

Scrutiny Review of Maternity Services

February 2004

*** HARINGEY COUNCIL ***

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Report of the Maternity Services Review (sub-committee), London Borough of Haringey Overview & Scrutiny Committee.

For enquiries or further copies of this document, please contact:

*Overview & Scrutiny
Civic Centre
Wood Green
London
N22 8LE*

Telephone: 020 8489 2933

E Mail: michael.carr@haringey.gov.uk

Contents

Foreword by the Chair.....	1
Executive Summary & Recommendations.....	4
<i>Members of the Review</i>	
<i>Scope and Aims of the Review</i>	
<i>The Scrutiny Process</i>	
<i>Scrutiny Recommendations</i>	
1. Introduction.....	13
2. The Haringey Context.....	16
3. Women's Voices.....	19
<i>Recommendation One: Extended Client Advocacy</i>	
4. Service Organisation.....	23
5. Access Information and Choice.....	27
<i>Recommendation Two: A Customer Charter for Maternity Care</i>	
<i>Recommendation Three: Communicating Choice</i>	
<i>Recommendation Four: Improved Client Information</i>	
6. Improving Access.....	39
<i>Recommendation Five: An Outreach Strategy</i>	
<i>Recommendation Six: Reaching Asylum Seekers and Refugees</i>	
<i>Recommendation Seven: Improving Access to Preferred of Place of Birth</i>	
<i>Recommendation Eight: Improved Access for NHS Home Visiting Staff</i>	
7. Continuity of Care.....	45
<i>Recommendation Nine: Improving the Continuity of Care</i>	
<i>Recommendation Ten: A Customer Care Service Plan</i>	
<i>Recommendation Eleven: Midwifery Led Care</i>	
8. Consultation Planning and Performance.....	51
<i>Recommendation Twelve: A Customer Satisfaction Response System</i>	
<i>Recommendation Thirteen: A Community Consultation Strategy</i>	
9. Monitoring & Review.....	57
<i>Recommendation Fourteen: Listening to Clients</i>	
<i>Recommendation Fifteen: A Local Performance Monitoring Framework</i>	
10. Conclusion.....	63
Glossary.....	68
Acknowledgements.....	74
References.....	75
Bibliography.....	77
Appendix.....	78

Foreword by the Chair

The Scrutiny Review of Maternity Services came about following a decision taken at Council in December 2001, which was made in response to a presentation to Council by the Enfield and Haringey Home Birth Campaign (EHHBC), which engendered a strong and passionate debate.

The reason why the home birth campaign group was established and the reason why the campaign was sustained, was the controversial decision taken by the North Middlesex University Hospital in October 2000 to disband its dedicated home birth team of two midwives and replace this with a strategy to develop and roll out 5/6 teams of midwives, offering a range of midwifery services, including home births. The opposition to this plan was organised into the EHHBC by a group of women who had experienced childbirth with the Home Births Team and who felt a strong commitment to the kind of service they had received. One witness talked not only of feeling re-assured and confident throughout a by no means easy home birth, but also explained that the aftercare she received from the midwife had enabled her to overcome the problems she experienced with breast feeding; "I would have given up without her help". The campaigner felt that in the re-configuration of the midwifery services, the knowledge and expertise of the Home Birth Team would be diluted. During 2001 and 2002 the new integrated midwifery service has been introduced by the hospital and concerns remained for EHHBC: will the new arrangements provide the continuity of high quality confident care was delivered by the dedicated home birth team? What campaigners wanted was a continuing and strengthened dedicated Home Birth Team, what they are still campaigning for is the kind of quality personalised care they feel was available through the previous model of service delivery.

A motion was presented to Council on "provision of an equitable and safe home birth service in Haringey" for debate. Following a general debate, the Lead Member for Social Services and Health, responded and a resolution was put forward.

The resolution by Council read;

1. That Members on the Health and Social Care Board/Executive be urged to consider the provision of an equitable and safe home birth service.
2. That a Scrutiny Review be held in respect of home birth service provision."¹

At the time of the Council resolution, local authorities had no particular powers for scrutinising the work of the NHS. The Government had only recently published the first set of guidelines on the setting up of arrangements for scrutiny of health services. The proposals were subject to consultation, with January 2003 as the start date given for this scrutiny function. This put a duty on Local Councils to make arrangements for the scrutiny of health and delivery of health services in their area. It is important to emphasise that such proposals were intended not just to examine the workings of the NHS but to incorporate Council services and to make an impact on the health of the local population.

The report that is being presented is therefore a pilot Health Scrutiny for Haringey.

Given that guidelines were in consultation and would ultimately be superseded by legislation, it was clear what the scope and remit of Health Scrutiny was to be. Local Authorities should look at: health issues in the light of proposed major/substantial change to provision in an authorities area; or health problems which have appeared as particularly serious (an example would be rising numbers of TB cases); or issues which indicate that a population is suffering health inequalities in access to and provision of services.

The actual numbers of women having home births is and has always been relatively small representing e.g. in 2001 72 Haringey mothers, 19 of which were from outside of the North Middlesex catchment area². The review could not become the champion of a small group of women but had to ask about the service's ability to provide equitably for the needs of all women, including those who want a home birth, and to ensure that no woman should be disadvantaged either by their age, ethnicity, social class or post code.

We addressed the review by asking the following questions:

1. To what extent are services offered "women centred", and to what extent do they represent real choice?
2. Are services equally accessible for women of different social and ethnic groups?
3. What measures are taken to address differing needs of women in Haringey?
4. What is the appropriate level of co-ordination between different NHS bodies over the structure of maternity services?
5. To what extent are women involved in the planning and monitoring of maternity services?

As with all scrutiny reviews much of the work we did was contacting, meeting and taking evidence from witnesses; service providers and service users. The Appendix Two at the end of the report lists those witnesses interviewed. Above all, in identifying users we wanted to reach people who could not necessarily put themselves forward to be heard. We set up a meeting with teenage mothers at one of their regular support meetings held by; we requested the asylum service to arrange a meeting with a group of asylum seeker women; we set up a stall in Mothercare in Wood Green and interviewed customers; we visited a local GP practice mother and baby clinic. We talked to representatives of the Home Birth Campaign and the National Child Birth Trust. We wanted to know what kind of service they had experienced during pregnancy and childbirth and to understand their point of view of what went right and what went wrong and what improvements to services they would like to see.

We were invariably gratified by the willingness of mothers to engage with us and indeed of their gratitude for the recognition that we were showing them.

We are not claiming that ours is the only way in which women are being or have been consulted, nonetheless, the women we worked with did recognise that we were not representatives of the National Health Service and that they were talking away from and free of a hospital or health context. This had added to both the objectivity of some of the evidence and to our ability to reveal some of the underlying issues felt by consumers. This it is hoped has contributed to making this investigation an important piece of research, a useful reference point for all those interested in the development of quality services locally and a platform for some innovative

recommendations, aimed at providing constructive suggestions for the ongoing quest for service improvement to improve patients experience of the quality of care.

Irene Robertson.

Councillor Irene Robertson
Chair, Overview & Scrutiny Committee

Executive Summary & Recommendations

Members of the Review

Cllr Irene Robertson (Chair)
Cllr Gina Adamou
Cllr Barbara Fabian
Cllr Richard Reynolds
Cllr Katherine Wynne
Ms. Michelle Von Ann (co-optee)



Scope and Aims of the Review

The Review was scoped according to the following terms of reference:

- To what extent are services offered "women centred", and to what extent do they represent real choice?
- Are services equally accessible for women of different social and ethnic groups?
- What measures are taken to address differing needs of women in Haringey?
- What is the appropriate level of co-ordination between different NHS bodies over the structure of maternity services?
- To what extent are women involved in the planning and monitoring of maternity service

The Review

The Review of maternity services was borne out of a concern raised at Council about the abolition of the specialised home birth team at the North Middlesex University Hospital. This issue has been dealt with throughout our investigations within the context of the underlying substantive themes involved in the quality of choice, continuity of care, consultation with service users and the planning of services.

The Review has been conducted in an objective and dispassionate way to consider these underlying themes with particular consideration to the perspective of the individual service user. The aim of the Review has been to arrive at conclusions and put forward recommendations to enhance services, not as an inquiry into past practices or performance. This report attempts to show the evidence for these conclusions and to clearly articulate each of the recommendations in a way that is conceptually sound, although framed to be sufficiently broad as to allow for interpretation and integration into existing arrangements and to provide initiatives that should have a significant impact upon service outcomes. As such, most of the recommendations are non-operational policy proposals around which institutional policies might be built.

The Review was informed by an underlying belief that the models of care provided should be women centred. The recommendations are aimed at introducing arrangements to ensure that services are driven by the experience of the woman in care, rather than the prerogatives of the medical process and of institutions of care. This is entirely in concert with the stated policy aims of all local NHS service

providers and we fully recognise their commitment to achieving the highest levels of quality care for the diverse needs of women in Haringey.

The Scrutiny Process

The overarching purpose of the scrutiny process is to put forward recommendations to executive bodies aimed at improving services. The Health and Social Care Act 2001 provided new requirements for health bodies to consider recommendations put forward by Overview and Scrutiny Committees and the process followed in respect of this Review should concord with the Government Guidance issued in July 2003³. It should also mirror the arrangements followed at Haringey Council in respect of internal Review recommendations⁴. This provides an opportunity for key stakeholders in the area under review to comment on a draft version of the report. A 2-week consultation period has been allowed for this, during which time the various agencies involved are asked to comment with specific reference to technical accuracy and feasibility. Key stakeholders will include the various implementing agencies, consumer groups, and other interested parties. Stakeholders are requested to consider the draft proposed recommendations positively, and to comment specifically on each individual recommendation.

Further to this, a final draft version of the report is prepared, taking into account stakeholder comments and agreed by the members of the Review and by the Overview and Scrutiny Committee. The chief executives of each implementing agency identified in the report are requested to prepare, within 6 weeks, a formal written Executive Response, which includes specific references to each of the recommendations. The implementing agencies can either accept or reject each of the recommendations, but where agreement is not possible are requested to provide a written response. The report, along with the Executive Response is then presented to Full Council for ratification and published.

The way in which the agreed recommendations will be applied is a matter for the implementing agencies to decide upon. When the recommendations are published, the relevant agencies will be asked to provide to the Overview and Scrutiny Committee an Implementation Plan, which should identify specific, measurable, achievable, realistic and time-based proposals for delivering the objectives specified by the implementing agencies.

Scrutiny Conclusions & Recommendations

This Scrutiny Review has considered a great deal of evidence from policy makers, service providers and service users and has arrived at conclusions and recommendations based around the scope for our investigation. In addition to the witnesses examined (listed in Appendix Two), we conducted a survey of local service users around the themes of the Review.

Our survey involved 43 women from Haringey who had given birth at a local hospital within the last year. They were asked about their experiences of maternity care. Specifically they were asked about their perceptions of quality and continuity of care, information, choice and customer care (see Appendix Four). Although the size of the survey was unable to deliver statistically significant results, it was a useful tool for some of the qualitative research used to inform the conclusions of the Review. Overall the survey indicated that women want better, more accessible and focused

information about services and about options for but also more caring care, responsive to their needs.

The recommendations put forward from this Review are intended as concepts to be applied by the implementing agencies in a way that fits into their respective current and prospective organisational strategies. They should as far as possible be interpreted in such a way as to fit within mainstream strategies in a way that can best achieve the objectives specified. The implementing agencies will be requested, after the publication of this report, to produce an implementation plan of how they intend to deliver the agreed recommendations, that clearly demonstrates how the implementation links with the recommendations described and includes key measurements against each.

The following recommendations have been put forward by members of the Review and are explained in more detail throughout the text of the report:

Recommendation One

Extended Client Advocacy

Description

Improved and extended advocacy for clients, according to clients' needs. A key to extended advocacy is the development of the role of lead professional carer as client advocate and greater continuity of carer throughout maternity. Advocacy should be also be achieved through the increased capacity and availability of translation services and suitable advocacy staff, enabled through linkages between health providers and the London Borough of Haringey Communications Department.

Implementing Agencies

North Middlesex University Hospital

The Whittington Hospital

Haringey Teaching Primary Care Trust

Barnet Primary Care Trust

Enfield Primary Care Trust

The London Borough of Haringey

Recommendation Two

A Customer Charter for Maternity Care

Description

To provide a Customer Charter for Maternity Care, following new National Service Framework guidelines. The Charter should outline all the stages of maternity care and provide a definition and scope of service. It should include key aspects of information and choice that users can expect to receive from the various agencies involved in their care, who is responsible and who to contact and where to direct complaints. This would include a definition of any operational boundaries that delimit the choice of service provider. The Charter should be available in all of the main community languages and published over the Internet.

Implementing Agencies

Haringey Teaching Primary Care Trust

Recommendation Three

Communicating Choice

Description

It is recommended that the North Central London Strategic Health Authority and the Haringey Teaching Primary Care Trust should review the effectiveness of arrangements to communicate with people for whom English is not the first language. It is also recommended that hospital trusts could link with the Council's translation services to improve capacity in this area of service, for example Translation and Interpretation Services at Haringey Council can supply translated written information. It is also suggested that more use of non-written, non-verbal communication might be employed, for example, using pictorial and video forms.

Implementing Agencies

Haringey Teaching Primary Care Trust

The London Borough of Haringey
North Middlesex University Hospital
The Whittington Hospital

Recommendation Four

Improved Client Information

Description

That a review and update is carried out to improve client information, including published booklets and leaflets outlining key information about processes and choices. This should cover GP stage and new referral stage, as it is vital that information is available at these key times. Information should be available in all of the main community languages and available over the Internet.

Implementing Agencies

Haringey Teaching Primary Care Trust

Barnet Primary Care Trust
Enfield Primary Care Trust
Barnet, Enfield and Haringey MSLC
North Middlesex University Hospital
The Whittington Hospital

Recommendation Five

An Outreach Strategy

Description

An outreach strategy for all identified special needs or minority groups, including an appropriate extension of the Sure Start service. The strategy should seek to complement the relevant outreach services and plans already being carried out, but identify gaps in provision by identifying "hard to reach" groups for maternity services and providing a strategy to reach them.

Implementing Agencies

Haringey Teaching Primary Care Trust

The London Borough of Haringey

North Middlesex University Hospital
The Whittington Hospital

Recommendation Six

Reaching Asylum Seekers & Refugees

Description

We are recommending that the London Borough of Haringey Asylum Seekers Service, local NHS trusts and local GPs work together to provide an outreach service specifically to reach pregnant asylum seeker and refugee women to make sure that they are able to access maternity care at an early stage. We are also recommending that the London Borough of Haringey Asylum Seekers Service and Housing Directorate liaise with the local NHS trusts to draw up and instigate measures to ensure that Asylum Seeker Women that leave maternity wards do not find themselves reporting as homeless.

Implementing Agencies

Haringey Teaching Primary Care Trust

The London Borough of Haringey

North Middlesex University Hospital

The Whittington Hospital

Recommendation Seven

Improving Access to Preferred Place of Birth

Description

We would like to see the option of choice of place clarified and improved. This includes choice of hospital provider of birth centre, as well as the option of home birth. This Review supports the Secretary of State's goal of making home birth more widely available and would like to see local policies developed in line with this objective. We recommend the development of strategies to measurably improve access to home birth services to all sections of the community. Measures should aim: to improve the knowledge of this option throughout maternity care; to clarify the right to home birth services both to clients and practitioners and to review systems to ensure that home birth services will be provided to all clients who elect them. The recommended Customer Care Service Plan should include the general principle of Continuity of Carer, in line with the recommendations in Changing Childbirth and the subsequent House of Commons Health Committee, as it is believed that this provides the most compatible model for both supporting the option of home birth and continuity of care.

Implementing Agencies

Haringey Teaching Primary Care Trust

North Middlesex University Hospital

The Whittington Hospital

Recommendation Eight

Improved Access for NHS Home Visiting Staff

Description

We recommend the development of strategies to improve access for midwives and other NHS Home Visiting Staff to conduct home visits. This includes a review of the lone-worker policy for home visiting staff to improve the security and confidence of health workers required to conduct home visits. It also includes a review of parking permits and an investigation of ways to introduce parking permits on private roads and estates. We call on the ALG and London boroughs to work with private landowners to get recognition of parking permits for visiting primary care staff.

Implementing Agencies

Association of London Government

Haringey Teaching Primary Care Trust
The London Borough of Haringey
North Middlesex University Hospital
The Whittington Hospital

Recommendation Nine

Improving the Continuity of Care

Description

To enhance the quality and continuity of care through strategies to measurably improve the quality of personal care in a way that is responsive to individual needs. To provide improved continuity of carer, through the development of the role of lead professional carer, through the specification of clear and consistent standards for continuity of carer. Where appropriate, this might include the nomination of key staff within the midwifery teams allocated to particular clients, as far as possible match the clients needs with the most appropriate person and maximise the personal knowledge of the woman in care.

Implementing Agencies

Haringey Teaching Primary Care Trust

North Middlesex University Hospital
The Whittington Hospital

Recommendation Ten

A Customer Care Service Plan

Description

This is a standardised Customer Care Service Plan across Haringey, Enfield and Barnet to set out how the quality dimensions of care set out in the Customer Charter for Maternity Care are to be delivered. This should be applied across the North Central London area, for use by service providers in planning and managing services and service audit and monitoring of the non-medical dimensions of services, including customer care.

Implementing Agencies
Haringey Teaching Primary Care Trust
North Middlesex University Hospital
The Whittington Hospital

Recommendation Eleven

Midwifery Led Care

Description

This recommendation runs in conjunction with the development of the role of midwife as lead professional carer. We are recommending that pregnant women should have a clear choice to present directly to midwives rather than to their GP, (while retaining the choice of lead professional and support from their GP) and that this should be enshrined in the Customer Charter for Maternity Care.

Implementing Agencies
Haringey Teaching Primary Care Trust
North Middlesex University Hospital
The Whittington Hospital

Recommendation Twelve

A Customer Satisfaction Response System

Description

The setting up of a customer satisfaction response system, which includes the completion of customer satisfaction forms at the closure of every maternity care period and which incorporates all the different stages of maternity care and different service providers. Customer responses will need to be designed to check that what is outlined in the Customer Charter and the Customer Care Plan is being delivered in practice, by asking service users directly for their views. This information is used to inform appropriate level management and policy review. This system should be managed to aim for a 100% response rate with a minimum of 75% of service users responding. Communication aids should be available in all the main minority languages and effective responses facilitated for all women according to their individual needs.

Implementing Agencies
Haringey Teaching Primary Care Trust
Barnet Primary Care Trust
Enfield Primary Care Trust
Barnet, Enfield and Haringey MSLC
North Middlesex University Hospital
The Whittington Hospital – Lead Agency

Recommendation Thirteen

A Community Consultation Strategy

Description

To draw up a Community Consultation Strategy which identifies: main issues for consultation; the mechanisms through which consultation will take place; those minority groups with discrete service needs and how their views are to be taken into account. It should include provision for a Needs and Views Survey to assess the real latent demand for dimensions of care (e.g. continuity of carer). The strategy should identify and plan how the views of so called "hard to reach" and minority groups will be accessed and incorporated in service development.

Implementing Agencies

Haringey Teaching Primary Care Trust

The North Central London Strategic Health Authority
Barnet Primary Care Trust
Enfield Primary Care Trust
Barnet, Enfield and Haringey MSLC
North Middlesex University Hospital
The Whittington Hospital
The London Borough of Haringey

Recommendation Fourteen

Listening to Clients

Description

We recommend that front line services on the maternity wards, especially the post-natal maternity wards, need to become more responsive and aware of client's needs. We envisage that management practice includes conducting a periodic review of patient care on the maternity wards involving conducting informal feedback sessions to women on the ward, and taking up any particular issues expressed. This is a proactive, assertive approach to identifying the problems experienced on the ground and then feeding these up into the management system to seek a consistent standard of quality for all patients, tailored to their individual care needs.

Implementing Agencies

North Middlesex University Hospital
The Whittington Hospital

Recommendation Fifteen

A Local Performance Monitoring Framework

Description

This is a recommendation for improved mechanisms for the monitoring and review of maternity services. It should include a clearly defined and invigorated role for MSLC, and the development of local performance targets by the MSLC and local hospitals to allow benchmarking of key local performance data both over time and between different service providers. In order to improve the effectiveness of the ongoing local monitoring and improvement of maternity services in line with locally defined

aspirations, the panel believes that the PCTs and MSLC need to establish an agreed performance-monitoring framework, designed specifically for local patients and user groups.

Implementing Agencies

Haringey Teaching Primary Care Trust

Barnet, Enfield and Haringey MSLC

Barnet Primary Care Trust

Enfield Primary Care Trust

North Middlesex University Hospital

The Whittington Hospital

1. Introduction

- 1.1. The Scrutiny Review of Maternity Services came about as a result of a strong local campaign against the re-organisation of midwifery services at the North Middlesex Hospital NHS Trust (NMUH). At a meeting of Council 3rd December 2001, a petition was presented by Cllr Kate Stafford. Council requested the Overview and Scrutiny Committee to review local maternity services in the light of the decision to reorganise the home birth midwifery team at NMUH. The re-organisation of the service integrated the dedicated home birth team and introduced a new structure for maternity care. This involved the roll out of community midwifery teams all with competencies to deliver home birth services as required.
- 1.2. This Review has pioneered Haringey's first Health Scrutiny Review and as such has also provided the opportunity for a case study to learn the way forward in reviewing and scrutinising health services. The new powers for Health Scrutiny are provided under the Health and Social Care Act 2001. This requires for local authorities to make provision for the scrutiny of health services and for health improvement within local communities.
- 1.3. Scrutiny Reviews are investigations led by local councillors, aimed primarily at service improvement through recommendations for policy development. Scrutiny Reviews largely focus on policy and strategic approaches and upon service outcomes. Certain aspects of the organisation of maternity services impinge upon the medical-operational aspects of service delivery, outside of the competencies for a Scrutiny Review and it was therefore decided that the Review should focus on maternity as a whole, to examine the broader issues of choice and women centred services. Our approach has been to investigate around issues of service improvement and health inequalities, by looking at the experiences of service users as the ultimate arbiter of quality and effectiveness. The Review took an overview of the issues around home birth within the context of maternity services as a whole, to examine the wider strategic context and considered the quality and accessibility of services to all users within what is, in Haringey, a diverse cosmopolitan population.
- 1.4. Haringey is a borough with an array of social and economic diversity. The diversity of the Haringey population accords with particular health inequalities. The Department of Health recommends that policies need to be developed to impact on the determinants of such health inequalities within particular localities and communities. Different communities within the population exhibit particular health issues, and this includes barriers to access to local health services. Various health indicators show that there are also geographical health variations within Haringey. The young population in Haringey is tending to increase, which by implication is leading to a greater demand for maternity services.
- 1.5. Maternity services for the majority of Haringey residents are delivered by the North Middlesex University Hospital (NMUH) in the London Borough of Enfield and the Whittington Hospital in Islington. Both NMUH and the Whittington maternity departments aim to offer a comprehensive maternity service in both the hospital and in the community. They have a commitment to

maternity care based on the partnership between a woman, her partner, the midwifery team and the obstetrician. Midwives are directly involved in care during a woman's pregnancy, during labour and the postnatal period, referring to medical colleagues and other health professionals as appropriate.

In the past midwifery teams at the NNUH were organised into 10 group practices, which included a designated specialised home birth team of 4 midwives (reduced to 2), on call 24 hours. However, due to a staff vacancy rate of 24% (reflective of the national average) the ambitious target of 60 midwives based out in the community could not be met. The shortage of midwives under these arrangements led NNUH to instigate an internal review of maternity services in 1998/99 and new structures of community midwifery services have now been rolled out.

1.7. This Review has considered the underlying themes of choice, equity, access, consultation, planning, co-ordination and monitoring arrangements for maternity care. It has also considered all of these themes against the concept of "woman- centered" services and has spoken to women from a variety of social backgrounds, who have recently used local services. We have taken evidence from policy makers, service managers, representative bodies and interest groups and have reviewed a range of relevant documentary and statistical data to inform our approach and final conclusions.

1.8. The Parliamentary Health Committee recently published reports following its review of maternity services nationally, and these include important findings on both choice in maternity services and equity of access. This review was itself a follow-up investigation to the preceding Health Committee a decade ago, which resulted in the highly influential Changing Childbirth publication⁶. Changing Childbirth made a number of recommendations to improve maternity services. The report emphasised issues around quality, information and choice, patient and public involvement in service planning and improving the continuity of care. The central theme of the report is that maternity care should be "women centred" and the report outlines some key components of women centred maternity care:

- The services provided should recognise the special characteristics of the population they are designed to serve.
- They should be attractive and accessible to all women, particularly those who may be least inclined to use them.
- Information about the local maternity services should be readily available within the community.
- The woman should be able to choose whether her first contact is with a midwife or her general practitioner and should feel confident that she will receive accurate and unbiased information from the professional she chooses.
- The woman, and if she wishes her partner, should be encouraged to be involved in the planning of care.
- Antenatal care should be designed to ensure that the woman is cared for by professionals who are acceptable to her and who have appropriate skills and expertise required in her particular circumstances.

- Every woman should have a named midwife to whom she can go for advice and help throughout her pregnancy.
- In some cases as circumstance change, the lead professional may be re-designated. The woman should always be involved when such decisions are made.
- Antenatal care should take place in the community, outside of the hospital setting.
- The woman should be able to make her decisions for the plan for birth when she is ready. Decisions about whether to have a hospital or home birth should be discussed in a supportive way.
- Throughout her pregnancy, and most particularly during Labour, the woman should be cared for by people who are familiar to her and aware of her plans for delivery.

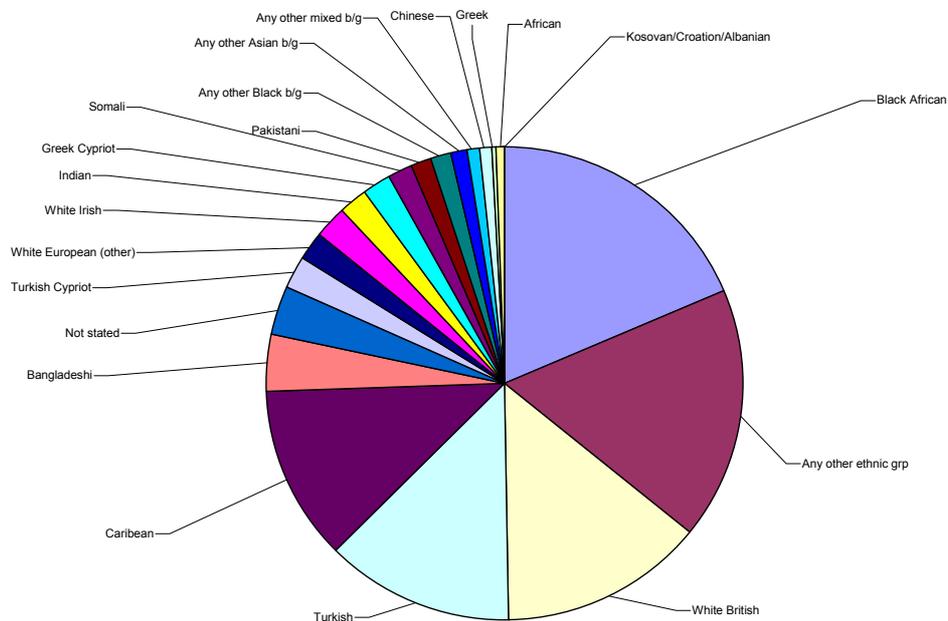
1.9. The panel believes that these proposals are, some ten years on, still fundamentally relevant to the practice and policy for maternity care and have been further endorsed by the recent parliamentary Health Committee findings. Our Review has found that although much progress has been made towards these goals locally, there is also some way to go to achieving women centred services, equity and choice in practice and we hope that through this Review we have been able to constructively assist health providers in driving forward this process.

2. The Haringey Context

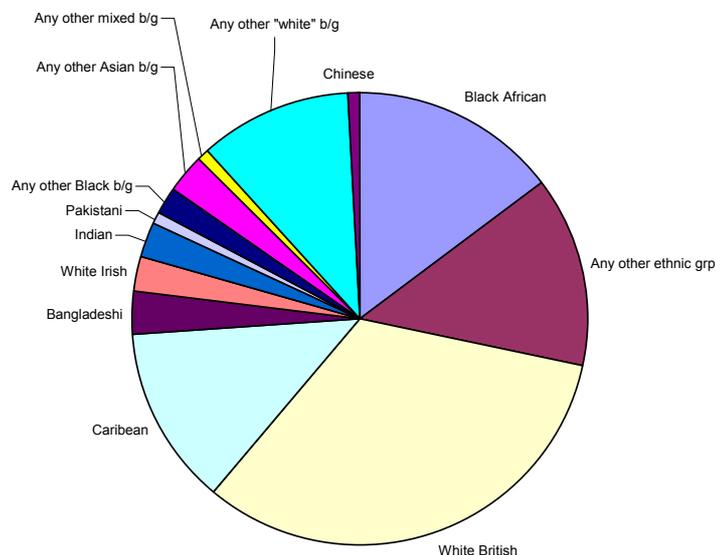
A Diverse Population

2.1. The resident population of Haringey, as measured in the 2001 Census, was 216,507, 48 percent male and 52 per cent female. The Census confirmed that Haringey is an ethnically diverse borough. Less than half of Haringey's residents (45.3%) were of "White British" ethnic origin, while one in five (20%) of residents were of "Black" or "Black British" origin, one in six (17%) residents were of "Other White" origin. Only 63% of residents were born in the UK.

2.2. The following chart illustrates the ethnic diversity of women giving birth at NMUH and shows the variety of different cultures of people using their services.



By comparison, the ethnic diversity profile of the Whittington is also diverse, albeit seemingly less so, although the data is indicative only (*Full data in Appendix Three*).



- 2.3. Concurrent with the ethnic diversity of the borough comes a wide range of cultural, religious and linguistic diversity, which presents maternity care, like other services, with a variety of challenges in meeting the different needs of patients. For example, some women from minority ethnic cultures can be especially sensitive towards medical intervention in childbirth.

Health Inequalities

- 2.4. It is well recognised that there is a direct correlation between economic deprivation and poor health and access to health services. The Index of Multiple Deprivation 2000 ranks the London Borough of Haringey as the 20th most deprived borough in England and Wales and the 6th most deprived in London. There is an extensive area of deprivation in the East and centre of Haringey, with nine Haringey wards featuring in the 10% most deprived wards in the country. Conversely, the West side of the borough features relative prosperity and there is a significant social and economic divide.
- 2.5. The health of the Haringey population compares relatively badly with London and with England and Wales as a whole. Nearly 16% of Haringey residents in the 2001 census reported a limiting long-term illness, and 9% reported that their general health was 'not good'. By illustration, amongst the major presenting illnesses at the North Middlesex emergency care services are syphilis, gonorrhoea, HIV, TB, and malaria⁷. As poor health is a feature of deprivation, it follows that women in high areas of deprivation will tend to be more at risk of complications in pregnancy. Antenatal care aims to reduce the risk.

Refugees and Asylum Seekers

- 2.6. Asylum seekers are a particular group that experiences a high level of deprivation and barriers to access to basic services. It is estimated that there are about 25,000 refugees and asylum seekers resident in the borough, and that there are between 25,000 and 30,000 refugees and asylum seekers registered with the practices within Haringey. Haringey's refugees and asylum seekers are themselves a heterogeneous population group, with diverse health needs.
- 2.7. These communities present with a range of physical and mental health problems, often associated with deprivation, that are not prevalent elsewhere. These factors, along with language communication difficulties, compound the risk. Refugee and asylum seeker women not only have an increased chance of high risk pregnancy, but are also more likely to present late to be diagnosed by health professionals, which in itself implies a higher health risk to mother and baby (e.g. undetected pre-eclampsia, abnormal presentation). In the course of the Review we learnt that refugee and asylum seeker communities may not readily access GP services. Indeed some groups are wary, suspicious even, of almost any contact with primary care services. As a result some women bypass their GP and other primary care providers and go straight into hospital care, often at a late stage into their pregnancy.

- 2.8. Women from different backgrounds not only have objectively different needs from maternity services, they also have different expectations and aspirations. Their views may, however, not always be clear to service providers and practitioners if women are not empowered to express informed preferences about their care.
- 2.9. Empowering women to make informed choices is central to meeting the differing needs of women, and this is particularly the case with "hard to reach" groups where there are significant social and economic barriers to services, although it is also a significant issue for mainstream service users. These issues are considered in more detail in Chapter 5, *Access Information and Choice*.

3. Women's Voices

Women's Focus

- 3.1. The focus for the Review throughout its investigations has been upon the actual experiences of service users. We wanted to gain an insight into the views and perspectives of the women themselves.
- 3.2. During the Review we interviewed and surveyed women who had recently been through childbirth. We met with women from the Asylum Seekers Service, from the Sure Start teenage mothers group, during a mothers street survey, at the Mother and Baby Clinic at Morum House Surgery in Wood Green and at the North Middlesex University Hospital Patient Focus Group. We also spoke to women from the African Women's Welfare Centre and to women from the Orthodox Jewish community.
- 3.3. Our surveys were conducted both at the Mothercare high street store and at a Mother and Baby clinic. Although our surveys in no way attempted to be statistically significant representative of views of service users, the process did elicit valuable insights into some of the individual stories of women who had experienced local maternity services first hand and revealed some important qualitative issues relevant to the scope of the Review.
- 3.4. We have also received informal evidence throughout the Review talking to individual women, each of whom has her own story to tell and each of whom related both feelings of delight and occasional frustration from their experiences of the care they received. A key message that we received is the importance of kindly, confident care to women during pregnancy and more acutely, during labour and birth.
- 3.5. The evidence we collected demonstrated variations in women's experience of care. Some women expressed a high regard for the choice and overall quality of the care they had received, others expressed not only dissatisfaction, but at times distress, particularly if they felt that they had been treated rudely or in an uncaring way. This may be because women feel particularly vulnerable at this time. It underlines the importance to most women of the quality of sensitivity during care. Evidence received during the Review indicated that women have more negative comments about postnatal services than any other aspect of maternity care, something that concurs with the national findings in the First Class Delivery reports.

Mothers' Surveys

- 3.6. The surveys investigated issues around information, choice, communications, continuity of care and overall quality. Respondents views varied and revealed both high and low estimations about the quality of care they had received, interjected also by some individual instances of distress and unhappiness during care. Individual responses can be subjective, so the surveys focused upon specific issues with the aid of a questionnaire (see Appendix Four).

One woman told the Review:

"Whittington midwifery team pre-birth offer an excellent service, but I had a very unsupportive, uncaring midwife during labour". When asked how she thought the service could be improved said, "I wish I had had a midwife with better interpersonal skills and who cared more. I had two midwives during my labour... one was very good and the other was disappointing".

Women Refugees and Asylum Seekers

- 3.7. During the Review, we interviewed several women from the Asylum Seekers Service (ASS) who had direct experience of using local maternity services. The interviews were facilitated by staff at the ASS, who provided translation services. Most of the women interviewed felt that they had been adequately informed about the services open to them, although most were advised towards care from a particular institution or not given any chance to express a choice in the matter when referred by their GPs.
- 3.8. Most of the women were satisfied with the antenatal care they received, although experiences were variable. There was one instance of a women who received no antenatal care at all until she was six months into her pregnancy, due to a late referral, which seems to be a significant problem for this client group. Two of those interviewed had expressed a desire to terminate pregnancy and slow referrals for this resulted in a continued pregnancy against their choice.
- 3.9. Some of the women did not feel that they were given adequate information for planning their births, and choices for pain relief and other procedures were ill explained. Some women were apparently only asked about what they wanted for their birth or informed of a procedure during labour itself. Others had been provided with leaflets, but with little in the way of additional explanation.
- 3.10. Some of the women did not feel in control of their births and felt that they had been forced to have medical interventions that they were unhappy with. Some of the women expressed resentment because they felt their care was different from that afforded to other women. The testimony received also indicated that there was little or no continuity of carer, especially for women who are not under direct hospital supervision.
- 3.11. A large part of the problem of delivering effective choice to refugee women is the linguistic barriers to effective communication. Even where a translator or link worker was provided, there was still some concern expressed about the quality of the information translated and provided. Translators were not generally available, making communication difficult. Some women had been able to access the link worker service, but reported dis-satisfaction with the interpretation and felt that their concerns were marginalised by the translator and were not fully discussed with the medical staff.

Teenage Mothers

- 3.12. Members of the panel also interviewed three young mothers from the Sure Start 16-29 Pregnancy Group. Two of the women had given birth at the Whittington and one at NMUH.
- 3.13. Although generally happy with their overall experience of care, there were a few issues of concern. None of these women felt that they had received sufficient information about their choices for maternity service provider, and no advice about services and support groups targeted towards teenage mothers, indeed the only advice one mother had received was her options for abortion.
- 3.14. Two of the women felt that, once antenatal care had begun, they were not allowed enough choice about the different tests available to pregnant women and were unable to make effective choices about this matter. None of the women had attended antenatal classes, although all expressed an interest in such classes.
- 3.15. Two of the women informed of very poor experiences during labour, both at the Whittington and NMUH. One mother reported being left alone for many hours and was denied pain relief. It was claimed that one of the women had been left alone and then actually gave birth without a midwife present, assisted only by her older sister. All of the women interviewed here expressed satisfaction with the support from health visitors and midwives when at home.

NMUH Women's Focus Group

- 3.16. We attended a Women's Focus Group at the North Middlesex University Hospital, which is being used as one way of picking up client feedback from women who have recently experienced care at the hospital. We were very impressed by this practice, which is one way the hospital uses to consult its service users. It is recommended that this good practice is extended and made more systematic, by incorporation into the Community Consultation Strategy (Recommendation Fourteen).
- 3.17. Some women testified to receiving what they perceived to be some harsh attitudes on the labour ward. The hospital promised to take up this issue, as an aspect of staff development and training. Other women expressed great satisfaction with the service they received.
- 3.18. The issue of communications was raised, as it was said that translation services were not always available for some users. It was claimed that there was a tendency for staff to talk louder when clients do not understand English.
- 3.19. Although women said they had been allocated a named midwife during antenatal and post-natal care, they were unaware of having a named midwife(s) during their stay in hospital. This it was felt would have helped to

provide a more personalised service and enable midwives to act more effectively as advocate for their client.

Recommendation One

Extended Client Advocacy

Description

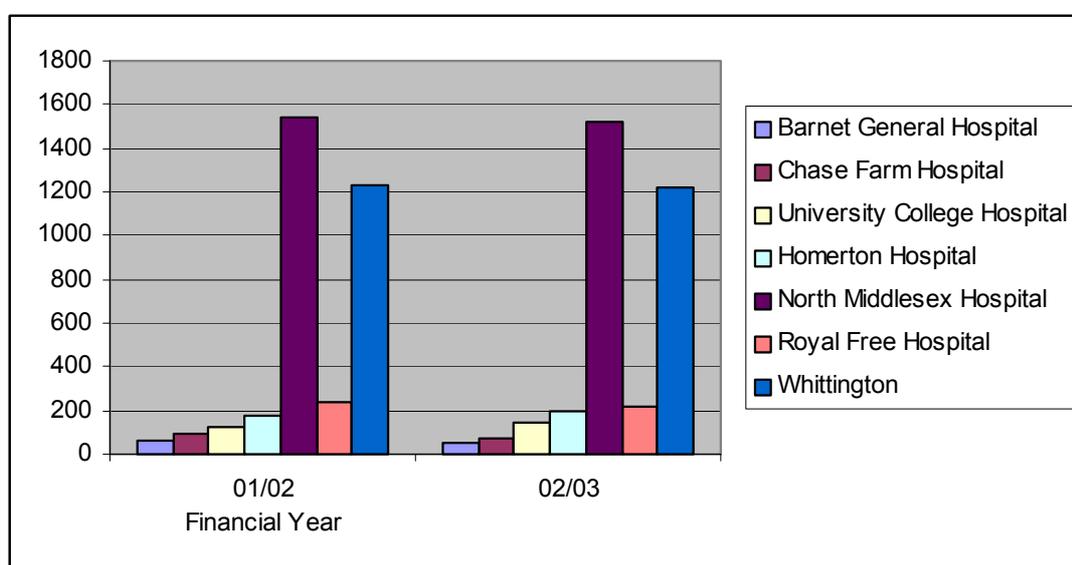
Improved and extended advocacy for clients, according to clients' needs. A key to extended advocacy is the development of the role of lead professional carer as client advocate and greater continuity of carer throughout maternity. Advocacy should be also be achieved through the increased capacity and availability of translation services and suitable advocacy staff, enabled through linkages between health providers and the London Borough of Haringey Communications Department.

- 3.20. As a way of improving service responsiveness to individuals in care and especially to those with particular needs, we recommend that hospitals implement strategies to extend client advocacy. Midwives already have an important recognised role as advocate. We believe that improving the continuity of carer, (see Recommendation Three), would also improve the capacity of midwives to act as advocates for women in care, through the development of greater one-to-one knowledge of the individual concerned, her needs and aspirations for childbirth.

4. Service Organisation

Institutional Context

- 4.1. As from April 2002, five Strategic Health Authorities and thirty-two Primary Care Trusts (PCTs) were established in London. The North Central London Strategic Health Authority (NCLSHA) and the Haringey Teaching Primary Care Trust (HTPCT) are responsible for the Haringey area. Strategic Health Authorities are responsible for overseeing the performance and management of NHS Trusts within their geographical area and ensuring that national priorities and targets are integrated with local health service plans. PCTs discharge around three quarters of the NHS budget and are responsible for commissioning health services, including maternity services.
- 4.2. All midwifery and labour/delivery maternity services, are "bought in" by HTPCT and provided by hospitals outside of the borough. Most maternity services are provided by the Whittington Hospital NHS Trust (The Whittington) in Islington and the North Middlesex University Hospital (NMUH) in Enfield. Other service providers are the Barnet and Chase Farm NHS Trust, the Royal Free Hampstead NHS Trust and the Homerton University NHS Trust. Labour units usually consist of a labour ward for the assessment of women in the early stages of labour, labour beds in single birth rooms and a post-natal ward for those who have already given birth.
- 4.3. This graph shows the relative demands for delivery services at the main institutions for babies being born from Haringey.



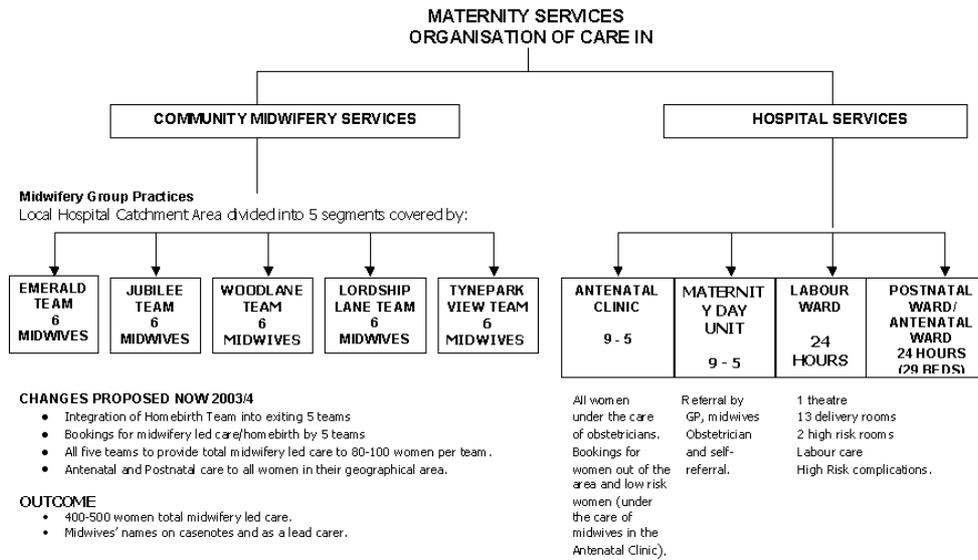
(Full data in Appendix Three)

The North Middlesex University Hospital

- 4.4. NMUH serve patients largely from Enfield and Haringey. Between 2002 and 2003 a total of 1655 women from Haringey delivered their babies at the North Middlesex. The hospital has a consultant-midwife led unit with 29 beds and a special care baby unit of 18 special care cots, including 2 designated

for intensive care. The labour suite includes 11 delivery rooms, and 1 theatre. NMUH has an establishment of 5 consultants and 91 midwives and offers a comprehensive service, including consultant/midwifery specialist clinics, a bereavement midwife, HIV haemoglobin services and a sickle cell and haemoglobin support unit.

- 4.5. NMUH has 36 midwives working within the community organised into 5 Community Teams. Each team is allocated 6 midwives and a caseload of 100 deliveries per year. Each provide antenatal, postnatal and home-birth care services within particular geographic area.



ALL STAFF IN HOSPITAL ROTATE IN ALL OF THE ABOVE AREAS, EXCEPT FOR THE CORE IN THE ANTENATAL CLINIC

Diagram: Profile of the NMUH departmental organisation

The Whittington Hospital

- 4.6. The Whittington Hospital tends to serve patients from Haringey, Enfield and Islington. It has an establishment of 9 consultant obstetricians, one consultant midwife and 56 community midwives, (8 groups practices, each allocated 7 midwives each). The Whittington Maternity department offers a comprehensive maternity service in both the hospital and community. The maternity department has 47 beds, a neonatal unit, a delivery suite and an obstetric theatre. Specialist maternity services provided include a high-risk medical and antenatal clinic, a combined obstetric/diabetic clinic, HIV services and an African "Well-Woman's Clinic". Between 2000 and 2001, a total of 3488 deliveries took place at the Whittington, 43% of these women were residents of Haringey. During this period, the Whittington recorded 96 home births¹⁰.

Models of Care

- 4.7. During the period of a woman's pregnancy, maternity care can be provided in various different ways. Some women receive antenatal care from midwives in community health centres and some in their own homes; some attend antenatal clinics in both settings. By far the majority of women deliver their babies in hospital.

4.8. Deliveries that take place in hospital maternity units can be divided into three broad categories:

- i. Consultant Units – These are most common and are typical in large hospitals. Women who book their deliveries in one of these units will typically be attended by midwives during most of their labour. Obstetricians and high-tech medical facilities are available on site if ever required.
- ii. Midwifery Led Units – These are often smaller units, which aim to offer midwifery led care. These units are staffed by midwives only and in the event of an emergency women can be transferred to a nearby consultant unit.
- iii. Midwife-GP Units – Midwives are overseen by GPs who are qualified to perform some intervention in the event of an emergency (this is not currently running in Haringey).

Service Development

4.9. "Keeping the NHS Local – a new direction of travel"¹¹ sets out 3 core principles for the development of proposals for the configuration of services:

- Developing options of change with people, not for them – starting from the patient experience and the commitment to improve choice, and working with staff to develop new ways of working
- Focus on redesign of services rather than re-location
- taking a whole systems view, exploring the contribution of all health and social care providers, working together to build sustainable solutions for the whole community¹²

4.10. PCTs commission services from hospitals through local service level agreements and hospitals develop and manage their services in accordance with projected demand.

4.11. Key drivers for the planning of commissioning of local services are:

- The Local Delivery Plan / Health Improvement and Plan (HImP)
- Government legislation and guidance
- Ensuring sufficient capacity
- Providing choice to service users
- Equity of service provision

Boundaries of Service Provision

4.12. Each midwifery service provider operates within certain geographical boundaries, but from the evidence we received from service users, the boundaries do not seem to be precisely or clearly defined to allow service users to see what service providers they are able to access.

4.13. We believe that women should be able to choose which NHS institution will provide their care. If, however, there is a necessity for service boundaries for different service providers, which inevitably restrict consumer choice, these

need to be clearly defined (see Chapter Five for a fuller discussion of this topic). In this case we would recommend that the boundaries for the areas covered by each respective hospital midwifery team be clearly defined, documented and made available. In the first instance this would be defined and agreed with the MSLC and thereafter documented in the *Customer Care Service Plan* (see Recommendation Ten).

Healthy Start Healthy Futures

- 4.14. NCLSHA undertook a pre-consultation exercise on outline proposals for the development and re-structuring of maternity and children's services in the North Central London area. The detailed proposals will be put out to full consultation and this will include specific consultation with the relevant local authority scrutiny committees.
- 4.15. This Review cannot comment upon the specific proposals as they have not yet been published, but we believe that there should be a presumption against the closure of smaller maternity units in the planned development of services, as decentralisation of front line services provides the best context for women centred care in the community and continuity of care throughout. Centralised services also raises concerns about access, especially for the most deprived groups within the community, who are most reliant upon public transport.
- 4.16. We would hope to see the detailed proposals developed in such a way as to enhance choice of service provider, enhance the standard and continuity of care across service providers, the availability of midwifery led care in the community, and which clearly consider the equalities implications of each proposed development.

5. Access Information and Choice

Quality Accessibility and Choice

- 5.1. Real choice and access to services, including accessible information, are key dimensions of the quality of health services, which run concurrently with the quality of medical care. Delivering real choice is dependent upon the achievement of accessibility for all, just as access is dependent upon full and available information about services. Ineffective communications can present significant barriers to quality care. Unequal access is an aspect of many health inequalities and unequal quality of care.
- 5.2. There are 6 main providers of maternity care for women in Haringey. This map shows the location of the main service providers. All of these institutions are situated outside of the borough.

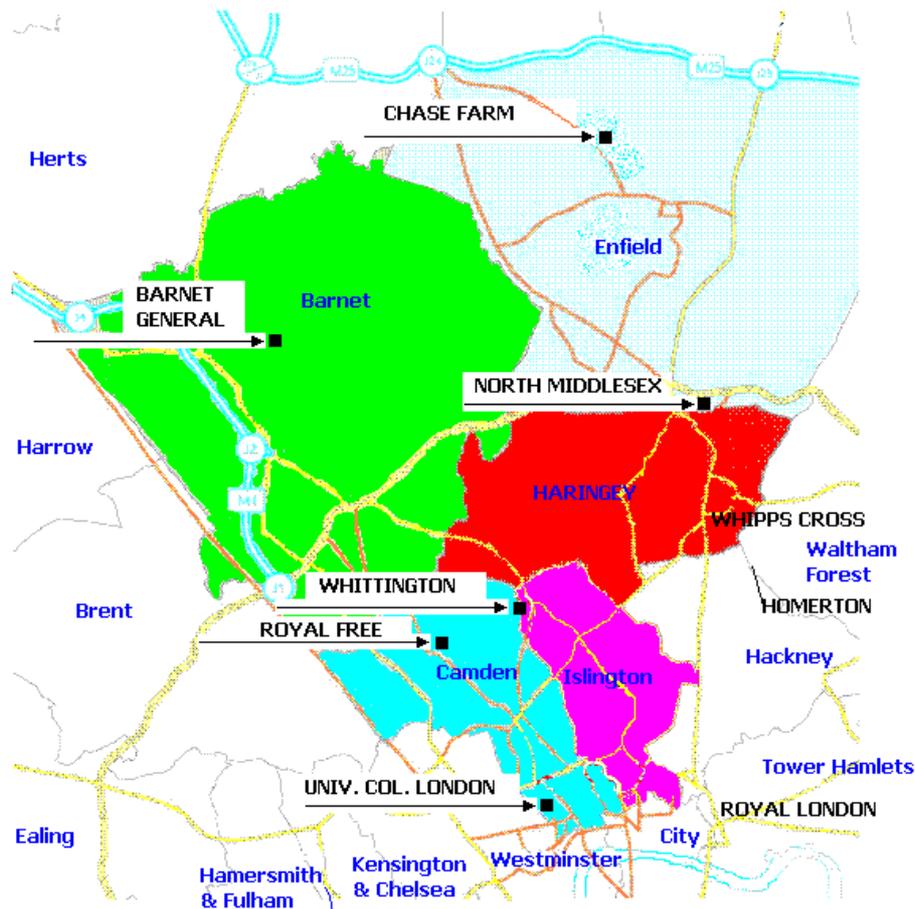


Diagram One

- 5.3. Patients should be able to choose which hospital will provide their care and the kind of care they can expect to receive. Each hospital provides a range of different types of delivery, including the option of home birth. Where childbirth takes place and how a baby will be delivered are fundamentally choices a woman makes about the disposition of her own body. In reality, this choice is compromised, both by resource constraints, which sets limits on the services available and by the imperatives of clinical-medical intervention.

The balance is worked out as a matter of professional judgement and agreement with the individual in care.

- 5.4. In many instances, however, it is clear from the evidence we have received that the balance of choice available to women about their care is tipped away from the client. The relative power of the individual patient can be diminished by the whole context of the institution of care, which can, for some women, be intimidating, confusing and overwhelming. This is especially the case when a patient is relatively dis-empowered by virtue of language, culture, age, disability and other socio-economic barriers. We believe that it is, fundamentally, the responsibility of the service providers to empower clients to make effective choices about their care.

"Choice is an illusion. The majority of women are conned into thinking that they have a choice. What they have is a specific menu that is offered them. If they choose within that menu, that is fine. If they choose outside of that menu, they have an enormous battle to get what they want".

*Beverley Beech, Chair of the Association for Improvement in Maternity Services*¹³.

- 5.5. We feel that it is by no means clear to women in maternity care, nor indeed to all practitioners, that women have the right to make informed choices about their care and we believe that the health service has a responsibility to make sure that patients are effectively empowered to make those choices. Women need to know what choices exist for them during care, what kind of care is available, what providers of care they are able to choose from, and how services can be tailored to meet their individual needs.

Key Choice Opportunities

- 5.6. Throughout a woman's maternity care, there are some key choices made about the kind of care she will receive. These key choices will be decided in consultation between the client and the health professionals providing care. In order to ensure that they are being provided effectively, the choice opportunities for women need to be defined in the Customer Care Service Plan (Recommendation Ten), and checked through a customer feedback response system. Diagram Two illustrates the key choice opportunities leading up to the birth.

Choice of Service Provider

- 5.7. When a woman first presents as pregnant, she usually attends her local GP clinic, where a doctor is able to confirm her pregnancy. Nationally, around 75% of women will visit their GP and most of the rest see a midwife¹⁴. The GP or midwife may advise on antenatal care, or women may attend a consultant clinic where a consultant obstetrician will advise on the most appropriate pattern of antenatal care. There is at present in Haringey no measure of the quality of the booking sessions. There is no evidence of people being denied choice and not a single complaint on record¹⁵, although this may of course be at least partly due to the fact that many women are unaware of the choices available to them if these are not presented and understood.

KEY CHOICE OPPORTUNITIES DURING MATERNITY CARE

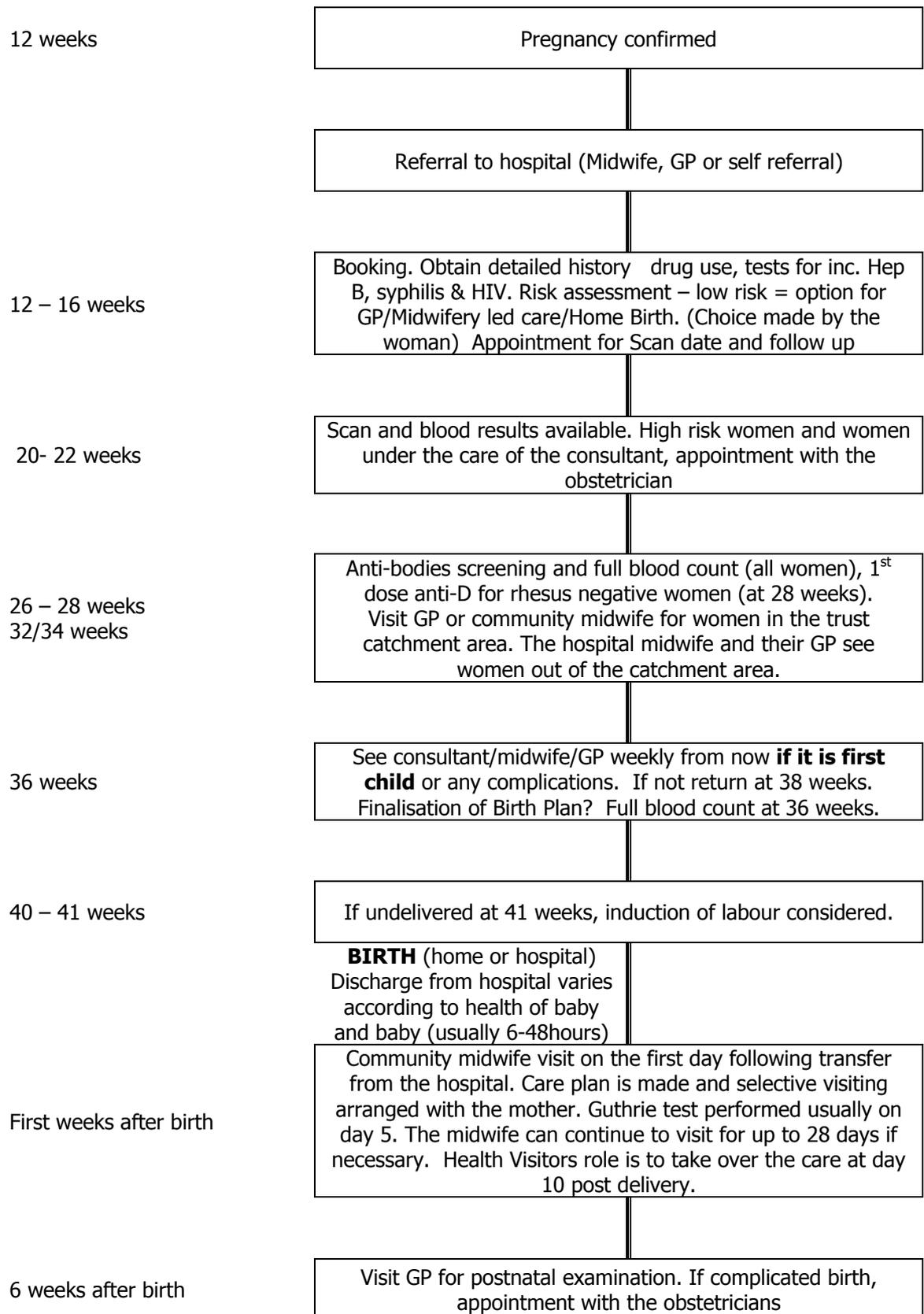


Diagram Two

- 5.8. Referral to hospital or other maternity care provider is usually made through the GP and this is a key opportunity for the woman to be asked to express a preference for which hospital she would like, the kind of care she would like to receive and to obtain information and advice to allow her to make the right decision for herself. Once referred, she should be given the option of GP/midwifery led care, hospital care and allocated a single lead carer that she is happy with.
- 5.9. A limiting factor on the choice of service provider is the service boundaries that appear to delimit catchment areas for each hospital. It would appear that these boundaries mean that:
- maternity services are provided by a hospital only to those within its catchment area, which artificially limits choice
 - it may be difficult for a woman to change to another service provider if she becomes dissatisfied with the service (or even if she just moves house). We have been informed that some hospitals “cap” – that is, put a limit on the numbers of women they will accept, and that it is geographic boundaries they use to do so
 - a particular problem arises with home births, in that it is quite often the case that midwifery vacancies or temporary shortfalls on the labour ward mean that community midwifery resources are redeployed to the hospital. A woman may therefore be told that, even though she is in the right catchment area, she can no longer be guaranteed a home birth and she must come into the hospital. Her choice is therefore taken away. She may then attempt to find alternative service provider, at short notice, but is told she is outside of the catchment area
- 5.10. It would be useful if these issues could be investigated by the service providers to find out to what extent the boundaries do inhibit choice and what flexibility may feasibly be introduced to overcome boundaries to consumer choice. The scope for choice should be clarified and defined in the Customer Charter for Maternity Care (see Recommendation Two).
- 5.11. We would like to see incorporated into the recommended Charter the following aspirational goals:
- right to choose service provider, this should apply both to hospital and to home birth if possible (see Recommendation Seven), in line with Government policy to increase choice of provider to all patients within the NHS
 - service users should be able to change providers if they are dissatisfied with the care they are receiving, or if there is other good reason to do so
 - if boundaries are, for good operational reasons, unavoidable, they should be implemented with a view to maximising flexibility and effective choice to service users
- 5.12. We believe that where boundaries are necessary, that they should be completely transparent to users; and their impact on choice should also be transparent. These aspirations should be assessed for feasibility and might eventually be incorporated into the Maternity Charter and the Customer Care Service Plan.

Foetal Tests and Scans

- 5.13. According to the Department of Health, all women are offered at least one ultrasound scan usually from 10 weeks onwards, which measures the size and age of the foetus. Women are also offered a range of screening tests to establish whether the foetus is developing normally¹⁶.
- 5.14. The diagnostic tests are:
- Serum screening for risk of Down's Syndrome at 15-20 weeks.
 - Amniocentesis—this is offered at 15 weeks onwards and can be used to detect chromosomal abnormalities such as Down's syndrome. This test involves a small risk of miscarriage so is not performed routinely. It is offered to those women at a higher risk of having a Down's syndrome baby if a woman's serum test was screen positive. It is also offered if there is a family history of chromosomal abnormalities and also in circumstances when an abnormal finding on ultrasound scan is seen.
 - Chronic villus sampling (CVS)—this is offered between 11-14 weeks and can detect some inherited disorders for example Down's syndrome, sickle-cell anaemia and thalassaemia. It carries a higher risk of miscarriage than amniocentesis so is only offered to women whose babies are at risk.
- 5.15. Not all tests are available in all areas through the NHS, e.g. nuchal translucency screening for Down's Syndrome is available in some areas but not in others. This could be a problem in Haringey because of the high rate of population transience.
- 5.16. Women are pleased to benefit from the availability of screening services locally, but it does also raise questions about the impact on the type of care offered to women and the propensity towards medicalisation, so there is an important judgement about the level of screening that is appropriate. The recent House of Commons Health Committee report on Choice in Maternity care concluded "We do not believe that simply making tests available is in itself an extension of choice. Testing and screening sometimes inhibit rational choice and sometimes encourage higher levels of intervention"¹⁷. We believe however, that women do appreciate the information and support available locally to inform their care and that screening services do add to the quality of choice to women.

Planning for Delivery

- 5.17. Somewhere around half way through her pregnancy, the woman should be invited to start thinking about her Birth Plan (this is discussed in more detail below). This is a plan of intrapartum care, how the birth will be managed, scenarios and options for pain relief and the possibility of surgical intervention. At around 36 weeks (or earlier) the Birth Plan should be finalised so that it can be referred to when labour occurs. For these dimensions of women's choice to be a reality, it is very important that the Birth Plan is drawn up by the women with professional guidance that it is adhered to in practice.

- 5.18. Most women are offered choices around pain relief. The choice will be made following discussions with the midwife or consultant. This may include gas and air, epidural anaesthetic, a transcutaneous electrical nerve stimulation (TENS) machine, or non-interventionist management of pain through breathing techniques. Some women also choose to involve alternative or complementary practitioners and techniques such as aromatherapy and massage although the woman usually funds these. When a woman goes into labour she should be asked to confirm her options for labour and delivery in the context of updated medical advice.
- 5.19. Women in labour should be encouraged by their midwife to find a position that they prefer and one which will make labour easier. Positions can vary. Some women choose to remain in bed with their back propped up with pillows, or stand, sit, kneel or squat. If a woman is too tired she can choose to lie on her side rather than her back and if backache has been a problem then kneeling on all fours can help. Women may be able to try these positions at their antenatal classes or at home to find the most comfortable position and their midwife can offer advice both before and during labour normally¹⁸.
- 5.20. Caesarean Section is the use of surgical intervention during labour where the baby is delivered through an incision in the abdominal wall and uterus. Options for Caesarean Section should be informed primarily by assessment of medical need, but it is still an option to be negotiated between the consultant and the woman in care. There is a genuine choice to be made by women who are advised of an especially difficult or painful birth, although evidence shows that hospital births are more likely to involve high levels of intervention, it is unlikely that this is due to elective choice of the woman in care. A recently commissioned audit of caesarean section found that maternal request as reported by the clinician was the primary indication for performing only 7% of caesarean sections¹⁹. The increase in the caesarian rate both locally and nationally reflects the effective removal of informed choice from a large number of women who would have preferred to be given the option to give birth naturally. The risks and options available should be carefully negotiated and planned in the woman's Birth Plan.
- 5.21. The report of the National Sentinel Audit of Caesarean Sections was published on 26th October 2001. The results of the audit have been referred to the National Institute for Clinical Excellence (NICE) to develop clinical guidelines on the use of caesarean sections. This will cover clinical indication for caesarean section, the optimal timing of the operation and conditions where caesarean section should not be the first choice of the method of delivery.
- 5.22. There are also some possible choices for women after the birth, including the length of hospital stay and options for postnatal care. The length of stay in hospital is often negotiable. A woman who has experienced an uncomplicated birth could feasibly be allowed to choose to be discharged as soon as six hours after the birth or alternatively to stay a day or more in hospital. Women with complicated births (e.g. Caesarean Section) are invited to remain in hospital for a longer period. Midwives have a statutory obligation to provide postnatal care to the mother, whether at home or in

hospital for at least ten days and up to twenty-eight days after birth. The pattern and quality of care can vary and is a matter for local discretion.

- 5.23. This broad outline of the choices in care will of course in practice be varied according to the needs and circumstances of the woman in care and under guidance and advice of health professionals. A key limiting factor on choice will be the assessment of risk and this needs to be clearly explained to the client. There are also a series of tests available to women to assess risk and these need to be explained also. The key choices available need to be clarified for service users and defined in the Customer Charter for Maternity Care (Recommendation Two).

The Birth Plan

- 5.24. One of the key ways in which a woman plans for childbirth is through her involvement in the development of her Birth Plan. The Birth Plan outlines the individual's care plan during labour, both for normal labour and in anticipation of complications. It includes a plan of what kind of care she wishes to receive during labour, what options will be followed for pain relief (as explained above) and the possible use of surgery (caesarean section). Women need to be briefed by their designated consultant on the implications of any of the options for the birth, such as the side effects or risk implications of certain drugs. Midwives are also able to act as advocate for their client to make sure their choices are understood.

- 5.25. *First Class Delivery*²⁰ found that many women do not feel involved in key decisions made during labour. Evidence we received from new mothers during the Review suggested that not all women were actively involved in the development of their Birth Plan. Furthermore, we received clear evidence that the Birth Plan is often not adhered to in practice. There may be various reasons for this, it is well-attested that labour and birth may not turn out how one expects, but it is recommended that the inclusion of women in drawing up their Birth Plan should be made a key aspect of identified choice for all women and identified in both the Customer Charter for Maternity Services (Recommendation One) and the Customer Care Service Plan (Recommendation Two). It is also important to check whether the agreed Birth Plan was adhered to in practice (at least to the satisfaction of the woman in care) and it is envisaged that this will be monitored through the Customer Satisfaction Response questionnaire (see Recommendation Eight). Adherence to the Birth Plan, as such, is not the only factor to be considered. The sorts of issues that might be monitored are:

- was the experience of care positive? was the quality of care good?
- were the woman's expressed preferences and choices respected (whether or not they were in the Birth Plan)?
- was she given the information and support she needed to make the choices required?
- was she treated with respect and dignity? were her cultural and religious beliefs respected?

Recommendation Two

A Customer Charter for Maternity Care

Description

To provide a Customer Charter for Maternity Care, following new National Service Framework guidelines. The Charter should outline all the stages of maternity care and provide a definition and scope of service. It should include key aspects of information and choice that users can expect to receive from the various agencies involved in their care, who is responsible and who to contact and where to direct complaints. This would include a definition of any operational boundaries that delimit the choice of service provider. The Charter should be available in all of the main community languages and published over the Internet.

- 5.26. In order to define, clarify and publicise the rights of women during their care, the panel believes that key dimensions of quality and choice for maternity services need to be outlined in a revised local Customer Charter for Maternity Care. The Charter should also define how continuity of care will be delivered (see Chapter 7)
- 5.27. This is a special charter for pregnant women and new mothers, which explains the patient's rights and the standards of service they can expect to receive during pregnancy, the baby's birth and post natal care. These rights and standards should be reflective of Government policy and follow the philosophy of the Changing Childbirth publication and the subsequent House of Commons Health Committee report Choice in Maternity Services²¹. Helpful guidance about what standards might be included is available in "Modernising Maternity Care – A Commissioning Toolkit for Primary Care Trusts in England"²². This sets out, for example, "benchmarks of a quality maternity service"; "a checklist for reviewing maternity services"; and "suggested minimum standards for maternity services commissioning". Among other things, it should cover:
- A women's choice about who will be responsible for looking after her; where she may have their baby delivered ; the type of care she wishes to receive, for example whether to have care led by a midwife, GP or consultant Obstetrician etc;
 - The screening tests available, parenting classes, provision of a Birth Plan and other key choices during pregnancy. It should also inform on how long a woman may stay in hospital after birth.
 - What information she can expect to receive to help her reach decisions about her care, including information such as ante-natal tests; and
 - The quality and continuity of care for her and her baby throughout maternity
 - Who is responsible and how to complain if standards are not met.
- 5.28. Copies of the Maternity Charter should be widely and easily available , including from GP's surgeries, antenatal clinics, hospital trusts, the PCTs, hospital trust's PALS outlets, the MSLC, the Patients Forums and in local libraries. It should also be available by telephone request and over the internet.

- 5.29. Although some of the dimensions of quality care are already in the public domain, there are some key aspects of the quality of services which need clarification. The aim of the Charter should be to bring together all of the key dimensions of the quality of care into one single, easy to ready document that can be used by consumers as reference. The Charter needs to be carefully drawn up, in consultation with the MSLC, to define those areas where service users should expect a particular standard of care and to outline the services available.

Recommendation Three

Communicating Choice

Description

It is recommended that hospital trusts could link with the Council's translation services to improve capacity in this area of service, for example Translation and Interpretation Services at Haringey Council can supply translated written information. It is also suggested that more use of non-written, non-verbal communication might be employed, for example, using pictorial and video forms.

- 5.30. Communicating choice is the responsibility of the various health practitioners delivering care. This begins when a woman first presents as pregnant and when she is referred to a particular care provider. Most women initially present to their GP. Midwives also give relevant information when booking a patient for her first visit. The GP is able to explain any particular issues, medical and procedural and answer questions about pregnancy. He/she is also meant to inform the woman about local maternity services, what to expect and when. Presentation and confirmation of pregnancy is then a key stage in informing women about their pregnancy and enabling them to make informed choices about their care.
- 5.31. It is clear from evidence received from a number of women who had recently experienced maternity care that some were not aware of the choices available for them to make about the kind of care services they would like. Some women were unaware that they had any right to choice at all. This includes place of birth and types of delivery available e.g. water birth. In March 1997, the Audit Commission published its report First Class Delivery – Improving Maternity Service – England and Wales, which was the first large-scale audit of maternity services since the implementation of Changing Childbirth. This report indicated that many women wanted more and better information about services and the options for care.
- 5.32. As discussed, women should be able to choose a service provider and the way in which they would like their care to be delivered. This includes the option of a home birth. The panel heard evidence to show that GPs do not always present women with full information about local services and the choices that are available to them and that some GPs are not supportive of home birth. For example, some women we surveyed were simply told by their GP which hospital they would be using rather than given a choice in the matter and some were not informed about options such as home birth, or felt discouraged from taking up this option. This does not in itself prohibit a woman from exercising choice but where the midwife feels that the GP is

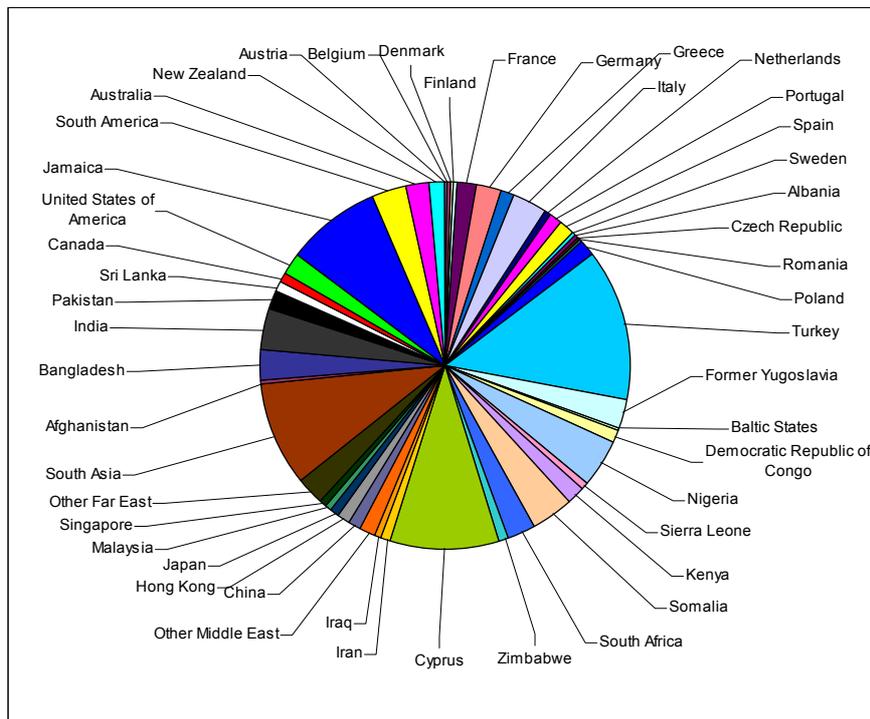
supportive of a home birth, the likelihood of transfer to hospital later is reduced²³.

"Changing Childbirth is not about actively promoting one place of delivery above another one, but allowing the woman to make her own choices on balanced information given to her. Home birth should be one of the options presented. For women with uncomplicated pregnancies it is not a high-risk option".

-Dr Mary Keenan GP Advisor
Changing Childbirth Implementation Team²⁴

- 5.33. PCTs provide information to GP practices that is used to inform service users where they can book services, this is usually fed through to patients through consultation with their GP. It would appear that some GP practices are not equipped to furnish women with either the right information about local services, nor are able to make women aware of choices that they are able to make. The panel therefore recommends that information disseminated by GPs is improved to make sure that it is clear and focused on what women need to know and that GPs improve the way in which they convey information to patients (see Recommendation Four). The GP should present the information regarding local options for place of birth to the woman in a clear, understandable and balanced manner. This includes the option of home birth and what this involves.
- 5.34. We are asking the Strategic Health Authority and the PCT to ensure that there is a standardised practice to inform women about their choices in maternity care and childbirth. This specifically needs to include a Customer Charter for Maternity Care (see Recommendation One). We are asking too, for this to be produced in leaflet form, translated and made available in all the main community languages (according to need) and given out to women at the appropriate stage of maternity.
- 5.35. The MSLC has identified, in its review of providers' plans for midwifery led care, a need for improved information about choices of care pathway. It is important for service providers to ensure that accessibility is improved by improving communications, especially for people who do not speak English as their first language. There needs to be improvement in the way that key information is communicated to women, especially at particular stages of maternity. A Communications Audit needs to consider both the way information is designed and the way in which it is disseminated. It is envisaged that this would be verbal and also backed up with easy to read leaflets / booklets. Ideally, all of the informative leaflets available need to be translated into the main minority languages, but perhaps especially the Down's Syndrome and the Alpha-Feta protein (double test) leaflets explaining Toxoplasmosis, (e.g. as raw meat is included in some recipes) and their accompanying consent form.
- 5.36. There are around 193 different languages in Haringey²⁵. This is partly due to a high rate of population transience, with people settling in the borough from right across the globe. The chart below illustrates the diverse array of

different origins of the Haringey population, which indicates the different languages that are used within the local population.



(Source: Census data, excludes people from UK and Channel Islands)

- 5.37. There are already available many leaflets in several different languages, although there are some gaps that need to be checked to ensure that information is accessible to everyone who needs it. There are information leaflets available on Breast Feeding, Vitamin K, Folic Acid, on staying in hospital and parent craft classes. There are interpretation services available to communicate choices to non-English speakers and translation of written material is understood to be in progress. Currently, some of the most required minority languages at the North Middlesex University Hospital are Turkish, Albanian, Portuguese, Somali, French and Farsi²⁶.
- 5.38. The audit needs to reveal the communications gaps within maternity care services. Health institutions need to identify what they need to communicate to women and when. The key information required at different stages of maternity needs to be defined and this needs to be audited to check that it is being communicated effectively. Communication should be made orally and backed up with written information or other media according to individual client's needs. As a substantial amount of information is available, it is important to avoid information overload, as supplying women with too much or irrelevant information actually inhibits communication and choice. It is also important that appropriate information is made available at the appropriate time.

Recommendation Four

Improved Client Information

Description

That a review and update is carried out to improve client information, including published booklets and leaflets outlining key information about processes and choices. This should cover GP stage and new referral stage, as it is vital that information is available at these key times. Information should be available in all of the main community languages and available over the Internet.

- 5.39. It is recommended that hospital trusts could link with the Council's translation services to improve capacity in this area of service, for example Translation and Interpretation Services at Haringey Council can supply translated written information. It is also suggested that more use of non-written, non-verbal communication might be employed, for example in pictorial and video form.
- 5.40. The panel heard evidence of the practice and occasional necessity of care staff relying upon relatives for translation and this practice can be very inappropriate. This practice should be risk managed with appropriate alternative means of communication prepared in advance for identified eventualities. The Communications Audit needs to identify the main languages that need to be used to communicate. These will include Turkish, Somalian, and Albanian language.

6. Improving Access

Recommendation Five

An Outreach Strategy

Description

An outreach strategy for all identified special needs or minority groups, including an appropriate extension of the Sure Start service. The strategy should seek to complement the relevant outreach services and plans already being carried out, but identify gaps in provision by identifying "hard to reach" groups for maternity services and providing a strategy to reach them.

- 6.1. Maternity services need to become more proactive in their approach to identifying, consulting and delivering services to the main "hard to reach" cultural groups within the borough. This would include refugees, teenagers, as well as special needs groups, such as the disabled, visually impaired and hearing impaired. Specifically, the panel recommends an invigorated and assertive outreach service for all identified special needs or minority groups, which, it is envisaged, would incorporate an extension and review of the Sure Start service and the 4YP (for young people) service.
- 6.2. Some local maternity services do already make provision for special needs and hard to reach groups, for example, there are services available to women with mental health problems or in need of psychological support (for example postnatal depression). There is one Sure Start dedicated midwife linked to the NMUH.

Improving Access For All

- 6.3. Barriers to care are particularly significant for women from particular cultural and specific minority linguistic backgrounds. These barriers impinge upon a client's access to services, as well as impact upon her access to quality care and responsiveness of services to her individual needs. The barriers to access to services information and choice need to be identified and overcome.
- 6.4. During the Review we interviewed several women from different identified minority user groups which experience particular barriers to services, both to expose some of the real issues for women with differing needs and to discover real-life examples of women's experiences. This evidence is explored in more detail in Chapter 3, *Women's Voices*.
- 6.5. The Review heard evidence from female asylum seekers at the Asylum Seekers Service (ASS) who had direct experience of using local maternity services. One particular issue for this client group is that some women do not present as pregnant to a GP or to the hospital midwifery services until very late into their pregnancy. The Review spoke to one woman who said that she had received no antenatal care at all until she was six months into her pregnancy. This is a serious barrier to care services which needs to be overcome.

- 6.6. Another issue for female asylum seekers and refugees is the lack of adequate information for planning their care, including the birth-plan choices for pain relief and other aspects of choice. Some women were only asked about what they wanted for their birth or informed of a procedure during labour.
- 6.7. At least part of the problem for this client group is associated with language barriers to effective communication, but even where a translator or link worker is available, there was still some concern expressed about the quality of the information translated and provided. It would seem, however, that translators are not generally available, often making effective communication impossible. Some women had been able to access the link worker service, but reported dis-satisfaction with the interpretation and felt that their concerns were marginalised by the translator and were not fully discussed with medical staff.

Recommendation Six

Reaching Asylum Seekers & Refugees

Description

We are recommending that the London Borough of Haringey Asylum Seekers Service, local NHS trusts and local GPs work together to provide an outreach service specifically to reach pregnant asylum seeker and refugee women to make sure that they are able to access maternity care at an early stage. We are also recommending that the London Borough of Haringey Asylum Seekers Service and Housing Directorate liaise with the local NHS trusts to draw up and instigate measures to ensure that Asylum Seeker Women that leave maternity wards do not find themselves reporting as homeless.

- 6.8. Another barrier to care services is that there appears to be a distrust of institutional care by asylum seekers, which includes a distrust of hospitals and doctors. One way of overcoming these barriers might be to bring service access points closer, to provide a bridge to care. During our interviews with ASS we discussed the possibility of setting up a room within their offices where Asylum Seekers can go to access primary care. This could be further facilitated with the introduction of an administrative co-ordinator to link the work between the health sector and the Asylum Service.
- 6.9. The review has also heard that there are many cases of asylum seeker and refugee women reporting as homeless when they leave the postnatal ward in hospital. This may be because children are not permitted or are not suitable at the accommodation where they had previously resided. We feel that it is important that the situation of these and other homeless women is ascertained well before pregnancy and that there are mechanisms in place to make sure that they are able to access appropriate accommodation for their needs during postnatal (Puerperium) care.
- 6.10. Members of the panel also interviewed three young mothers from the Sure Start 16-29 Pregnancy Group. According to their testimony, none of these women felt that they had been given satisfactory information about their choices for maternity service provider, and no advice about relevant services and support. Another issue for these individuals was access to effective

information, for example about the options during pregnancy and about antenatal classes.

- 6.11. Equally some women encounter barriers to choice through disability. Disabled women are not always given the same choices as other clients, decisions about the type of birth or anaesthesia used or mode of delivery may be taken without adequate discussion with the woman or her partner (Inequalities in Access to Maternity Services, Health Committee). Whatever the barriers to effective choice, care needs to be responsive to individual differences and needs to enable different people from different background equity of choice.

Access Through Advocacy

- 6.12. Empowering women should be a key part in the strategy for removing barriers to accessing service and client advocacy is an important part of empowering clients. Advocacy is an important role for all front line health practitioners, but especially midwives, who should be able to develop an intuitive understanding of their client's needs. This is a key part of the strategy for improving the continuity of carer (see Recommendation Nine) and should be identified as a key outcome of implementation.
- 6.13. Improving advocacy for all women can be enabled through the development of the role of the lead professional and through improving the continuity of carer in line with the recommendations originally made in Changing Childbirth would facilitate this. A named lead professional midwife could act as advocate for her client to provide a more personalised service and one which is tailored more to the client's individual needs.

Recommendation Seven

Improving Access to Preferred of Place of Birth

Description

We would like to see the option of choice of place clarified and improved. This includes choice of hospital provider of birth centre, as well as the option of home birth. This Review supports the Secretary of State's goal of making home birth more widely available and would like to see local policies developed in line with this objective. We recommend the development of strategies to measurably improve access to home birth services to all sections of the community. Measures should aim: to improve the knowledge of this option throughout maternity care; to clarify the right to home birth services both to clients and practitioners and to review systems to ensure that home birth services will be provided to all clients who elect them. The recommended Customer Care Service Plan should include the general principle of Continuity of Carer, in line with the recommendations in Changing Childbirth and the subsequent House of Commons Health Committee, as it is believed that this provides the most compatible model for both supporting the option of home birth and continuity of care.

- 6.14. One of the findings of the Changing Childbirth Publication²⁷ is that the policy of encouraging all women to give birth in hospitals cannot be justified on the grounds of safety. For most women, with low risk pregnancies, the choice of where to have their baby delivered is therefore a legitimate one, although

would seem to be the preferred option for only a minority of the population. It is a key choice a women can make during her maternity care. During the Review we have spoken to a number of women who either seemed unaware of the option of home birth or had been frustrated in accessing this service. This is evidently not because there is no information available to women, nor because the service is not at least theoretically available to everyone, but it does indicate that there are barriers to accessing the service in practice, which effectively denies people of a choice that they are entitled to have.

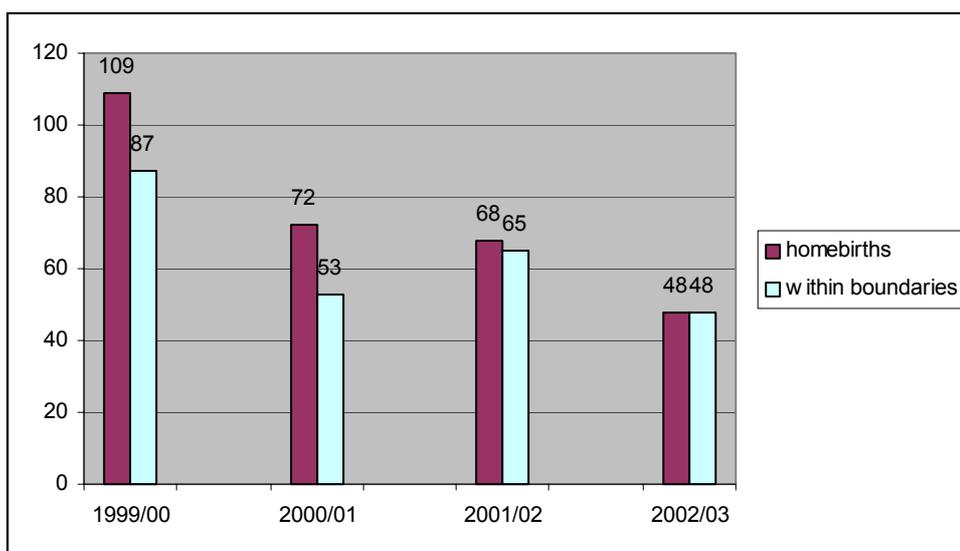
6.15. Assessing whether or not choices such as home birth are a reality to consumers of services can be problematic, both because there may be supply side barriers to access and because the uptake of the service is not a definitive indicator of its availability. We are recommending that strategies are developed to identify barriers to accessing this service and making the choice for home birth a visible and real one for all women. This will involving monitoring and assessing the availability of the service and therefore will be the subject of review both by service providers and by the MSLC. One way of assessing the availability of home birth and other key choices in maternity care will be through the recommended Customer Care Response System (Recommendation Thirteen), another will be through audit of procedures. The Commissioning Toolkit²⁸ recommends that "the home birth rate is a useful indicator of a service's responsiveness to women's choice" and this is undoubtedly the right way to view home birth rates. This suggests that the uptake of the service should also be monitored as one indicator of the availability of services.

6.16. This table shows the uptake of home births year on year at the two main service providers. NNUH is the main provider of home birth services, both in total and a proportion of total deliveries.

	99/00	00/01	01/02	02/03
Home Births NNUH	109	72	68	48
Home Births Whittington	<i>not available</i>	37	39	44

source: NNUH and Whittington NHS Trusts²⁹

In the recent past there were differences in the way in which the home birth services operated, so that the total number of home births carried out included some that were outside of the hospital catchment area. This seems to indicate that there was greater choice for people to opt for NNUH as a service provider for people outside of the catchment area, but it also means that the number of home births has reduced partly due to the fact that they are carrying out less home births from outside of the area. The table below shows the number of home births carried out at NNUH over the past few years, since the re-configuration of services and the abolition of the home birth team³⁰. It shows that the number of home births carried out by the hospital is falling, but falling less markedly and less consistently for "within boundaries" deliveries (ie women who live within the hospital catchment area).



This table shows the numbers of people of different ethnic backgrounds using home birth services at the Whittington. The percentage figures show that "White British" are the main users.

Ethnic Origin	Home Birth	%
Black African	2	4.55%
Any other ethnic grp	4	9.09%
White British	23	52.27%
Not stated	12	27.27%
White Irish	1	2.27%
Any other "white" b/g	2	4.55%
Total	44	

6.17. Choices about where a women should have her baby need to be informed by the best professional advice, acknowledging any risk factors that may be involved in any individual case. The crucial point is that it is, we believe, ultimately the woman's right to choose. According to the RCM's position paper on Home Birth³¹, "The role of the midwife is to facilitate women's informed choice by drawing on the available evidence and her own clinical judgement to provide advice on the risks and benefits associated with each place of birth ... ultimately a women may decide on a course of action against midwifery advice. Midwives should continue to provide care for the woman and they are legally obliged to provide emergency care. Therefore, if a woman intends to give birth at home, contrary to professional advice, the midwife and her supervisor should draw up an action plan to ensure that any risks are minimised and that untoward incidents are anticipated and catered for...This plan should be carefully recorded and communicated to all those involved, including the woman...At all times, great care should be taken to preserve the quality of the mother-midwife relationship, and to sustain as much mutual trust and respect as possible".

Recommendation Eight

Improved Access for NHS Home Visiting Staff

Description

We recommend the development of strategies to improve access for midwives and other NHS Home Visiting Staff to conduct home visits. This includes a review of the lone-worker policy for home visiting staff to improve the security and confidence of health workers required to conduct home visits. It also includes a review of parking permits and an investigation of ways to introduce parking permits on private roads and estates. We call on the ALG and London boroughs to work with private landowners to get recognition of parking permits for visiting primary care staff.

- 6.18. The panel received evidence during the Review of problems of access for NHS staff visiting women during and after pregnancy, due to the fact that their parking permits are not universally recognised. Some midwives have been given numerous fines. We heard from one midwife who had had her car wheel clamped and was verbally abused on a private road, despite the fact that she had displayed her identity badge. Home visits are often conducted by loan workers. A matter that was presented to us many times during the course of the Review was the insecurity, fear even, felt by some midwives in carrying out home visits in locations that they are not familiar with and which may have a reputation for being unsafe.
- 6.19. It has been suggested that such difficulties may be an underlying reason why some midwives are reluctant to carry out home births and why women who have booked a home birth may subsequently find that she is asked to book for a hospital birth. The availability of confident teams of midwives and health visitors is essential to providing effective community services. For this reason it is recommended that there should be a strategy introduced to improve access for NHS home visiting staff, which is an aspect of improving service accessibility (see Recommendation Eleven).
- 6.20. The panel noted the valuable work undertaken by the joint London Assembly and Mayor of London Scrutiny Review, *Access to Primary Care*³² and in particular welcomes Review recommendation to address impeded access to health workers through a review of parking permit schemes London wide, which should also incorporate private roads.

"The Association of London Government must work together with London local authorities to establish schemes that will facilitate the provision of parking permits in all London boroughs for all primary care staff who conduct home visits to patients".
(To Association of London Govt. and London Boroughs).

Recommendation of the joint London Assembly and Mayor of London Scrutiny Report April 2003.

- 6.21. Information, choice and access to services are key to overcoming barriers to quality care and to providing greater equality of health care. We consider that these dimensions of care need to be integrated within existing service plans, as a first step to ensuring that the aspiration of Changing Childbirth for women centred care and for improved health equalities can be delivered.

7. Continuity of Care

Dimensions of Continuity

- 7.1. Continuity of care is key dimension of the quality of care. It relates both to the standards of consistency and equity of access to the range of maternity services available across the different service providers, the continuity of care within institutions and to the consistency and thread of services throughout an individual client's experience of care. How these dimensions of continuity are to be provided need to be clearly defined and implicitly understood both by the various service providers and by service users. Like other key dimensions of service quality, there need to be mechanisms to ensure that it is being achieved in practice.
- 7.2. Continuity of care and continuity of carer was identified in Changing Childbirth as "a fundamental principle underpinning woman centred care". It said that "within five years, 75% of women should be cared for in labour by a midwife whom they have come to know in pregnancy"³³.
- 7.3. The Audit Commission study First Class Delivery – Improving Maternity Services in England and Wales³⁴ concluded that "continuity of care" (meaning that care is delivered in a consistent way, regardless of the professional providing it) is important to all women. "Continuity of *carer*", on the other hand, (meaning that care is provided by a small number of professionals, or by professionals whom women know), is important only to some women.

"Just over 80% of women felt that continuity of carer within labour is important, although only half said that their care was provided this way ... just over half the women in the survey felt that it was important to meet the staff before labour begins, and they were more likely to hold this view if that had been their actual experience. In postnatal hospital care, women value the opportunity to discuss their care with someone they know, and who knows what happened during their labour. ... Postnatal home visits by midwives are highly valued by most women, regardless of whether they had met the midwives before".

The Audit Commission study First Class Delivery

- 7.4. NMUH's recent user survey of 20 women under midwifery led care (a 40% response rate), 9 of whom delivered at home and 11 at hospital, found that 18 thought that it was important to have met their midwives prior to labour and 18 thought it was important to have met the midwives throughout.
- 7.5. The new structure for delivering midwifery services at NMUH was a response to the need to improve the overall quality and continuity of care. NMUH hopes to build, through the new structures, improved overall quality, equity and continuity of care, including greater capacity of skill and expertise for home-birth services. Within the new structure for maternity care at the NMUH, the hospital aims to increase the take-up of midwifery led care and facilitate the option for home birth services.

NMUH Home Birth Services

- 7.6. A perceived drawback of the specialised home-birth unit was that the service was not consistently available. It also prevented the transfer of skills to other community midwives and built in dislocations within the midwifery service teams. This in itself undermines the continuity of care, such as an even spread of skills and service standards. We received evidence however, through testimonial evidence, to suggest some midwives may be reluctant to carry out a home-birth, even for uncomplicated pregnancies. According to some midwives, not all feel equally confident in this special area of competence.
- 7.7. The fear among the home birth campaigners is that the loss of the specialised home-birth team at NMUH means the loss of the expertise, experience, confidence and willingness of local maternity midwives to provide home births to those women who choose them. The new model of care at the NMUH has arguably also diminished the continuity of carer throughout pregnancy in comparison to the specialised home birth unit, which offered a more personalised service.
- 7.8. Key areas for measuring the quality of maternity services are the practical application of choice and the continuity of care: home birth services are an expression of both of these. The right to choose home birth cannot simply be measured through the take up of the service, which may be due to a number of extraneous factors. It is the availability and access to choice in maternity care that is the tangible expression of these dimensions of quality care.
- 7.9. The take up of services in an environment of enhanced information and choice should not be expected to fall. We believe that the NMUH needs to monitor local performance indicators to measure its success in increasing the take-up of home births to a level exceeding the pre-integration structures, as this is to be reasonably expected where the application of choice is extended. The key issue remains however, the ability to demonstrate that women are given a real choice about the place of birth rather than the actual take up of the service.

Recommendation Nine

Improving the Continuity of Care

Description

To enhance the quality and continuity of care through strategies to measurably improve the quality of personal care in a way that is responsive to individual needs. To provide improved continuity of carer, through the development of the role of lead professional carer, through the specification of clear and consistent standards for continuity of carer. Where appropriate, this might include the nomination of key staff within the midwifery teams allocated to particular clients, as far as possible match the clients needs with the most appropriate person and maximise the personal knowledge of the woman in care.

- 7.10. The Customer Care Service Plan (Recommendation Ten) needs to set out how the dimensions of continuity of care are to be delivered. This will include both the consistency of quality standards across the service providers and the

continuity through an individual's experience of care. Evidence received during our investigations has indicated that the type of care a woman is likely to receive can vary significantly from hospital to hospital and even between different consultants in the same unit.

One woman told us; "The care I received in the hospital ward when I was in the early stages of labour at the Whittington was really good, I was treated well, the staff were polite, the toilets were clean and meal times were something to look forward to. After the birth I had to stay in hospital for a few days on a different ward, but this was an awful experience".

- 7.11. As part of a project commissioned for the Maternity and Neonatal Workforce Group (MNWG), a survey was conducted nationally of approximately 2300 women which found that 33% of women felt it important to know the midwife assisting their labour delivery and 32% found it unimportant. It is therefore suggested that the Needs and Views Survey (see Recommendation Fourteen, *A Community Consultation Strategy*) attempts to measure the real latent demand within the community for continuity of carer and these views be taken into account in the way in which services are organised and delivered.
- 7.12. Hospitals should define what they mean by "continuity of care" in their Customer Care Service Plan (see Recommendation Two), and set out how they intend to deliver this. This should be defined in line with the "Indicators of Success" in the Changing Childbirth report and the findings of the recent House of Commons Health Committee review of maternity services nationally³⁵.
- 7.13. It is recommended that strategies need to be developed to improve both the continuity and the quality of personal care to make services more responsive to individual needs. We envisage that it might also allow specific midwives to be allocated to particular cases and provide greater continuity of carer and improved continuity of care. Part of this recommendation is focused on the management of midwifery teams and we envisage that the maternity service midwifery teams might allocate specific midwives within their jurisdiction to conduct home birth services as a first call. This strategy would allow for a degree of specialisation, which could be facilitated by the required targeted training. Although all midwives should still be trained to deliver the home-birth maternity model of care, this might allow midwives to elect some degree of specialisation according to their particular skills and aptitudes.

Recommendation Ten

A Customer Care Service Plan

Description

This is a standardised Customer Care Service Plan across Haringey, Enfield and Barnet to set out how the quality dimensions of care set out in the Customer Charter for Maternity Care are to be delivered. This should be applied across the North Central London area, for use by service providers in planning and managing services and service audit and monitoring of the non-medical dimensions of services, including customer care.

- 7.14. Part of the scope of this Review was to examine the appropriate level of co-ordination between different service providers. We have concluded that there needs to be inculcated greater continuity of care across service providers and within the services themselves, improved continuity both across the different services and within the institutions of care. This implies enhanced standardisation of quality practice to bring about an improved shared philosophy of care, that is responsive to individual needs.
- 7.15. The Customer Care Service Plan should inform service providers about the standards of service they are expected to achieve. It is essentially a plan of how maternity services will be delivered, as described in the proposed Maternity Services Charter. This should include identified improvement targets. It should be consistent with existing service plans but include greater emphasis and focus on customer care. The plan should include all of the various departments and providers of the different services of maternity care provided throughout pregnancy and should set out broad definition of the service provided by each.
- 7.16. It is envisaged that the proposed Customer Care Service Plan might be drawn up in line with the Nine Principles of Public Service Delivery outlined in Appendix Six. The Plan should set out what the service is, what the minimum standards of service are and provide a vision for what counts as excellence. The plan should focus on customer care, information and choice and key dimensions of quality and should be used to inform service providers about the standards of care they need to achieve. The plan should outline the stages of maternity care, the options available to service users, and the different institutions involved at the different stages of care.
- 7.17. The Customer Care Service Plan needs to include an outline of the process of care throughout maternity and to identify the main actors. Key stages of care include; GPs, maternity hospitals in the local area, key choices about where and how maternity care can be delivered, the required examinations and tests that may need to be carried out. Dimensions of customer care need to be identified against these key stages, including how services will respond to client's particular emotional and support needs, identification of any special needs, key patient information and advice including key contact information for service providers and contact details of relevant support groups (voluntary organisations). The care plan should define how continuity of care is going to be interpreted and delivered in practice. It should demonstrate that the concept and commitment is embedded within local services.
- 7.18. Obstetric/midwifery/antenatal/labour case notes are maintained by maternity services and are available to women throughout their care. These may eventually need to be reviewed to ensure that it is consistent with the key stages outlined in the Customer Care Service Plan and that all the relevant dimensions of customer information and choice are included.
- 7.19. It is envisaged that each service provider should follow the Customer Care Service Plan, and although the plan should be flexible enough to allow for local variations. The framework and template for the plan should be uniform

throughout the area of North Central London Strategic Health Authority and agreed by the PCTs and the MSLC.

Recommendation Eleven

Midwifery Led Care

Description

This recommendation runs in conjunction with the development of the role of midwife as lead professional carer. We are recommending that pregnant women should have a clear choice to present directly to midwives rather than to their GP, (while retaining the choice of lead professional and support from their GP) and that this should be enshrined in the Customer Charter for Maternity Care.

- 7.20. Changing Childbirth and the recent Health Committee reports champion the cause for "women centred services". The historical context of the institutions of care, the availability of ever advancing technological processes and tests, the rationalisation of resources, tend to mean that the gravitational pull of the direction of services is drawn inextricably towards the medicalisation of care. We believe that greater emphasis on midwifery led care, making this a clearly identified choice for all women, is a step away from the trend of over-medicalisation and towards women centred services.
- 7.21. In Haringey, women find it difficult to access maternity care without a referral from a GP. We recognise that women can already self-refer and it is an important option to have, as it is included in the Commissioning Toolkit as one of the proposed minimum service specifications³⁶. We believe that women should be given the clear option to contact a midwife as a first port of call, rather than seeming to have to go through their GP. This could be achieved by ensuring that all GP receptions and hospital units are able to refer women to the appropriate midwife, by clear notices in GP practices to advise women on how to contact a midwifery service, by updating local telephone directory information and by updating the information available from the NHS Direct advice line.
- 7.22. However, we do not believe that this option should be imposed upon women. Moreover, we feel that the best way to promote choices as to where and how to give birth (including home birth and midwifery led care) is to work closely *with* GPs rather than appear to exclude them. It is anticipated that the GP rout will remain for most women the preferred rout into care.
- 7.23. Though both NMUH and the Whittinton Trusts offer midwifery led care, neither has a midwifery led unit as such, nor a midwife/GP unit. If Haringey women want a midwifery led unit (or "birth centre") they have to travel well out of the borough to Edgware Birth Centre, the Ridgeway Birth Centre at Chase Farm, the new Birth Centre at the Royal Free, or the Bloomsbury Birthing Centre at UCH/EGA. This clearly presents issues of access and equity, but we believe that it is important that the options of Midwifery led care should be made clear for all Haringey women, as one means of increasing both the continuity of care and continuity of carer as envisaged in this report.

7.24. Continuity of care is a very important dimension of quality both in terms of the standards of care between and within maternity service providers and in terms of the personal knowledge and experience of the individual woman. This Review has put forward recommendations aimed at improving both the standards of continuity and the transference of personal knowledge and personalised services. Continuity of *carer* is, we consider, as far as is feasible, a vehicle for delivering this.

8. Consultation Planning and Performance

Patient & Public Involvement

- 8.1. The Health and Social Care Act 2012 introduced new requirements for patient and public involvement in health services and this places consultation on NHS services at the forefront of the Government's reforming agenda. Government guidance on Section 11 of the Act, issued in May 2012³⁷, places a duty on strategic health authorities, primary care trusts and NHS trusts to make arrangements to consult patients and the public on on-going service planning, on proposals for service development and change and on decisions that may affect how services operate.
- 8.2. This should include consultation on:
- Patient and public experiences
 - Patient's and public's ideas
 - What patients and public want from services
 - NHS plans
 - Why services need to change
 - How to allocate resources effectively
- 8.3. This Review has included consultation with service users to find out about their experiences and views and where they feel there may be areas for improvement in service provision. There were a varied spectrum of responses, many very positive, but significant numbers of the women we talked to conveyed at least one bad experience during their maternity care. The most frequent complaint was of being spoken to harshly and of their own anxieties being brushed aside, or of their knowledge of their own bodies and what was happening to them being dismissed. One woman told us "I had had several babies so I knew that I was about to give birth, but the midwife told me I was wrong and left me... when she saw that I was right she panicked".

Women Centred Services

- 8.4. Changing Childbirth³⁸ championed women centred services. Although "women centred" can be interpreted in a variety of different ways and incorporates a range of issues for maternity care, what the term does convey is that services should be focused on the individual client and not just on the overall standards or measurements clinical targets. It also implies that services are delivered in a natural and comfortable environment. It endorses the view that childbirth should be regarded as a natural process and unless there is a clear need, should be as natural and as medically un-obtrusive as possible.
- 8.5. The Review received evidence from service users that particular maternity services in hospital have developed a negative image and reputation. For example, there is a perception amongst some service users that maternity services at NNUH are being integrated at the expense of quality, choice and women centred care. This perception lies at the core of the argument about

discontinuing the dedicated home birth team. This move was seen by many as a limit to women's choice and a diminution of quality. This Review does not attempt to judge the validity of these perceptions, but we do suggest that there needs to be a clear demonstration that proposals for service development are considered within an overall strategy to deliver women centred care and that consultation highlights any concerns that may exist.

- 8.6. We believe that maternity services need to more effectively identify the key areas of concern of their clients. There is a need to improve the image of some hospital services to clients, celebrating successes when targets and improvements are achieved. Communication and consultation is also an opportunity for promotion of services. We believe that, in order to identify clients' concerns, a more rigorous client satisfaction response system needs to be put in place.

Recommendation Twelve

A Customer Satisfaction Response System

Description

The setting up of a customer satisfaction response system, which includes the completion of customer satisfaction forms at the closure of every maternity care period and which incorporates all the different stages of maternity care and different service providers. Customer responses will need to be designed to check that what is outlined in the Customer Charter and the Customer Care Plan is being delivered in practice, by asking service users directly for their views. This information is used to inform appropriate level management and policy review. This system should be managed to aim for a 100% response rate with a minimum of 75% of service users responding. Communication aids should be available in all the main minority languages and effective responses facilitated for all women according to their individual needs.

- 8.7. The panel has concluded that there needs to be improvement in the way in which maternity service performance is considered from the perspective of the individual client, with a view to improving the responsiveness of services to individual client's needs. One way of measuring this is to ask patients themselves at the end of their maternity care (or at the end of specific stages of care) what they think of the service they have received. This might be aided with the use of a satisfaction survey, which could be included at the end of a client's case notes as part of a "signing off" of the client from care (for example at the end of the particular stage of maternity care). Such a survey should include a questionnaire that is brief, focused, user friendly and which positively encourages both complaints and praise. It should be made available in all identified community languages, depending on need.
- 8.8. We were particularly impressed by the work carried out at the NMUH in their PALS patients consultation sessions and recognise that this is a good way of picking up on salient issues expressed by women who have used the service. We believe that this practice needs to be expanded and rationalised to ensure that the main dimensions of quality identified in the Customer Charter for Maternity Care are being monitored. The survey questionnaire devised as part of the Customer Satisfaction Response System should be used to guide these feedback sessions. The Consultation Strategy needs to identify the

main user groups within the community and to identify how the Customer Satisfaction Response System will be used to engage with the various agencies, including voluntary groups and community organisations, including specifically, the asylum service.

- 8.9. In order to benchmark consumer satisfaction between and across different service providers and over time, the questionnaires and other customer feedback need to consider and focus on some specific salient issues and should include a continuity of questions both year by year and across the sector. Specifically, patient feedback should include questions to monitor both continuity of care and continuity of carer (see Glossary), as well as dimensions of information and choice. It should include all key aspects of the service, which are considered by patients to be relevant to their experience of the quality of care. Aspects of clinical care and performance are already measured and should be monitored in conjunction with the more qualitative aspects of quality care.
- 8.10. The Customer Satisfaction Response survey should include questions around availability of information for main options for childbirth for example, choice of hospital, options for home birth, options for possible intervention etc. Questions should cover each stage of maternity care and identify service providers, including GP services, prenatal services, labour ward and post-natal services. Key aspects of patients feedback also need to include consideration of access and equalities issues, as these are significant barriers to information and choice (see Chapter 5, *Access, Information and Choice*).
- 8.11. The MSLC, PCTs, hospitals and midwifery teams should monitor patient feedback as performance data, but the focus of the Customer Satisfaction Response survey should be drawn up by the PCTs in agreement with the MSLC, which should be invited to contribute and approve the survey.

CONCEPTUAL MODEL OF THE CUSTOMER RESPONSE SYSTEM

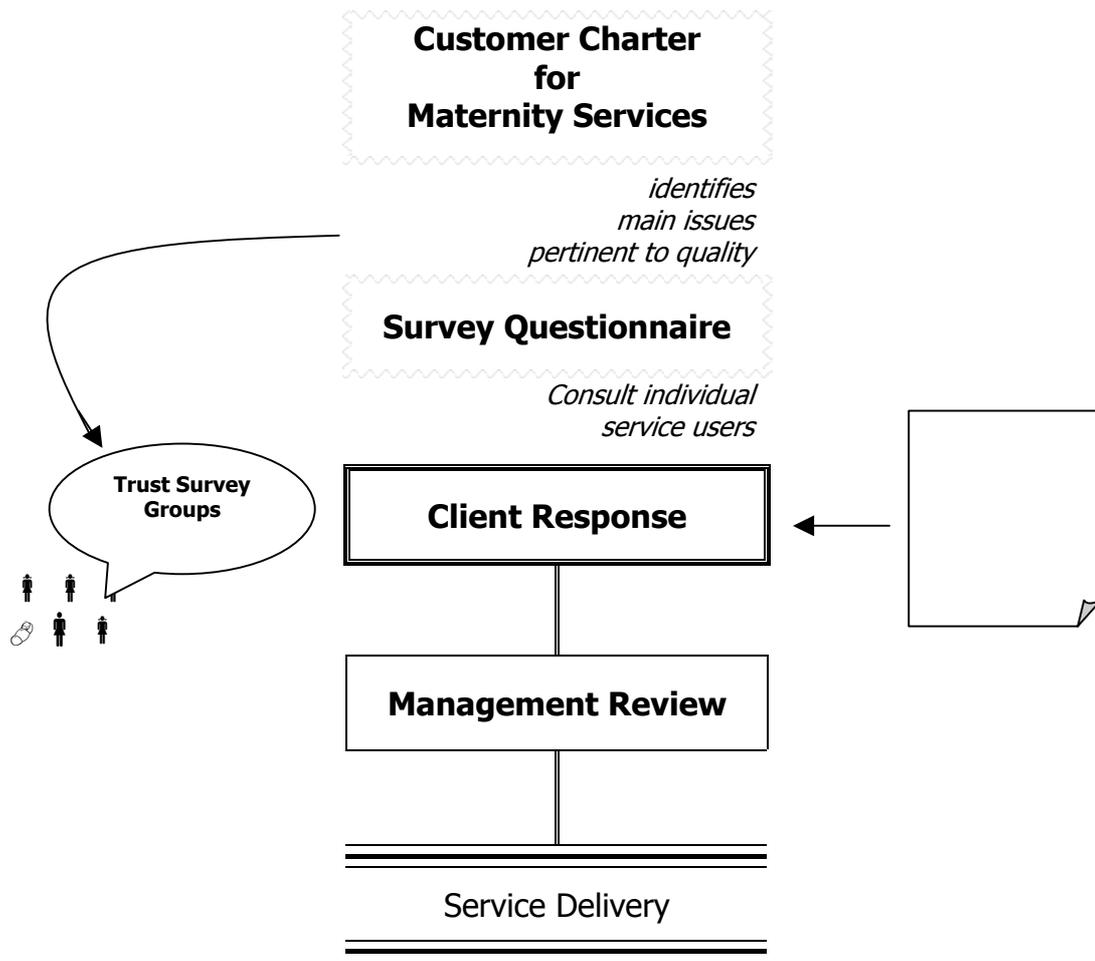


Diagram Three

8.12. The questions in the Customer Satisfaction Response survey should be linked directly to the Customer Charter and Care Service Plan and should focus on identified issues pertaining to quality. The way in which customer feedback feeds through into the policy and management process needs also to be defined and this should be described in the Community Consultation Strategy (Recommendation Fourteen).

Recommendation Thirteen

A Community Consultation Strategy

Description

To draw up a Community Consultation Strategy which identifies: main issues for consultation; the mechanisms through which consultation will take place; those minority groups with discrete service needs and how their views are to be taken into account. It should include provision for a Needs and Views Survey to assess the real latent demand for dimensions of care (e.g. continuity of carer). The strategy should identify and plan how the views of so called "hard to reach" and minority groups will be accessed and incorporated in service development.

8.13. To draw up a Community Consultation Strategy which identifies: main issues for consultation; the mechanisms through which consultation will take place;

those minority groups with discrete service needs and how their views are to be taken into account. It should include provision for a Needs and Views Survey to assess the real latent demand for dimensions of care (e.g. continuity of carer). The strategy should identify and plan how the views of so called "hard to reach" and minority groups will be accessed and incorporated in service development.

- 8.14.* A particular challenge locally is the effective involvement and consultation of local service users. A main channel for user consultation is through the Maternity Services Liaison Committee (MSLC). For this reason, it is particularly important that the MSLC is truly representative of local service users and not perceived as a vehicle for particular interest groups or sections of the population. As MSLCs are also jointly made up of health professionals and users, it is important that they are able to distinguish the discrete representations of services users in expressing a view. There is an identified need to effectively consult with community groups that do not currently access the formal consultation process.
- 8.15.* The highly transient nature of the Haringey population makes it difficult to represent or consult some local service users on local services. The HTPCT makes agreements with local hospitals each year to gear commissioning towards recent historic trends, and this is monitored throughout the year.
- 8.16.* The consultation undertaken by the Review, talking to mothers who had recently experienced maternity care first hand has been a useful way of exposing real issues on the ground. Some of the issues and concerns identified appear to conflict with the policy and service standards, which currently exist. We believe that effective consultation with clients should be seen as an ongoing process undertaken by service providers to identify their success and failures in delivering the quality of customer care they aim to achieve. We believe that this can be best achieved through a co-ordinated, strategic approach.
- 8.17.* We have concluded that consultation on maternity services could be improved and it is recommended that there needs to be a defined consultation process that is agreed with the MSLC through the Community Consultation Strategy (Recommendation Fourteen). Maternity services need to ensure that they take measures to know their clients, consulting with the relevant users groups. Client consultation will include customer satisfaction surveys, feedback through the MSLC, and feedback through the new Patient Forums.
- 8.18.* The Community Consultation Plan should identify who service users are, including special needs and hard to reach groups within the local community, how they are to be consulted and how their views are to be taken into account. The fact that some are "hard to reach" and the need to take special measures in consultation is readily acknowledged by service providers, but there is a need to identify effective solutions, plan and measure the success of consultation. This needs to be identified in the Community Consultation Plan.
- 8.19.* The plan should describe the main mechanisms for client consultation and how the views will feed through into management review. The Community

Consultation Plan should seek to ensure that services are listening to their clients, identifying their concerns and taking their views into account, through periodic management review, intervention and targeted action.

8.20. It is envisaged that the Community Consultation Plan will include:

- Identification of the different groups of service users to be consulted
- Main representative bodies for these user groups, inc. MSLC
- An identification of "hard to reach" and special needs service users
- An explanation of how issues for consultation will be defined, inc. identification of the Customer Care Service Plan key themes
- An explanation of how and when users are surveyed, including the Customer Response questionnaire
- The main mechanisms for considering survey and customer feedback results, including how they are to be monitored by the hospital trusts, the PCTs and by the MSLC
- An explanation of how consultation will inform management decisions

8.21. The good practice by the PALS customer feedback sessions should be prescribed in the Community Consultation Plan and extended to all hospital trusts. These sessions should use the customer response questionnaire as a tool to focus on the main issues pertaining to quality, so that there is increased focus on the main quality issues and to achieve the same high standards of care for all.

8.22. There is a need to improve awareness of the MSLC by staff and service users. This will involve including the postal address, telephone contact and e mail address in the client's maternity information pack and case notes so that the existence of the MSLC is promoted and known by individual users of maternity services. People should be able to access the MSLC both through the PALS services in each NHS Trust and via the new Patients' Forums due to be set up for 2004. It will also involve defined linkages between the MSLC and the new Patients' Forums.

9. Monitoring and Review

Involving Women in Monitoring and Review

- 9.1. The MSLC is currently a key channel for patient representation for maternity services and monitoring performance of maternity services is already within its terms of reference. The MSLC is a standing committee of the Boards of Enfield, Barnet and Haringey Primary Care Trusts to act as a multi-disciplinary forum, bringing together the various different professions and user representatives involved in maternity care. The MSLC advises the Strategic Health Authority, and other community health organisations on all aspects of maternity services provided for local residents. The key role of the MSLC should be as a channel for user representation and as a monitoring body for the performance of maternity services and these two functions operate in tandem.
- 9.2. The long term status of MSLCs within the context of the reforming agenda for health consultation is as yet unclear, but it seems likely that the MSLC or else a similar body will continue to function into the future. The panel considers that the role of MSLC as an advocate for women maternity patients past current and prospective is central, and it is for this reason that there are recommendations for improvement in the way in which the PCTs, hospitals and GPs work with MSLC.
- 9.3. The operational credibility of the MSLC is very important to its effectiveness. Service providers and users need to have confidence that the MSLC able to represent the views of the broad spectrum of users and not just particular factions or interest groups. MSLC needs to be viewed and to demonstrate credibility and effectiveness as a body that can represent all sections of the community. Specifically, we believe that the MSLC needs to review its membership to ensure representation from all key user groups, including ethnic minority representation and needs to appoint vacant positions to minority and special needs representation soon. Representatives from the new Patient's Forums might also be included in the membership of the MSLC, to create linkages to wider patient participation and the health sector.
- 9.4. As the MSLC is a key channel to access clients views, the PCTs and MSLC need to define its place clearly within the Community Consultation Plan and need to ensure that the specified consultation process is followed, (i.e. the views of users including special needs and "hard to reach" groups are being considered).
- 9.5. Consulting with minority and hard to reach users needs to be given a particular focus within the Community Consultation Plan and by the MSLC. Representation of ethnic minority user groups on the MSLC is considered essential, but is not alone sufficient to ensure access to consultation from the diverse populations in Barnet, Enfield and Haringey. Whilst the membership of the MSLC is made up of service providers and users, the user perspective is a discrete and important dimension of the consultation process and it is suggested that this might be clarified within the new MSLC Terms of Reference.

- 9.6. MSLC should use the Community Consultation Plan to ensure that it is able to monitor the needs and views of "hard to reach" groups and make sure that they are being reached. This should demonstrate that they have considered the specific issues relating to users and to the diversity of users within the population. The MSLC needs to clearly consider and present the different perspectives of service users within the community, clearly delimiting consideration of the equalities implications of every service plan and policy issue they consider. This should aim to monitor inequalities of access and quality to the range of services offered within maternity care.

Responding to Individual Needs

- 9.7. Local NHS Trusts are rightly focused on driving up overall performance and quality of care in accordance with Government targets and standards, but the individual experiences of care also reveal important aspects of the integrity and responsiveness of services to the individual needs of women. These aspects of care often remain undiscovered, unquantified, and unrecognised by the performance management agenda. We would like to see improvements in the way that services are planned delivered and monitored, that bring about a greater shared philosophy of care, which incorporate individual choice and are able to respond to individual needs.

"The woman must be the focus of maternity care. She should be able to feel that she is in control of what is happening to her and able to make decisions about her care, based on her needs, having discussed matters fully with the professionals involved"³⁹.

- 9.8. Even when the overall quality of a service is high, it can be the small number of instances of poor uncaring service that impact upon both the individual's experience and also upon the reputation of the service or institution as a whole.

Recommendation Fourteen

Listening to Clients

Description

We recommend that front line services on the maternity wards, especially the post-natal maternity wards, need to become more responsive and aware of client's needs. We envisage that management practice includes conducting a periodic review of patient care on the maternity wards involving conducting informal feedback sessions to women on the ward, and taking up any particular issues expressed. This is a proactive, assertive approach to identifying the problems experienced on the ground and then feeding these up into the management system to seek a consistent standard of quality for all patients, tailored to their individual care needs.

- 9.9. It is envisaged that the key themes defined in the Customer Care Service Plan (Recommendation Ten), will be checked informally by conducting a periodic review of patient care on the maternity wards including holding informal feedback sessions to women on the ward, and taking up any particular issues expressed. This is a proactive, assertive approach to identifying the problems

experienced on the ground and then feeding these up into the management system to seek a consistent standard of quality for all patients, tailored to their individual care needs. We note that there are examples of good practice on maternity wards and to the extent to which this is already being carried out, it is envisaged that it should become standard practice, but also needs to focus on the main themes pertinent to the individual woman's experience of the quality of care defined in the Customer Care Service Plan (Recommendation Two), as this should provide an objective check-list of key themes identified as pertinent to women's experience of the quality of care.

- 9.10. It is important to note that a respondents overall impression of a service can sometimes be bound up with her particular experiences of childbirth, not all of which are to do with the service provided, but the usefulness of client feedback is to flag up those problems that are within the scope of service management as a means to control the integrity of the quality standards achieved. This approach aims to identify customer complaints and issues of concern through regular dialogue with individuals receiving the service and to deal with every customer complaint by investigating solutions through appropriate management intervention.

Customer Complaints

- 9.11. Although NNUH and the Whittington Hospital have well-established customer complaints procedures, we have received evidence that these are not always effective. Very often it seems that women are not informed about how they might be able to make a complaint. Customer complaints can show how services have fallen below user expectations the standard outlined in the Customer Care Service Plan and the Customer Charter. As such all customer complaints should be managed and investigated as a tool for service development and improvement. Customer complaints should be investigated and referred to the appropriate level of management to review service policy and practice.
- 9.12. Customer complaints are an important part of user consultation and we believe should be integrated with the recommended Customer Satisfaction Response System and defined within the wider Community Consultation Strategy, as a way of flagging up issues to improve the quality and integrity of services. It is currently compiled for the last 5 years and reviewed by service managers. The Review has concluded that there needs to be an improvement in the way in which individual customer complaints are handled so that they can be effectively used to improve service delivery. Specifically, access to complaints mechanisms need to be improved and complaints used as a management tool to flag up potential problems on front line services. Customer complaints contacts and procedures leaflets should be readily available from all service providers, and included in the Maternity Services Customer Charter, with the customer satisfaction survey and in an individual clients' care plan.
- 9.13. To improve access to the complaints process, customer complaints materials need to be made more obvious and more accessible, including greater availability on maternity wards and in discharge notes. Complaints forms need to be available, upon request, in all community languages. Maternity

services need to clearly identify to clients the name and address of the manager responsible for the service they are receiving and enable them to complain where the client feels the service has not been satisfactory. Institutions should actively encourage complaints so that this client feedback can be used for management intervention in a "no-blame" investigation into improving services when things go wrong.

- 9.14. Customer complaints data should be used as a tool for ongoing service improvement. Customer complaints data should also be collated and monitored both by hospital management and independently by the MSLC. Recurring issues should be identified and management intervention and outcomes monitored. Customer complaints monitoring information should be compiled by the PCTs in an easy to read format and presented to the MSLC and the new Patients Forums on a quarterly basis, as part of the agreed local performance monitoring framework.

Performance Monitoring

- 9.15. Evidence received from service users during the Review indicated that some of the high standards of customer care policy are not always achieved in practice but that these issues are not always flagged up. We believe that performance monitoring needs to be enhanced to ensure that key dimensions of quality (defined in the Customer Charter for Maternity Care) are being achieved in practice. The quality of maternity services is multi-dimensional, and includes the customer focus dimension as well as clinical dimensions of care. The MSLC needs to be able to maintain focus on strategic development of appropriate services that reflect the evidence based needs of the whole population. This can be achieved by narrowing down on the key issues, local concerns, defining key areas it decides to monitor and commissioning local KPIs from the PCTs and other trusts.

"For most women, giving birth is a normal physiological process, not an illness. It is not clear to us that the usual methods the Department employs to measure the effectiveness of services (which must inevitably focus on clinical outcomes) are necessarily the most appropriate for maternity services"³⁹.

Recommendation Fifteen

A Local Performance Monitoring Framework

Description

This is a recommendation for improved mechanisms for the monitoring and review of maternity services. It should include a clearly defined and invigorated role for MSLC, and the development of local performance targets by the MSLC and local hospitals to allow benchmarking of key local performance data both over time and between different service providers. In order to improve the effectiveness of the ongoing local monitoring and improvement of maternity services in line with locally defined aspirations, the panel believes that the PCTs and MSLC need to establish an agreed performance-monitoring framework, designed specifically for local patients and user groups.

- 9.16. In order to improve the effectiveness of the ongoing monitoring and improvement of maternity services in line with locally defined aspirations, we believe that the PCTs and MSLC need to establish an agreed local performance-monitoring framework with the MSLC. This framework should bring all of the different aspects of performance monitoring and review together, including the Customer Satisfaction Response System, customer complaints and review by the MSLC. The Local Key Performance Indicators for Maternity Services need to be reviewed and agreed annually by the MSLC, defined in relation to client feedback (the Customer Satisfaction Response survey) and other performance measures and should include information to indicate local trends and how the service performs in relation to customer requirements. Key local performance measures should be agreed, based on locally defined priorities and not just in relation to national Department of Health (DoH) targets. The performance issues identified should clearly link both the Customer Satisfaction Response survey and the overall consultation process. Local performance targets should be specific, measurable, achievable, realistic and time-based.
- 9.17. Local performance measures need to be consistent and comparable over time and between different service providers. As an example of a local performance issue, the information on the number of home births at the NMUH taken up over the past 5 years needs to be presented to the MSLC in a format that distinguishes between the number of women receiving a home birth from within the present catchment area and excluding out of borough "bought-in" maternity care. This would enable the MSLC in order to monitor the effect of the new service structure on the take up of home births locally. If the number of home births is found to be falling, then the hospital should respond with a view as to why home birth delivery is falling and to what extent this reflects genuine choices and preferences expressed by service users.
- 9.18. The local Key Performance Indicators for Maternity Services need to be reviewed and agreed annually by the MSLC, defined in relation to client feedback (the Customer Satisfaction Response survey) and other performance measures and should include information to indicate local trends and how the service performs in relation to customer requirements. Key local performance measures should be agreed, based on locally defined priorities and not just in relation to national Department of Health (DoH) targets. The performance issues identified should clearly link both the Customer Satisfaction Response survey and the overall consultation process. Targets should be specific, measurable, achievable, realistic and time-based and clearly monitored against these indicators.
- 9.19. Given that both Government and local policy is aimed at reducing the levels of medical intervention in childbirth, and insofar as home birth is a proven example of low intervention birth, it is essential to understand the reasons for changes in the take-up of different options during maternity care. Above all, what needs to be monitored and improved is the extent to which all women are offered effective choices. Trusts and the MSLC will decide on what particular choice issues they will monitor, but these may include choice of hospital, choice of midwifery or GP led care, choice of home-birth, options for pain relief during labour, options for planned caesarean delivery etc. The

choices available to women need to be described clearly in the Maternity Services Charter and measured through quality audit and review. select key audit information needs to be effectively monitored, which should include monitoring by the MSLC.

Service Development

- 9.20. Local service provision and development, as far as is practicable, needs to reflect the needs and aspirations of the local population. This is evidenced partly against demographic indicators, but also measured through planned consultation strategies and customer feedback. It also needs to be planned in such a way as to remain flexible and responsive to the different and diverse needs of the local community. During the Review, we received evidence about the arrangement for seminars at which Orthodox Jewish women give talks to maternity services staff at the NMUH and we would like to commend this good practice to other hospitals and suggest that it may be a useful way of revealing relevant issues for other sections of the community.
- 9.21. The planned approach to ongoing community consultation envisaged by this Review is hoped could provide a strategic framework for consulting on service development, by identifying which groups within the community need to be consulted and how their views can be taken into account in the development of services. It may be useful to define what may be considered as a significant or substantial development of services, which might trigger a wider consultation process. This will enable, we envisage, policy makers to take on board the views of all of the diverse sections of the population for future development of maternity services, to ensure that service configuration and outcomes concord with the needs and expectations of the whole local community.

10. Conclusion

- 10.1.* This Review has been an extensive investigation and has involved field research, consultation with policy makers, service managers and with service users from a variety of backgrounds. We hope that this work in itself provides a useful reference point for service development. We hope also that we have been able to put forward some innovative recommendations, which can be considered as solutions to identified areas that may need improvement in line with Government policy and local user expectations for service development.
- 10.2.* The object of this Review has not been as an inquiry into past practice, not a judgement on the quality and performance of local services, but an extensive piece of research and investigation aimed at constructive suggestions for policy development and to flag up issues of concern to local service users. The strength of the scrutiny review process lies not in the technical evaluation of detail but in the independence of the investigation by an outside review body, able to take a distanced and impartial view, from the perspective of the lay user.
- 10.3.* The Review has examined the themes of choice, consultation, quality and continuity of care and the extent to which women are involved in the planning and monitoring of service development and the recommendations put forward reflect these concerns. From the feedback we have received from service users, we have found that the overall quality of local maternity services demonstrates a high degree of customer satisfaction. Our informal surveys have however highlighted a number of important areas where women do have concerns from their experience in care and the recommendations put forward are presented as a way to improve the overall responsiveness of services towards these issues.
- 10.4.* Inevitably there are some issues that are intractable, or perhaps expensive to change, but a great many of the concerns raised with the Review are such as may be easily avoidable and yet make a substantial impact on the quality of the experiences to those women who encounter them. This relates especially to the quality of individual care, which is perhaps the main concern that service users have raised with us.
- 10.5.* Throughout this Review, we have been aware of the fact that the expectations of services users are inevitably constrained by finite resources and that any recommendations made would have to take this into consideration. We have sought to put forward recommendations that are broad enough to be integrated with current and prospective practices and yet measurably impact upon service outcomes. We believe that although services are restrained by limited resources, it is the management, direction and focus of resources that shape the quality and consistency of services delivered. We also recognise however, that the recommendations put forward to voluntary organisations such as the MSLC do have resource implications that would have to be worked out with co-operation with the health services and commissioners. It is envisaged at least that these will require a higher level of resourcing and administrative support for the MSLC

than it currently receives, but this should be seen in the light of the overall consultation strategy, as outlined in the report. The National Consumer Council recently reported on involving consumers in health care and commented that users must be “adequately and rewarded in some form to value their contribution and retain their involvement, particularly individuals from hard to reach groups”⁴⁰.

10.6. We are pleased to note that, from the evidence we have received from policy makers and service managers, many of the overall objectives of our recommendations are objectives shared by the services themselves. Local service providers and commissioners have high standards of practice and we recognise that in this Review. From the evidence we have received from service users we have found that there are times when the actual experience of care can fall short of stated policy standards, that women do not always feel that they are involved in decisions about their care and that women are not always consulted fully on service development and performance. Fundamentally, we would like to see development made in such a way as to integrate existing policies and resources into a more systematic approach to making services responsive to women's individual care needs.

10.7. The recommendations we have put forward provide conceptually what we believe are important areas in future service development. The interpretation and realisation of these proposals is a matter for local service providers, which will be asked to respond to this report and provide an implementation plan that is able to demonstrate how they intend to deliver the specified objectives. An important element in the way in which these recommendations should be implemented is not just with reference to the individual recommendations themselves, but also to the way in which many of the recommended plans and strategies will work together. The diagram below illustrates a “whole systems view” of the recommended service planning; consultation and quality framework concepts should work together.

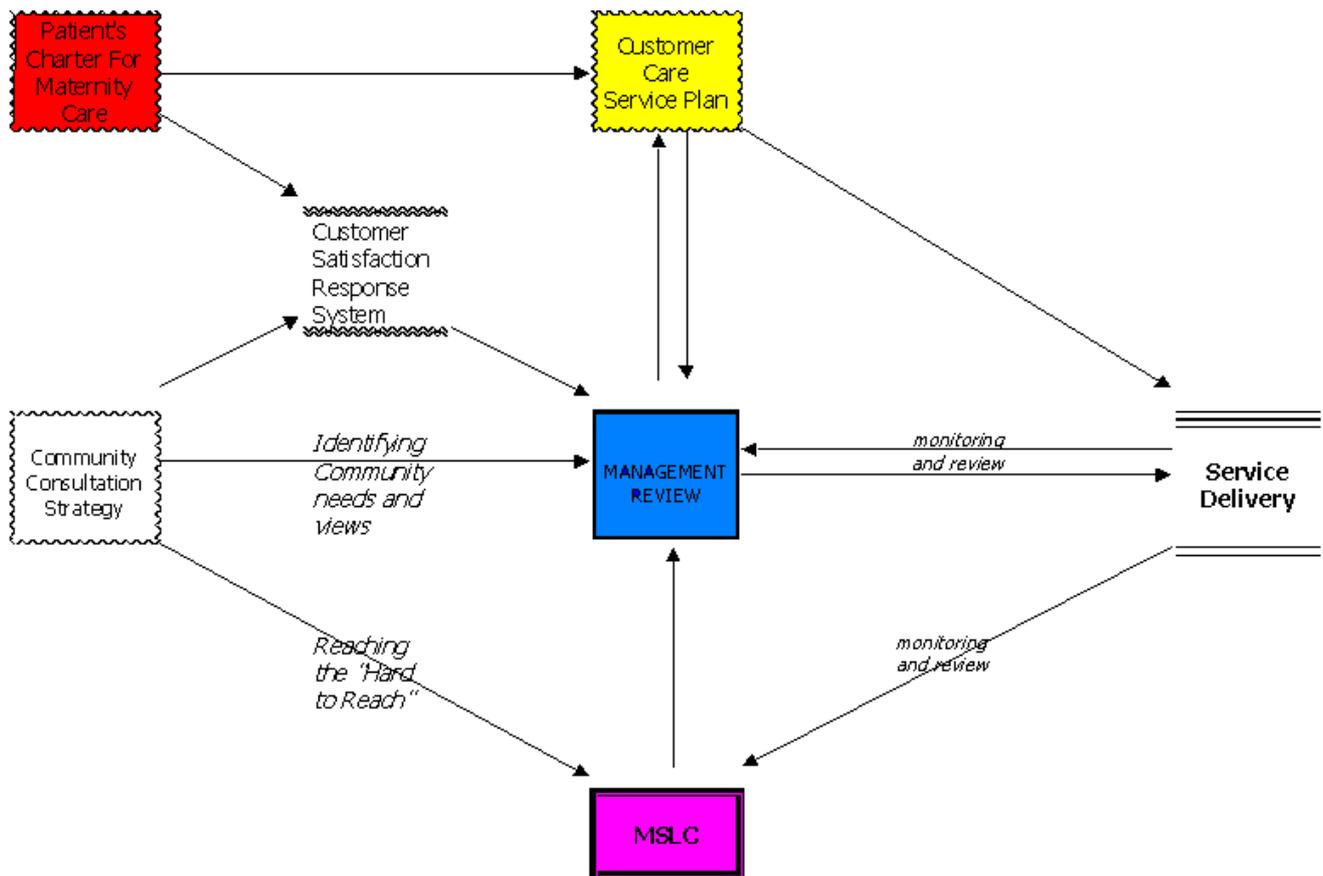


Diagram Four

10.8. The diagram attempts to illustrate the relationship between the recommended Customer Charter For Maternity Care (Recommendation Two), the Customer Care Service Plan (Recommendation Ten), the Community Consultation Strategy (Recommendation Fourteen), and the local performance monitoring system (Recommendation Fifteen) and how all of these work together through management review to ensure that services are responsive to local service users. Greater clarity about service standards in the charter should provide definition for realistic expectations for service users, the Customer Care Service Plan outlines how these standards will be delivered. The Customer Satisfaction Response System provides a mechanism by which implementation is measured and monitored and the Community Consultation Strategy defines how the views of service users and particularly "hard to reach" groups are taken into account in the development and performance review of local services. All of these are envisaged to work together towards enhancing user choice, consultation and involvement and the quality of the experience of care.

10.9. A fundamental issue encountered throughout this Review is that patient choice is necessarily constrained both by finite resources and by the technical complexities of the medical process, where expert professional judgements must be relied upon. The appropriate balance of these issues needs to be clarified so that the discrete areas for patient choice can be understood by service users. It is envisaged that the proposed charter should reflect this and should clarify the scope for choice and reasonable expectations and that

the customer care plan will provide the operational plan of how this is to be carried out within the context of the delivery of choice and care in front line services. The customer satisfaction response system is envisaged as a defined means by which services can check that the key themes outlined in the charter and the care plan are being delivered. The Community Consultation Strategy provides a framework of how all groups in the community, including those least heard, shall be listened to and how their views will be taken into account. The MSLC is shown as a key group that aims to represent all service users within its terms of reference, and is envisaged as a key way of making sure that local service users are involved in monitoring local issues and local performance review.

- 10.10.* The Review has considered home birth as a key dimension of choice and has concluded that there is as yet insufficient evidence as to whether this choice has been expanded under the new service configuration at the NNUH or constrained, but we have made recommendations aimed at monitoring the future performance of local issues such as this and recommendations aimed at clarifying a woman's choice about where to have her baby and on her choice for midwifery led care. The actual uptake of the home birth service is not considered to be the absolute arbiter of the availability of the service, but it is an indicator and one that should be monitored over the next couple of years. The real underlying issue is whether or not choice is a reality for all women, regardless of culture, language or postal code. This Review has found that there does seem to be real barriers to choice about how and where a woman can elect to go through childbirth, whether that be a choice of hospital, choice of midwifery led care or the choice of a home birth. All of the measures recommended from this review are aimed at clarifying and improving the reality of choice for all women and checking that the policy concurs with the actual experience of service users locally.
- 10.11.* The Review has also put forward recommendations to improve the quality and continuity of care. What matters most to most women is that their care is provided in a way that is in a safe, clean, reassuring environment by supportive and caring professionals, responsive to individual care needs. We have encountered examples of women whose experience of hospital has fallen short of this but believe that this often goes undetected. We have also encountered examples where the knowledge of individual women appears to have been lost or disregarded, leaving their special needs (such as non-English language communication) uncatered for or the identified needs of individuals in care unmet. This was illustrated to us, by example, by one woman who felt that her need for wheelchair assistance, which had been agreed with one health professional on the postnatal ward, was not acknowledged by another health professional when the time came for her to visit her baby in intensive care. Another example is of a woman, not confident to communicate in English, felt unable to communicate properly in the labour ward. It would seem that such examples might be overcome if greater continuity of care and greater continuity of carer could be achieved. This is why we have put forward proposals to improve both the continuity of care and for greater continuity of carer is considered to be one way that this can be achieved, by improving the personal knowledge of the woman in care.

10.12. The overall conclusion of the Review and the object of all of the proposals we have outlined in this report is that maternity services should be made more "women Centred". A concept expounded in the Changing Childbirth publication and the recent Health Select Committee reports. We believe that this means making services for caring, more responsive to individuals, enshrining choice at the pivot of service provision and involving and consulting women in the way in which services are delivered and reviewed. What we envisage is that this concept is married to the prerogatives of medical care, a way that places the actual experiences of care as a key arbiter of quality, to ensure that the existing high quality of services we have seen locally are enhanced for the woman at the centre of care.

Glossary

Accessible Care

Care which women are able to reach and to receive.

Advocate

A person who takes up issues about the care of a pregnant woman on her behalf and challenges practices in the NHS to meet her needs. An advocate should ideally be able to communicate with the pregnant woman in her own language.

Amniocentesis

Gathering a small sample of fluid surrounding the baby to test for detect genetic conditions.

Antenatal Care

The care of a woman during pregnancy by doctors and midwives in order to predict and detect problems with the mother and unborn child. Advice is also offered relevant to the pregnancy and birth.

Aromatherapy

Massage with essential oils that can be beneficial. This should only be done under the guidance of a qualified therapist; some oils should not be used during pregnancy.

Audit

The evaluation of care against a standard, with the purpose of maintaining quality standards and where necessary, improving practice (see also clinical audit and medical audit).

Bag and Mask Resuscitation

Manual revival using an air-refillable bag and close fitting face mask to push air into the lungs.

Birth Plan

A written record of a woman's preferences for her care and that of her unborn child during labour and childbirth.

Caesarean Section

An operation by which the baby is delivered through an incision in the abdominal wall and uterus.

Chorionic villus sampling (CVS)

This can be carried out in a specialist centre around 11 weeks of pregnancy. A small sample of the developing placenta is tested for genetic conditions.

Client

A person who engages or receives advice or services of a professional person or organisation.

Clinical Audit

The assessment by groups of professionals of care they have provided against a standard, with the purpose of improving practice, where necessary, within the audited group.

Community Midwives

Midwives providing a maternity service to mothers and babies mainly outside of hospital.

Complicated Pregnancy

A pregnancy in which a risk of complication is evident or in which a complication occurs.

Consumer/ Customer

The user of the maternity services; the pregnant woman. This designation infers more rights in relationship to service providers.

Continuity of Care

Provision of care responsive to the individual needs of the woman irrespective of who delivers that care.

Continuity of Carer

Provision of care from one professional or a small group of professionals throughout the continuum of pregnancy and childbirth.

Domino Care

A model of maternity care in which women are taken into hospital in labour by their own midwife who delivers them and then transfers them home shortly after birth (Domino abr. "domiciliary in/out")

Down's Syndrome

A chromosomal problem which causes a baby to be born with severe learning difficulties.

Epidural Anaesthesia

A local anaesthetic injected around the spinal sac causing complete loss of sensation in the lower part of the body, to a level which allows a surgical procedure to be undertaken in that area without pain.

Epidural Analgesia

A local anaesthetic injected around the spinal sac causing some numbness in the lower part of the body. It relieves labour pains effectively.

Foetal: Of foetus.

Foetus: The unborn child.

Health District

A defined geographical area, within which health care services are purchased for the resident population by a district health authority or agent acting on behalf of the authority.

Health Inequalities

Inequalities in health outcomes. Generally refers to variations in health according to variations in socio-economic status.

Intervention

Clinical procedure in pregnancy or labour, for example induction of labour or delivery of a baby with the aid of instruments, or by caesarean section.

Intrapartum: During Labour.

Lead Professional

The professional who will give a substantial part of the care personally and who is responsible for ensuring that the woman has access to care from other professionals, as appropriate.

Link Worker

A person who acts as an advisor on healthcare issues, and in some cases will also provide interpreting services. A link worker will be able to communicate with the pregnant woman in her own language.

Maternity Hospital Episode System

A system of collecting statistics about the level and distribution of activity in the NHS maternity services. The statistics are collected by the Office of Population, Censuses and Surveys on behalf of the Department of Health.

MSLC - Maternity Services Liaison Committee

A local committee which brings together all the professionals involved in maternity care with lay representatives of the women who use the services, with the purpose of agreeing procedures and monitoring their effectiveness as they apply to women.

Maternity Unit

A building or group of buildings in which maternity care is provided. It can be located within or adjacent to a general hospital, or away from the general hospital.

Medical Audit

The assessment by doctors of medical care they have provided against a standard, with the purpose of improving practice, where necessary, within the audited group.

Midwife/GP Unit

A maternity unit in which midwives and/or general practitioners are the professionals leading the maternity care.

Miscarriage

A foetus expelled from the mother before the 24th week of pregnancy.

NICE – National Institute for Clinical Excellence.

A national body created to ensure every NHS patient gets fair access to quality treatment. It sets clear national standards of what patients can expect to receive from the NHS. It promotes clinical and cost effectiveness through guidance and audit to support front line staff.

NSF – National Service Framework

A national plan, including national targets, to address service improvements to address specific issues and service areas.

Named Midwife

A named, qualified midwife responsible for co-ordinating a woman's midwifery care.

Neonatal

The first 28 days of life in a baby.

NMUH: The North Middlesex University Hospital

Overview and Scrutiny Committee (OSC)

Overview and scrutiny committees are bodies established by local authorities, (under the Local Government Act 2000 Part II), responsible for the scrutiny of services provided by the local authority and other service providers within their area, now with specific powers under the Health and Social Care Act 2001 to scrutinise health services.

PALS - Patient Advice and Liaison Service

Services provided within all NHS trusts and PCTs to provide on the spot help and advice.

Patients' Forums

Facilitated groups where patients have a voice in service provision. Patients' Forums are now required for each NHS Trust.

PCT – Primary Care Trust(s)

Organisations which commission and in some cases provide health services for the population within their area, including acute and specialised services and family health services. They are responsible for the local health planning, public health at a local level, and have a budget reflecting their population's share of available resources for almost all local health care needs. They assess the needs of the local population and determine local targets and standards to improve quality and efficiency.

Perinatal

The time of birth and the first week of life.

Perinatal Mortality Rate

The number of stillbirths plus deaths in the first week of life per thousand total births.

Pharmacological Pain Relief

The relief of pain through the administration of drugs.

Physiological

In accordance with the natural functions of the body.

PPI: Patient and Public Involvement

Population Profile

The description of a population group which takes particular account of the characteristics of the people within it, such as age mix, general state of health, ethnic and social mix.

Postnatal

The period after birth of baby and placenta lasting up to 28 days.

Prenatal

During pregnancy: antenatal.

Professional

In the context of this report, professional usually refers to the general practitioner, the midwife and /or the obstetrician, but includes anaesthetists, paediatricians and other specialists as appropriate.

Provider: A hospital, NHS trust or unit providing maternity services.

Primigravidae: Women who are pregnant for the first time.

Puerperium: The 6 weeks immediately following childbirth.

Purchaser: A health authority or agent acting on behalf of the authority, to purchase health services for a local population.

Review

An ad-hoc time-limited scrutiny committee/panel that considers a specific topic commissioned by the Overview and Scrutiny Committee, under the arrangements for Overview and Scrutiny at the London Borough of Haringey (see Haringey Council Constitution).

Respiratory Distress Syndrome

A lung disorder which results in difficulty with breathing. It occurs in some babies born several weeks before term.

Serum screening

A blood test offered at 16-18 weeks of pregnancy to test for conditions such as spina-bifida and Down's syndrome.

Sickle-cell anaemia

An inherited blood disorder.

Stillbirth

A baby born dead after 24 completed weeks gestation.

Strategic Health Authority (SHA)

Re-named former Health Authorities with the role of performance managing NHS trusts and PCTs.

Stakeholder

A group or individual with an interest in an initiative, project or activity and its outcomes.

TENS machine

Transcutaneous electrical nerve stimulation machine

Thalassemia

An inherited blood disorder.

Toxoplasmosis

An illness caused by toxoplasma gondii, found in raw meat and cat faeces, that can affect pregnant women and sometimes the unborn baby.

Ultrasound scan

An image of the developing baby and placenta that is checked for wellbeing and accurate dating of the pregnancy.

User (service user)

A person who uses services, a client, consumer or customer.

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References

1. *Minutes of Council 3rd December 2001, the London Borough of Haringey*
2. *Kanta Patel North Middlesex University Hospital NHS Trust Maternity Services*
3. *Overview and Scrutiny of Health – Guidance, Department of Health, July 2003.*
4. *The Haringey Council Constitution, the London Borough of Haringey.*
5. *Kanta Patel North Middlesex University Hospital NHS Trust Maternity Services*
6. *Changing Childbirth, Report of the Expert Maternity Group, Department of Health, Crown Copywrite 1993 (extracts from P5)*
7. *Local Delivery Plan 2003-6, Haringey PCT NHS Trust.*
8. *First Class Delivery report.*
9. *Kanta Patel North Middlesex University Hospital NHS Trust Maternity Services*
10. *Bernadette Herbert, Whittington NHS Trust, Midwifery Services*
11. *"Keeping the NHS Local – a new direction of travel", Department of Health*
12. *Overview & Scrutiny Health – Guidance p.27- Department of Health*
13. *Choice in Maternity Services, House of Commons Health Committee, Ninth Report of Session 2002-03, Vol.1, published 23rd July 2003, the House of Commons London: Stationary Office Ltd.*
14. *First Class Delivery – Improving Maternity Service – England and Wales, The Audit Commission 1997*
15. *Haringey Teaching Primary Care Trust, evidence to the Review, Tuesday 25th March 2003*
16. *Memorandum by the Department of Health June 2003, cited as Appendix One, Choice in Maternity Services, Health Committee.*
17. *Choice in Maternity Services, House of Commons Health Committee, Ninth Report of Session 2002-03, Vol.1, published 23rd July 2003, the House of Commons London: Stationary Office Ltd.*
18. *Memorandum by the Department of health June 2003, sited as Appendix One, Choice in Maternity Services, Health Committee.*
19. *Memorandum by the Department of Health June 2003, sited as Appendix One, Choice in Maternity Services, Health Committee.*
20. *First Class Delivery – Improving Maternity Service – England and Wales, The Audit Commission 1997*
21. *Changing Childbirth, Report of the Expert Maternity Group, Department of Health, Crown Copywrite 1993, House of Commons Health Committee report Choice in Maternity Services*
22. *Modernising Maternity care, A Commissioning Toolkit for Primary Care trusts in England, published by the Royal College of Obstetricians and Gynaecologists 2001.*
23. *Report of the Northern Region Home Birth Survey 1993. Northern & Yorkshire Health Authority*
24. *"The GP's guide to home birth" [Oct 1996; 32-8]*
25. *Sevilay Kazim, PALS, North Middlesex University Hospital*
26. *Identified by Kanta Patel (NMUH) as main minority languages at NMUH, 5/03/03, (Evidence to the Review).*
27. *Changing Childbirth, Report of the Expert Maternity Group, Department of Health, Crown Copywrite 1993.*
28. *The Commissioning Toolkit, Modernising Maternity Care, a Commissioning Toolkit for Primary Care Trusts in England*
29. *The North Middlesex NHS Trust and the Whittington NHS Trust*
30. *Kanta Patel, The North Middlesex NHS Trust).*
31. *the RCM's position paper on Home Birth (REF. position paper 25*
32. *Access to Primary Care the joint London Assembly and Mayor of London Scrutiny Review 2003*
33. *Changing Childbirth: Report of the Expert Maternity Group, Department of Health, The Stationery Office, 1993, p 14 and 17*
34. *The Audit Commission study First Class Delivery – Improving Maternity Services in England and Wales (Ref!-34) (published 1997, p15 -35).*
35. *House of Commons Health Committee report, 2003*

36. *The Commissioning Toolkit, Modernising Maternity Care, a Commissioning Toolkit for Primary Care Trusts in England*
37. *Government guidance on Section 11 of the Health and Social Care Act 2001, issued in May 2003*
38. *Changing Childbirth, Report of the Expert Maternity Group, Department of Health, Crown Copyright 1993 (Choice in Maternity Services, Health Committee, p. 32)*
39. *NCC, Involving Consumers in Health Care, September 2002, available on the CHI website*

Bibliography

1. Changing Childbirth, Report of the Expert Maternity Group, Department of Health, Crown Copyright 1993.
2. Choice in Maternity Services, House of Commons Health Committee, Ninth Report of Session 2002-03, Vol.1, published 23rd July 2003, the House of Commons London: Stationary Office Ltd.
3. From Here to Maternity, Health Service Journal, 22nd August 2002
4. Inequalities in Access to Maternity Services, House of Commons Health Committee, Eighth Report of Session 2002-03, published 23rd July 2003, the House of Commons London: Stationary Office Ltd.
5. Modernising Maternity care, A Commissioning Toolkit for Primary Care trusts in England, published by the Royal College of Obstetricians and Gynaecologists 2001.
6. Why Mothers Die 1997-1999, The Confidential Enquiries into Maternal Deaths in the United Kingdom, published by the Royal College of Obstetricians and Gynaecologists 2001.
7. Modernising Maternity Care – a commissioning toolkit for Primary Care Trusts in England, London: Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, National

Appendix

Appendix One – Key Stakeholders

Appendix Two – Evidence to the Review

Appendix Three - Women Giving Birth in Haringey

Appendix Four – Review Survey Questionnaire

Appendix Five – Haringey Residents' Country of Origin

Appendix Six – The Nine Principals of Public Service Delivery

Appendix One

Key Stakeholders

- ❖ The North Central London Strategic Health Authority
- ❖ Haringey Teaching PCT - Commissioner of Maternity Services
- ❖ The Barnet, Enfield and Haringey Home Birth Campaign
- ❖ Midwifery Services at respective hospitals
- ❖ G.P.s
- ❖ Obstetricians
- ❖ Paediatricians
- ❖ Mother & Baby Clinics
- ❖ Maternity Services Liaison Committee
- ❖ Services Users (general)
- ❖ Asylum Seekers Service
- ❖ African Women's Welfare Group

Appendix Two

Evidence to the Review

The following organisations, representatives of organisations and individuals presented oral and written evidence to the Review. Interviews with key witnesses were held in order to receive evidence on technical/operational issues, from service providers, policy makers, comparisons and examples of best practice elsewhere and customer feedback.

Witness		Organisation
<i>anonymous witnesses</i>		Asylum Seekers Service
Gail McConnel (Chair)		Barnet, Enfield and Haringey Maternity Services Liaison Committee
David Sloman,	Chief Executive, <i>HTPCT</i>	Haringey Teaching Primary Care Trust
Mandy Ansell,	Deputy Dir Planning & Commissioning, <i>HTPCT</i>	Haringey Teaching Primary Care Trust
Dr. Anne Marie Connally,	Dir Health Improvement, <i>HTPCT</i>	Haringey Teaching Primary Care Trust
Mrs. Jackie Langford,	Dir Planning & Commissioning, <i>HTPCT</i>	Haringey Teaching Primary Care Trust
Ms. Tessa Thomas		The Home Birth Campaign
<i>anonymous witnesses</i>		Morum House Surgery, Mother & Baby Clinic
<i>anonymous witnesses</i>		Mothercare department store
Ruth Brown		National Childbirth Trust
Rose Gibb	Chief Executive	North Middlesex University Hospital
Barbara Beale	Dir Nursing & Patient services	North Middlesex University Hospital
Bernadette Herbert	Divisional Manager Women and Children's Services	Whittington Hospital
Kanta Patel		North Middlesex University Hospital
PALS	Focus Group of Midwives	North Middlesex University Hospital & Whittington Hospital
Miss Francis Evans	Obstetrician (birth operations)	North Middlesex University Hospital
Margaret Hill	Home Birth Team	North Middlesex University Hospital
Sandra Vaughan	Home Birth Team	North Middlesex University Hospital
<i>anonymous witnesses</i>		Sure Start 16-20 Teenage Pregnancy Group
<i>anonymous witnesses</i>	focus group of midwives	Whittington Hospital
Ben Brown	Assistant Director	Asylum Service, The London Borough of Haringey
<i>anonymous witnesses</i>		African Woman's Welfare Group
<i>anonymous witnesses</i>		(Orthodox Judaism)

Appendix Three

Birthplace of Haringey residents (Hospital deliveries only)

<i>Trust Name</i>	<i>Financial Year</i>	
	<i>01/02</i>	<i>02/03</i>
<i>Barnet General Hospital</i>	<i>57</i>	<i>50</i>
<i>Chase Farm Hospital</i>	<i>88</i>	<i>74</i>
<i>University College Hospital</i>	<i>127</i>	<i>143</i>
<i>Homerton Hospital</i>	<i>171</i>	<i>194</i>
<i>North Middlesex Hospital</i>	<i>1545</i>	<i>1519</i>
<i>Royal Free Hospital</i>	<i>238</i>	<i>216</i>
<i>Whittington</i>	<i>1235</i>	<i>1222</i>
<i>Grand Total</i>	<i>3461</i>	<i>3418</i>

Haringey TPCT Patients only source: ONS Birth File (Haringey Teaching Primary Care Trust)

Women giving Birth in Haringey by ethnicity:

North Middlesex University Hospital NHS Trust

Ethnic Origin	Total	%
Black African	530	18.5%
Any other ethnic grp	494	17.2%
White British	394	13.8%
Turkish	363	12.7%
Black Caribbean	324	11.3%
Bangladeshi	105	3.7%
Not stated	94	3.3%
Turkish Cypriot	64	2.2%
Other White European	60	2.1%
White Irish	60	2.1%
Indian	58	2.0%
Greek Cypriot	56	2.0%
Somali	46	1.6%
Pakistani	39	1.4%
Any other Black b/g	37	1.3%
Any other Asian b/g	36	1.3%
Any other mixed b/g	24	0.8%
Chinese	23	0.8%
White and Black Ca	18	0.6%
(blank)	15	0.5%
Greek	10	0.3%
White and Black Af	9	0.3%
White and Asian	3	0.1%
Kosovan	1	0.0%
Croatian	1	0.0%
Albanian	1	0.0%
Total	2865	

Whittinton NHS Trust

Ethnic Origin	Home Birth	%	Hospital Birth	Total
Black African	2	1.60%	123	125
Any other ethnic grp	4	3.50%	109	113
White British	23	8.30%	254	277
Caribbean			106	
Bangladeshi			28	
Not stated	12	2.80%	414	426
White Irish	1	5.30%	18	19
Indian			21	21
Pakistani			9	9
Any other Black b/g			15	15
Any other Asian b/g			24	24
Any other mixed b/g			7	7
Any other "white" b/g	2	2.20%	90	92
Chinese			6	6
Total			1224	

Deliveries at Whittinton NHS Trust by Ethnicity of Mother - excluding "Not Stated".

MATERNITY SERVICES QUESTIONNAIRE

The purpose of this questionnaire is to find out about women's experiences of maternity services. Individual details will be treated as confidential.

The findings of this Review will help contribute to the Scrutiny Review of Maternity Services being carried out by Haringey Council to help improve maternity services for Haringey residents.

NAME	
ADDRESS	
POST CODE	
<i>this information is optional.</i>	
About You & Your Baby	
When did you give birth to your baby? month year.....	How old is your baby? <input type="radio"/> 0-3 months <input type="radio"/> 4-6 months <input type="radio"/> 7-12 months <input type="radio"/> +13 months
Where did you give birth to your baby? <input type="radio"/> The Whittington Hospital <input type="radio"/> The North Middlesex <input type="radio"/> At Home <input type="radio"/> Other... (please give details)	

Information and Choice	
<p>Were you given a choice as to where to give birth to your baby?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p>	<p>Do you think you were provided with enough information to allow you to make informed choices about:</p> <p><input type="radio"/> Where to have your baby delivered</p> <p><input type="radio"/> options for pain relief (during labour)</p> <p><input type="radio"/> Tests available to be carried out during pregnancy</p>
<p>Do you think you were provided with enough information about the maternity services locally – what to expect and who delivers the service?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p>Comment.....</p>	<p>If English is not your first language, was all information available to you in your language?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p>
<p>Did you experience any particular communication difficulties during your pregnancy? (please give details)</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	<p>Are you satisfied with the degree of personal care you received, the extent to which care was tailored to your personal needs?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p>
Continuity of Care	
<p>Were you able to get to know the midwives supporting you prior to labour?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p>	<p>Were there any periods of time during your pregnancy that you felt that care was not as good as other at times?</p>

Quality of Services Throughout

How would you rate the maternity services received from:

Your GP

- Excellent
- Good
- Satisfactory
- Poor
- Dismal

Your midwifery team leading up to pregnancy

- Excellent
- Good
- Satisfactory
- Poor
- Dismal

During Labour

- Excellent
- Good
- Satisfactory
- Poor
- Dismal

Post-natal Care

- Excellent
- Good
- Satisfactory
- Poor
- Dismal

Were you at any time invited to give your views of the maternity services you received:

- Yes
- No

If yes – how were you invited to give your views?

- feedback questionnaire
- informal feedback session
- verbal feedback
- other

From your experience, what are the strengths and weaknesses of maternity services in Haringey?

Overall rating

- Excellent
- Good
- Satisfactory
- Poor
- Dismal

How do you think you maternity care could have been improved?

.....
.....

Your Background (Respondents Ethnicity)

Please provide us with an indication of your ethnicity. This information will help us to determine if we have talked to a cross section of people.

Would you describe yourself as:

"White"

- British / English
- Irish
- Greek Cypriot
- Turkish
- Other "white".....

Asian or Asian British

- Indian
- Pakistani
- Bangladeshi
- East African Asian
- Other Asian

"Black" or "Black British"

- Caribbean
- African
- Other "black".....

Chinese or other ethnic group

- Chinese
- Other.....

Appendix Five

Haringey Residents' Country of Origin (Census Data)

TABLE UV08 COUNTRY OF BIRTH	
2001 Census: Standard Tables, © Crown Copyright	
Table population: All people	
Geographical level : Local Authority to England and Wales	
Cells in these tables have been randomly adjusted by ONS to avoid the release of confidential data	
Haringey	
ALL PEOPLE	216,507
Haringey	
Haringey	
Europe	163,513
Haringey	
United Kingdom	136,274
Haringey	
England	128,766
Haringey	
Scotland	3,497
Haringey	
Northern Ireland	1,586
Haringey	
Wales	2,319
Haringey	
UK Part not specified	106
Haringey	
Republic of Ireland	5,944
Haringey	
Channel Islands	122
Haringey	
Other Western Europe	8,506
Haringey	
EU countries	8,035
Haringey	
Austria	169
Haringey	
Belgium	197

Haringey	
Denmark	
	203
Haringey	
Finland	
	137
Haringey	
France	
	1,092
Haringey	
Germany	
	1,370
Haringey	
Greece	
	814
Haringey	
Italy	
	1,875
Haringey	
Luxembourg	
	8
Haringey	
Netherlands	
	278
Haringey	
Portugal	
	817
Haringey	
Spain	
	802
Haringey	
Sweden	
	273
Haringey	
Non EU Countries in Western Europe	
	471
Haringey	
Eastern Europe	
	12,667
Haringey	
Albania	
	64
Haringey	
Czech Republic	
	221
Haringey	
Romania	
	156
Haringey	
Poland	
	868
Haringey	
Turkey	
	8,589
Haringey	
Former Yugoslavia	
	1,604
Haringey	
Baltic States	
	180

Haringey	
Other European Counties in former USSR	460
Haringey	
Other Eastern Europe	525
Haringey	
Africa	19,226
Haringey	
North Africa	1,082
Haringey	
Central and Western Africa	7,869
Haringey	
Democratic Republic of Congo	667
Haringey	
Nigeria	2,680
Haringey	
Sierra Leone	483
Haringey	
Other Central and Western Africa	4,039
Haringey	
South and Eastern Africa	10,275
Haringey	
Kenya	1,026
Haringey	
Somalia	2,194
Haringey	
South Africa	1,722
Haringey	
Zimbabwe	509
Haringey	
Other South and Eastern Africa	4,824
Haringey	
Asia	18,086
Haringey	
Middle East	7,822
Haringey	
Cyprus	6,036
Haringey	
Iran	582
Haringey	
Iraq	274

Haringey	
Other Middle East	
	930
Haringey	
Far East	
	4,339
Haringey	
China	
	618
Haringey	
Hong Kong	
	725
Haringey	
Japan	
	596
Haringey	
Malaysia	
	434
Haringey	
Singapore	
	235
Haringey	
Other Far East	
	1,731
Haringey	
Asian countries in former USSR	
	66
Haringey	
South Asia	
	5,859
Haringey	
Afghanistan	
	186
Haringey	
Bangladesh	
	1,637
Haringey	
India	
	2,438
Haringey	
Pakistan	
	932
Haringey	
Sri Lanka	
	629
Haringey	
Other South Asia	
	37
Haringey	
North America	
	10,617
Haringey	
Canada	
	516
Haringey	
United States of America	
	1,186
Haringey	
Jamaica	
	5,384

Haringey	
Other Caribbean & West Indies	
	3,450
Haringey	
Other North America	
	81
Haringey	
South America	
	1,884
Haringey	
Oceania	
	2,238
Haringey	
Australia	
	1,303
Haringey	
New Zealand	
	892
Haringey	
Other Oceania	
	43
Haringey	
Other	
	943
Footnotes :	
1. The European Union as defined on Census day (29 April 2001)	
2. 'Other' consists of people born at sea or in the air; or with country of birth not stated.	
3. People born in Central America have been included in North America.	
Source: 2001 Census Standard Tables	
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The Nine Principles of Public Service Delivery

Every public service should:

Set Standards of Service

Set clear standards of service that users can expect; monitor and review performance; and publish the results, following independent validation wherever possible

Be Open and Provide Full Information

Be open and communicate clearly and effectively in plain language, to help people using public services: and provide full information about services, their cost and how well they perform

Consult and Involve

Consult and involve present and potential users of public services, as well as those who work in them; and use their views to improve the service provided

Encourage Access and the Promotion of Choice

Make services easily available to everyone who needs them, including using technology to the full, and offering choice wherever possible

Treat All Fairly

Treat all people fairly; respect their privacy and dignity; be helpful and courteous; and pay particular attention to those with special needs

Put Things Right When They Go Wrong

Put things right quickly and effectively; learn from complaints; and have a clear, well publicised, and easy-to-use complaints procedure, with independent review wherever possible

Use Resources Effectively

Use resources effectively to provide best value for taxpayers and users

Innovate and Improve

Always look for ways to improve the services and facilities offered

Work with Other Providers

Work with other providers to ensure that services are simple to use, effective and co-ordinated, and deliver a better service to the user.

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