you very much emphasised to me that the minute you become aware of whistleblowing concerns you personally intervene.

**Sir David Nicholson:** When people have contacted me, I have.

**Q206 Stephen Barclay:** So it is only if they write to you personally, like Gary Walker did, that you personally intervene?

**Sir David Nicholson:** They can write to me. People have rung me and they have e-mailed me. With Gary Walker, I intervened straight away.

**Q207 Stephen Barclay:** Dr Tattersall’s concerns were raised internally with the hospital, as I understand it, and raised with the Care Quality Commission. The Care Quality Commission then subsequently produced a report upholding some of his concerns. Has none of that been brought to your attention?

**Sir David Nicholson:** I do not recollect any of that.

**Q208 Stephen Barclay:** Would you not expect someone raising serious concerns like that to be brought to your attention, Ms O’Brien?

**Una O’Brien:** If I knew about it, I would certainly act on it. What strikes me is that the people who can do something about it have been informed and have acted. That is the whole point of having the CQC and strengthening its role and relationship to this.

**Q209 Stephen Barclay:** But I understand the doctor is currently suspended. We have just had a hearing where we have been looking at the importance of having consultants available and how that improves patient safety. I have never met the doctor concerned—I am just going on media reports—but the media have reported this case and I am just surprised if I, as a Back-Bench MP, can pick up on it, that the Department of Health does not seem to have done so. Is he currently suspended?

**Una O’Brien:** I am very happy to follow up with you. I do not know the specific details about the issue you are raising.

**Q210 Stephen Barclay:** But in general, would you find it acceptable, as the permanent secretary of the

---

18 November 2013 NHS England

---

Department of Health, for a clinician to be suspended on the grounds of talking to the media after raising concerns internally?

**Una O'Brien:** The Department of Health has been very clear that people who raise concerns about the safety of patients or the safety of care need to be listened to and treated fairly. We have been consistently clear about that, and that is the position, as firmly as I can state it.

**Q211 Stephen Barclay:** Just to be clear—let's take it away from the individual case—as a general policy, would you expect someone who has raised whistleblower concerns internally to be suspended on the grounds of talking to the media?

**Una O'Brien:** As I said before, I don't know the details of the case, but I expect whistleblowers to be properly listened to, treated with respect, and treated properly and fairly.

**Q212 Stephen Barclay:** Sure. That is the same answer you gave a moment ago. What we are trying to establish is whether treating them with respect and treating them fairly includes suspending someone who is a clinician.

**Una O'Brien:** I generally do not think that whistleblowers should, as a matter of course, be suspended. That is not a sensible approach. A sensible approach is to listen to what people have to say, to respect what they are saying and to treat them with dignity and fairness.

**Q213 Stephen Barclay:** So the suspension of whistleblowers is not consistent with the new culture that the NHS is seeking to achieve?

**Una O'Brien:** In general terms, that is not what we are looking to do. As I say, I don't know the specifics of the case, but now that you have raised it with me, I will most certainly look at it.

**Q214 Mr Bacon:** May I invite you to reread the NAO Report on the management of the suspension of the clinical staff—it came out certainly pre-2005, but I will have to look up the exact date; it was quite a long time ago? Taxpayers' money was spent to suspend clinicians, whose clinical competence was not in doubt, sometimes for long periods of time while management rows went on. More recently, I have had constituency cases involving clinicians in my area, where exactly the same thing has happened. My guess is that no matter what you wish and no matter what you think is good practice, it is still going on. It is probably not a bad idea for the NAO and this Committee to revisit this subject at some point, because it does not sound like the new culture you are talking about is percolating through. Here we have an example of at least one consultant obstetrician who is no longer available, reducing further your capacity, plainly not because of a clinical reason to do with doubts about their clinical competence, but because that person tried to be a professional by raising safety concerns. I do not think you have gripped that. I do not think you gripped it 10 years ago, and I have seen no evidence that you have gripped it since. I think you

should. That is not really something for you to respond to; it is something for you to take away.

**Una O'Brien:** All I can say is that I can most certainly assure you that safety issues that are raised are centre stage with the Government. In a matter of days—it may even be tomorrow—the Secretary of State will give his full response to the Francis inquiry, in which all these matters of openness, transparency and encouraging people to raise issues when they have concerns about patient safety are absolutely centre stage. We have got a long way to go to embed that culture.

**Mr Bacon:** You have a big cancer in the culture to cut out. We saw that over the severance payments. One of the clinicians involved in the Baby P case was offered £80,000 to go quietly. When she said, "This has nothing to do with money; it is to do with patient safety," she was offered £120,000 and told, "Take it, or you'll be sacked." That is not what we are looking for. May I ask one more question?

**Chair:** One last question, then Fiona.

**Q215 Mr Bacon:** I am surprised that Sir David had not heard of the Women's Institute report.

**Sir David Nicholson:** I haven't read it.

**Mr Bacon:** But you were aware of it.

**Sir David Nicholson:** Only when you told me about it.

**Mr Bacon:** That surprises me, because this is a hearing on maternity services, and the report was published in May. It is a pretty hefty report on women's experiences of maternity services. As we all know from a famous incident, which I will not labour, it does not pay to mess with the Women's Institute. I will read one quote about choice, because it is utterly pertinent to what was being said earlier by Mr Heaton-Harris. Page 59 of the report states: "To be honest, my community midwife, as lovely as she is, didn't present me with the options for my area. It was just assumed that as it was my first child I would go to hospital and assumed I knew what options were available. The information on the NHS website wasn't easy; I couldn't determine if there was a birthing centre locally. There was no conversation, discussion or options presented!" Can I invite you and your colleagues to go away and have a look at this WI survey? It is a thorough piece of work and I think it merits more attention that it sounds like it has had so far.

**Sir David Nicholson:** Okay.

**Q216 Fiona Mactaggart:** I was struck by something you said at the beginning of this hearing, which implied that the birth rate was declining quite significantly. Am I right in thinking that?

**Una O'Brien:** I think it was the previous witnesses who referred to that.

**Q217 Fiona Mactaggart:** Perhaps you could tell me what is happening.

**Dr Calderwood:** It has risen by 23% in the past decade and is now predicted to plateau and then fall.

**Chair:** On what basis? I just do not believe it.

---

18 November 2013 NHS England

---

**Q218 Fiona Mactaggart:** What has happened in the past six months?

**Dr Calderwood:** I do not know exactly about the past six months. Those are ONS data.

**Una O'Brien:** Those are the predictions from the ONS.

**Q219 Fiona Mactaggart:** Presumably, you know how many children were born in the NHS in the past six months.

**Dr Calderwood:** ONS data have a lag time before they are reported, so our most recent data would be from July of this year for the previous six months.

**Chair:** You have till July 2013.

**Q220 Fiona Mactaggart:** I am sorry to say this, but I am slightly struck that you depend on ONS data,

when you are in charge of the NHS where the babies are being born. It just seems odd to me.

**Chair:** To be fair to them, Fiona, we had exactly the same on school places. If you remember, it took the ONS until 2008 to decide that there has been an increase in the birth rate—completely mad. We ought to look at the ONS—an issue for another time.

**Mr Bacon:** I can tell you that, on farms in my constituency, they know how many pigs have been born straight away.

**Fiona Mactaggart:** Exactly.

**Dr Calderwood:** Each maternity unit will be aware.

**Fiona Mactaggart:** I ask the question because I was speaking to a chief executive of a hospital recently, who told me that the birth rate had dramatically fallen in that institution.

**Chair:** Okay. I am going to close the session. Thank you very much indeed.

---

# Written evidence

---

## Written evidence from Dr Susan Bewley on Maternity Services

In the Committee's hearing on Maternity Services on Monday 18 November, Dr Susan Bewley made the following comment on unhappiness in the obstetrics profession:

**Q21 Mr Bacon:** When you talk about a shorter working week, that is to do with the working time directive and consultants, registrars and the people who are training not getting the exposure and the number of hours that they would have done. Is that what you mean?

**Professor Bewley:** Yes. And if you look at the GMC reports on unhappiness in specialties and the different staff specialties, it is an unhappy specialty. There are morale problems.

This was refuted by Dr Catherine Calderwood when questioned on the matter during the main panel:

**Q167 Mr Bacon:** This is probably one for Dr Calderwood: Professor Bewley said earlier that obstetrics is not a happy service; there is a morale problem. Why is that? You are talking about something that ought to be almost the most joyous part of the NHS—it is the nice part, as the Chair said earlier. It is the bit that is really good and fun and usually—dreadful tragedies excepted—results in something really good happening. Surely it ought to be the best bit to work in.

**Dr Calderwood:** I am not aware of data from lots of staff, certainly from obstetricians, saying that it is not a happy service.

Dr Susan Bewley has since written to the Committee with the following information to support her comments:

With respect to an interchange with Mr Bacon about the training, skills and morale in obstetrics, I was making my comments based both on experience and a number of reports collated over the years, and would be happy for you to pass this on to him.

In particular, I was thinking about recent information that O&G trainees have the lowest satisfaction scores of all specialties (Table 2 GMC 2013) [http://www.gmc-uk.org/National\\_training\\_survey\\_key\\_findings\\_report\\_2013.pdf\\_52299037.pdf](http://www.gmc-uk.org/National_training_survey_key_findings_report_2013.pdf_52299037.pdf)

Other contextual information:

RCOG downturn in recruitment 2006 <http://www.rcog.org.uk/files/rcog-corp/uploaded-files/WPRCareerinOandG2006.pdf>

Working time directive compliance 2008 was coming along <http://www.rcog.org.uk/files/rcog-corp/uploaded-files/WPRChildrensandMaternityServicesWTD2008.pdf>

Experience in operative teaching is falling with time in successive RCOG trainee surveys (ie being skilled and confident) 2009 <http://www.rcog.org.uk/news/rcog-release-trainees-survey-results>

RCOG 2009 A “hard pressed specialty” that “should be frank about the sources of stress and discontent” [http://www.rcog.org.uk/files/rcog-corp/uploaded-files/Getting\\_a\\_Life.pdf](http://www.rcog.org.uk/files/rcog-corp/uploaded-files/Getting_a_Life.pdf)

## Written evidence from the Royal College of Midwives

*Is anyone being held to account for the performance of NHS maternity care?*

A central issue with regard to improving NHS maternity services, particularly under the new arrangements, became apparent during the questioning of the second set of witnesses. That issue is accountability and was summed up by Q33 from the Chair: “Who is accountable in this world if there are not enough midwives? You?” and her subsequent question (Q34), “Who is accountable?” We do not feel an answer was ever arrived at.

In answer to Q38, Una O'Brien states, “Well, I say again, it is the responsibility of commissioners working with providers to commission the service clearly and make sure that the resources are there to meet that demand.” There is a difference however between being responsible and being accountable. Commissioners are responsible, but are they accountable; if they are, to whom do they account? What happens if commissioners overlook policies with regard to maternity care, or—even worse—just ignore them? As far as we can tell, nothing happens. Indeed, we know—as Sir David Nicholson admits this himself in response to Q62—that only one third of clinical commissioning groups (CCGs) have a service specification in place with regard to maternity services.

This absence of accountability was touched upon later in the evidence too, this time at the national level. At Q78, Richard Bacon MP asked, “There is not a named person responsible for implementing Maternity Matters in the same way as there is for Compassion in Practice?” To which Sir David replied, “No.”

## FUNDING OF NHS MATERNITY SERVICES

It is clear from the NAO report and the subsequent evidence sent to the Committee that NHS maternity services are not in direct receipt of enough money to fund what is needed. Many trusts have to subsidise their maternity services from money received from other areas. We may have spotted why this is the case. In answer

to Q42 (and again in answer to Q66), Sir David spells out that the tariff—ie the money received by a provider for providing a service—is calculated based on what NHS trusts have historically spent. The problem with this is that trusts collectively have been employing thousands fewer midwives than needed (2,300 full time equivalent midwives, according to the NAO report). Employing an adequate number of midwives would therefore inevitably cost more per birth, meaning the true tariff for an adequate service should be higher than it is; paying less based on how much trusts spend when they don't employ enough midwives effectively locks underfunding into the system. As midwife numbers have risen, trusts have had to spend more per birth, and have been punished by the tariff system as a result.

Additionally, again in response to Q42, Sir David stated that the tariff is set on what was spent on maternity two years ago. This builds in a permanent pressure as standards and guidelines are published regularly that require midwives and others involved in maternity care to do more and more, but the two-year time lag on the tariff means there will not be any money to pay for the impact of any new requirement for at least two years.

Sir David also mentioned in answer to Q42 that an extra £300 million was put into the tariff to make up for the fact that not enough money was going into maternity services. It is important to point out that this was only a temporary injection of funds; it was not a permanent uplift in the tariff to address the chronic underfunding. It is interesting that Sir David accepts that that was an underfunding but only addressed it with a temporary uplift.

#### FINANCIAL VIABILITY OF FREESTANDING MIDWIFE-LED UNITS (600 BIRTHS PER YEAR)

In answer to Q163, Professor Juliet Beal stated, “A free-standing maternity unit normally needs up to 600 deliveries a year to be sustainable. Again, it is up to individual providers and trusts to look at their free-standing units and how they make the use of that capacity. But for financial viability, it is about 600 births.” This is not a figure we recognise, and indeed we seriously question the evidence base used by Professor Beal. Challenged with regard to the use of the 600 figure on twitter on 20th November, Professor Beal (@JulietBeal) responded: “Average figure from the three stand alone midwifery units I have previously managed—includes staffing and facility costs”. We would question whether this is a sufficiently robust basis on which to make such a confident assertion to the Committee.

#### NUMBER OF MIDWIFE-LED UNITS (MLUs)

In response to Q175, Professor Beal stated, “There has been a large increase in midwifery-led units over the past couple of years to help promote women's choice.” It is important to point out that this is not true at least as far as freestanding MLUs are concerned. Indeed, in England in February 2013 there were 59 freestanding MLUs, compared with 53 in April 2001. During these twelve years 30 new units opened and 21 units were permanently closed; a further three are temporarily closed, with the possibility that they will not reopen.

With regard to the other type of MLU, those that exist alongside existing obstetric units, whilst the number of units is on the rise—which is welcome—the data on the number of births in them are unclear. Often the number of births in the alongside MLU is conflated with the number of births in the accompanying obstetric unit. There are many problems with the collection of data in maternity care, with this being one example.

27 November 2013

#### Written evidence from the Department of Health and NHS England

Please find attached Notes relating to the Maternity Services in England Hearing requested by the Committee. A copy of the corrected transcript has been sent separately.

For clarity the information is presented in the following Annexes:

<i>Annex number</i>	<i>Question</i>	<i>Note subject</i>
Annex A	Q46	GP Contract covering antenatal/maternity care
Annex B	Q88–9	Clinical negligence—international comparisons
Annex C	Q96–8	Distinction between the premium for a midwifery-led unit and obstetric-led unit
Annex D	Q108–112	Compliance around IT standards
Annex E	Q122	Ethnic breakdown of the midwife workforce
Annex F	Q172–3	National tariff for neonatal care
Annex G	Q188–9	Smoking in pregnancy outcome indicator
Annex H	Q190–1	Supporting breastfeeding to at least 8 weeks

I trust the information provided is of help to the Committee.

Una O'Brien  
Permanent Secretary  
Department of Health

Sir David Nicholson  
Chief Executive  
NHS England

2 December 2013

## Annex A

### QUESTION 46: NOTE ON GP CONTRACT PROVIDING ANTENATAL CARE TO WOMEN

*The Committee asked about the basic GP contract for providing antenatal care to women under the new system.*

The provision of maternity services is recognised as an additional service within the Global Sum element of the GP contract, this makes up 2.1% of the global sum payment.

Schedule 2 of the GMS contract regulations requires a contractor whose contract includes the provision of maternity medical services to:

- “provide to female patients who have been diagnosed as pregnant all necessary maternity medical services throughout the antenatal period;
- provide to female patients and their babies all necessary maternity medical services throughout the postnatal period other than neonatal checks; and
- provide all necessary maternity medical services to female patients whose pregnancy has terminated as a result of miscarriage or abortion or, where the contractor has a conscientious objection to the termination of pregnancy, prompt referral to another provider of primary medical services who does not have such conscientious objection.”

As part of the seasonal flu enhanced service, pregnant women are identified as one of the “at risk” groups who must be offered a flu vaccine. GP practices that sign up for this enhanced service are required to identify pregnant women under their care and offer a flu vaccination.

NHS England has, on behalf of Public Health England, commissioned a further enhanced service for a Pertussis- Pregnant immunisation programme. Under this programme practices are required to identify pregnant women under their care and vaccinate them against pertussis between the weeks 28–38 of pregnancy.

## Annex B

### QUESTIONS 88–89: NOTE ON CLINICAL NEGLIGENCE—INTERNATIONAL COMPARISONS

*The Department and NHS England were asked if any work had been done on comparing best practice overseas, within Europe or Canada, in relation to clinical negligence.*

The NHS Litigation Authority has conducted some research into claims data from other countries. However it concluded that it was very difficult to make meaningful comparisons as the legal and social welfare systems tend to be very different. We therefore need to be extremely careful about making comparisons between the compensation system in England and those in other parts of the world.

The following factors, which can all influence the volume and cost of claims, vary between different countries:

- availability of support to actually bring a claim;
- the legal burden of proof to make a claim successful, which may affect the number of claims;
- the losses that claimants are entitled to recover are capped in some jurisdictions and some types of losses are not compensable; and
- variation in international market costs of itemised losses, for example hip replacement or personal care.

During the hearing, Canada was raised as a specific example. Canada operates a health insurance scheme that covers virtually all residents. Most doctors are in private practice and their services are billed through the insurance plans. Each doctor requires medical liability insurance, which is usually obtained through a professional organisation. Claims numbers and costs are lower in Canada than in England for a number of reasons. For example, Canada’s highest courts have set limits on awards and the country’s liability laws make establishing professional negligence more difficult.

Other countries’ systems and negligence claims experience will be different again. To get to the same position with regard to some of these cost-drivers in the NHS in England, both in terms of legal fees and damages awards, would require a significant overhaul of the legal system, including reform of the law relating to all types of negligence, not just in relation to the health system.

Where practical change can be made to lower costs, in general the Government has acted. For example, the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO), which came into force on 1<sup>st</sup> April 2013, made significant changes to civil litigation funding. This particularly related to no-win no-fee (CFA)

arrangements, and includes abolishing the recovery of success fees and After the Event (ATE) insurance, and banning referral fees.

### Annex C

#### QUESTION 96–98: NOTE ON DISTINCTION BETWEEN THE PREMIUM FOR A MIDWIFERY-LED UNIT AND THAT FOR AN OBSTETRIC-LED UNIT

*The Department and NHS England were asked whether litigation costs were picked up centrally or cross-charged to the trust responsible and if this is broken down between midwifery-led units compared with obstetric-led unit.*

The NHS Litigation Authority charges members a “general” contribution, and where applicable a “maternity” contribution. The charges levied under the Clinical Negligence Scheme for Trusts (CNST) for maternity services, are not specifically amended so as to distinguish between midwifery versus obstetric led. They are set taking account of the staff numbers (all midwives & all obstetrics staff) and the number of registered births, to give a relevant charge to reflect the volume of activity carried out by the organisation concerned. The charge is also affected by the claims experience of the member organisation and those with a good claims record can expect to pay less for their cover.

Overall the total collected from all members who provide maternity services is anticipated to provide the funding stream to deal with those maternity cases which will fall due to be paid in that financial year regardless of the financial year in which the treatment giving rise to the claim (ie the birth) occurred.

### Annex D

#### Questions 108–112: COMPLIANCE AROUND IT STANDARDS

*The Committee was interested in connectivity, particularly the compliance around IT standards, and asked who is checking compliance to try and mitigate risks.*

In terms of setting those requirements to ensure that there is connectivity, the Health and Social Care Act 2012 empowers the Secretary of State for Health and also NHS England to publish information standards that will apply across all publicly funded organisations providing health and adult social care in England. The Act’s explanatory notes describe three types of information standards, namely:

- (a) **Data standards**—regulating the format, use, and interpretation of information in electronic information systems.
- (b) **Information Governance standards**—regulating the protocols that support data and information integrity, privacy, confidentiality and security.
- (c) **Technical standards**—regulating the structures and processes used for communication between different electronic information systems and between information systems and their users.

Alongside these standards, we are also leading the drive for providers and their contracted IT suppliers to make available open **application programming interfaces** (APIs) for locally purchased IT systems, to ensure that systems are able to share information appropriately and can “talk to one another” to deliver system interoperability. NHS England’s published guidance “Safer Hospitals Safer Wards: achieving an integrated digital care record” <http://www.england.nhs.uk/wp-content/uploads/2013/07/safer-hosp-safer-wards.pdf> says:

“When purchasing new ‘best of breed’ systems, the flow of information in and out of the system will be enabled through Open Application Programming Interfaces (APIs). Specification of open APIs should form a part of the procurement criteria for Trusts purchasing digital systems both for core systems and for ‘integration layers’ such as portals/integration engines.”

Whilst the Department of Health and other central organisations including NHS England will oversee and monitor implementation, implementation will be driven at the local level, responding to local priorities and needs across health, social care and public health.

This activity is all within the context of implementing the Government’s Information Strategy for health and care in England, “*The power of information: putting all of us in control of the health and care information we need*”, published in May 2012. A copy can be found on the GOV.UK website. The strategy sets a ten-year framework for transforming information for health and care. It aims to harness information and new technologies to achieve higher quality care and improve outcomes for patients and service users.

### Annex E

#### QUESTION 122: NOTE ON ETHNIC BREAKDOWN OF THE MIDWIFE WORKFORCE

The Committee asked for information on the ethnic breakdown of the midwife work force.

Although information about the ethnicity of midwives is not collected centrally, public data for the UK is held on the Nursing and Midwifery Council website, which does provide some historical information regarding

the ethnicity of midwives. The data below has been extracted from the Nursing and Midwifery Council website as a whole but specifically relates to midwives within the UK.

Midwives % of those responding (response was voluntary):

White British	79%
Other White	11%
Asian	2%
Black African	4%
Black Caribbean	2%
Other/Mixed	1%

*NOTES: Equality and diversity data for the register as of July 2011.*

*Data Source: <http://www.nmc-uk.org/About-us/Equality-and-diversity/Analysis-of-diversity-data-2011/>*

## Annex F

### QUESTIONS 172- 173: NOTE ON THE NATIONAL TARIFF FOR NEONATAL CARE

*The Committee asked if the two-year tariffs include a national tariff for neonatal care.*

There will be no mandatory national tariffs for neonatal care in 2014/15. These services will continue to be subject to local negotiation on price.

For services which do have mandatory national tariffs, it is anticipated the prices that will come into effect on 1 April 2014 will apply for one year, ie the 2014/15 financial year.

In his response, Sir David was referring to financial allocations to commissioners that will be made by NHS England, which will cover a two-year period, ie 2014/15 and 2015/16.

## Annex G

### QUESTION 188-9: NOTE ON SMOKING IN PREGNANCY OUTCOME INDICATOR

*The Committee asked if there the public health framework includes an outcome indicator around smoking and pregnancy.*

The Public Health Outcomes Framework sets out and the Government's objectives for the reformed public health system. The whole system is focused on achieving positive health outcomes for the population and reducing inequalities in health focusing two high-level outcomes:

- Increased healthy life expectancy.
- Reduced differences in life expectancy and healthy life expectancy between communities.

As part of this, an expectant mother's smoking status at time of delivery' is included in the Public Health Outcomes Framework, as indicator 2.3 under Domain 2: Health improvement.

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/256825/2901502\\_PHOF\\_Improving\\_Outcomes\\_PT1A\\_v0\\_4.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256825/2901502_PHOF_Improving_Outcomes_PT1A_v0_4.pdf)

## Annex H

### QUESTION 190 NOTE ON SUPPORTING BREASTFEEDING TO AT LEAST 8 WEEKS

The Committee asked how breastfeeding is monitored.

The core health visiting national service specification requires that health visiting services provide on-going support for mothers who are breast-feeding. The performance management framework that accompanies the service specification requires quarterly reports on the % of mothers who are asked about their breast-feeding at the 6-8 week check and the % reporting breast-feeding.

Area Teams are encouraged to set targets for improvement in breastfeeding rates with their providers. NHS England is working with Public Health England's child and maternal health network to produce a benchmarked atlas of public health outcomes for young children. This will be produced at a local authority level and will include breast feeding. For each of the indicators included there will be a review of the evidence on effective interventions particularly focusing on the role of health visitors (available January 2014).

## Written evidence from the Royal College of Obstetricians and Gynaecologists

### 1. INTRODUCTION

The Royal College of Obstetricians and Gynaecologists (RCOG) watched the hearing on *Maternity services in England* on 18 November 2013 with interest and looks forward to the Public Accounts Committee's report.

To follow are notes to supplement the discussions that took place in the afternoon.

### 2. CONTINUITY OF CARE AND MATERNAL CHOICE

The RCOG agrees that continuity of care, including a named maternity professional for all women throughout pregnancy, including support provided during the postnatal period, contributes to high quality services and a better experience for women. In addition, one-to-one midwifery care for women in labour and the availability of consultant care when needed are key to high quality services and a better experience for women.

To enable care closer to home, the RCOG believes that 30% of pregnant women (often those with a previous uneventful birth) could be cared for potentially outside the traditional hospital environment, as outlined in our report *High Quality Women Health Care* (2011). The Birthplace cohort study (2011) by the National Perinatal Epidemiology Unit (NPEU) supports this concept.

The RCOG supports maternal choice of providers for low-risk women having a second or subsequent baby who have been appropriately risk-assessed, provided all the safeguards such as emergency transport arrangements are in place and there are adequate midwives to provide the home birth service. The RCOG favours the expansion of co-located midwifery units for low-risk women who chose to deliver in hospitals.

### 3. BIRTH TRENDS

The NAO report has shown that the rise in the population and pregnancy complication rates, partly as a result of emerging demographic and lifestyle trends such as maternal obesity which have added to the extra costs of NHS maternity services due to additional morbidity.

The increase in these high-risk pregnancies makes the case for 24/7 consultant care in the larger units if these women are to have safe childbirth. Multidisciplinary team working is required and workforce planning must bear in mind the need for neonatal and anaesthetic presence in labour wards, in addition to obstetricians and midwives. These professional relationships must be formalised in consultant contracts, as noted in our report *Tomorrow's Specialist* (2012) to enable better care for women.

### 4. STRATEGIC CLINICAL NETWORKS

The RCOG believes that configuring services within strategic clinical networks will not only help link all health and social care services together, thereby providing a more responsive service to women, this approach should also help reduce health inequalities.

Networks have been proven to be successful in gynaecological cancer and neonatal services and will help ensure that timely care by the appropriate healthcare professionals are provided across the range of women's and children's services. This is because intelligence about the individual patient's history and health needs are shared between different providers and data is collected and linked. All trusts providing maternity services should therefore work in managed clinical networks.

### 5. PAYMENT BY RESULTS

The argument that the current financial system in maternity services drives hospitals to undertake unnecessary interventions in order to raise income is simplistic, perverse and must be challenged by the Department of Health and NHS England. There is no evidence to support this. It is unhelpful to state that the payment system incentivises against normality and that, for example, more c-sections have been carried out even when they are not required because hospitals stand to receive more money if they undertake more procedures.

Instead, the focus should be on the reasons for these interventions and the clinical outcomes for performance benchmarking to improve NHS care. The RCOG's *Patterns of Maternity Care in English NHS Hospitals* report has demonstrated wide variation in clinical practice across England.

### 6. DATA COLLECTION

Risk adjusted data on outcomes and well-defined quality indicators can help units to plan their service and manage capacity and provide evidence for CQC inspections. CCGs should have a role in ensuring that such information is collected by all services.

Central to the safety agenda is the development of a robust information system that allows for the flow of information about the individual patient from provider to provider across the NHS and social care. Women should have access to such information in the interests of openness and transparency.

Similarly, the RCOG believes that the implementation of mandatory national datasets, from April 2014, will help to improve care. The present focus on outcomes in the NHS Mandate will help ensure that national clinical standards and guidelines are followed. This may reduce the mismanagement of labour and lower litigation costs in the long term.

#### 7. EUROPEAN WORKING TIME DIRECTIVE (EWTD)

The European Working Time Regulations have impacted on all specialities and has had an adverse affect on trainee experience and continuity of care.

Repealing the EWTD will not solve the problem of out-of-hours care in obstetrics and gynaecology. Better supervision of trainees, addressing the professional skills needs of doctors, the configuration of units in conurbations to meet the requirements of local communities and the implementation of strategic clinical networks will do more to help improve women's sexual and reproductive health services.

The RCOG supports the call for better evidence of the outcomes from resident consultant presence at nights. The RCOG has developed materials to advise units on better workforce planning to provide round-the-clock care but would reiterate that in the larger units, because of the higher volume of births involved, consultant care is crucial at nights and over weekends.

The Academy of Medical Royal Colleges *Seven Day Consultant Present Care* (2013) report outlines the requirements for maternity and gynaecology services on weekends, over days and nights. It is essential that commissioners heed these recommendations in planning the provision of local services.

#### 8. STAFF MORALE IN OBSTETRICS

An issue that arose during the witness session was that of low morale among O&G doctors. This was identified as a problem within the specialty in an RCOG report in 2005. The main reasons then were: heavy workloads, unsocial hours and poor work-life balance, fear of litigation and poor relationships with other maternity professionals. The RCOG has addressed these concerns by offering solutions on flexible working and career development, investing in e-learning and online technologies and by providing advice to support doctors in difficulty. Recruitment into the specialty has improved over the last five years.

However, the annual GMC National Training Surveys continue to show lower satisfaction rates among O&G trainees in comparison to other specialties. An area of significant concern for the RCOG is undermining, as identified by the GMC, and the RCOG has worked closely with the RCM to reduce unacceptable and bullying behaviours in the workplace through the development of workplace leads to promote good practice in trusts and the publication of a joint statement.

#### 9. THE HIGH COSTS OF MATERNITY CARE

The NAO report has highlighted that the average cost per birth is £3,700. This reflects the multidisciplinary nature of maternity care and, alongside the growing numbers of complex pregnancies cared for in the NHS, demonstrates that continuous investment is needed to provide high quality, safe care.

The RCOG believes that healthy mothers give birth to healthy babies and maternity and gynaecological services must be underpinned by Sir Michael Marmot's life-course model of healthcare. Aside from investing in facilities and technology, there is a need to shift our thinking in society to concentrate on preventing rather than treating diseases.

In practical terms, this means that health issues such as smoking and alcohol consumption levels, poor diet and nutrition and low physical activity are addressed before a woman becomes pregnant.

A co-ordinated, public health approach in women's sexual and reproductive services will help improve the nation's health and wellbeing. This also helps to prevent the lead causes of perinatal death such as prematurity, fetal growth restriction, low birth weight and stillbirth. The RCOG believes that better data collection and analysis and research into the above mentioned areas will help the NHS to provide better maternity care.

17 December 2013