What have maternity networks ever done for us?

Simon Jenkinson FRCOG
Consultant Obstetrician and Gynaecologist; and Lead Clinician, Staffordshire, Shropshire and Black Country Maternity Network, Department of Obstetrics and Gynaecology, Royal Wolverhampton Hospitals NHS Trust, New Cross Hospital, Wednesfield Road, Wolverhampton WV10 0QP, UK
Correspondence: Simon Jenkinson. Email: simon.jenkinson@nhs.net

Introduction

The question, ‘What have maternity networks ever done for us?’ anticipates an impressive list of effective contributions to the world of obstetrics attributable to managed, collaborative working. While maternity networks are a feasible solution to the challenges faced by present and future maternity services, their full potential has not yet been realised. An expectation that maternity services will naturally join forces across localities without commissioning input or regional strategic planning has discouraged their use and limited the extent of their work. High-quality, collaborative maternity services need commissioned, managed maternity networks to ensure that women receive the right treatment in the right place at the right time.

Ethical issues

How can we ensure that maternity services meet the demands of women and families?

Keywords care pathways / Department of Health / European Working Time Directive / funding / neonatal services

How did we get here?

The UK model of maternity care has undergone significant change over the last 20 years. While individual hospitals have in the past provided all the care needed by women throughout pregnancy and by their newborn babies, maternity units are now differentiated by the level of care they are able to provide and women are transferred accordingly.

The report of the Department of Health expert group into the provision of neonatal services in 2003¹ made two main recommendations:

- Care should be provided across managed clinical newborn networks.

- Within each network units should have a level of care designation ranging from routine care up to neonatal intensive care (level 3 units). When extreme prematurity is anticipated, mothers should be transferred, with their babies in utero if possible, to an appropriate unit within the network.

This new model is supported by evidence suggesting a significant improvement in outcome for preterm infants transferred in utero to larger centres focusing on low-volume, high-technology care.²–⁴ At the same time, advances in fetal and maternal medicine have been concentrated in larger units or perinatal centres. Smaller units often refer maternity cases to these centres for diagnostic or therapeutic services.

Minimum training standards and shorter, more structured training times⁵ have been introduced for doctors in training, together with a reduction in working hours (the New deal⁶/European Working Time Directive). These changes have meant that some smaller units which have relied in the past on long working hours and extensive service provision from a small junior doctor establishment have had to scale down or cease obstetric services altogether.

All this has led to a need for more collaboration between units over wide geographical areas and there are implications for staffing, skill mix and training for individual maternity units collaborating within such a network of units.

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**What are we trying to achieve?**

In 2004 the National Service Framework for Children, Young People and Maternity Services set out a vision for maternity networks as linked groups of professionals working together to ensure equitable provision of high-quality, clinically effective care.

Knowing which path to follow, and who is responsible for providing what, will help to reduce clinical variation, eliminate duplication of services, maintain quality of care and adherence to clinical or other guidelines and give professionals agreed control over the care of the delivery process.

In 2007, in the *Maternity Matters* report it was stated that women and families should be offered a choice of antenatal care and type and place of birth, depending on their circumstances (Figure 1).

Development of maternity, neonatal and perinatal mental health networks will ensure that all women and their babies have equitable access to the whole range of more specialist services where necessary and can be readily transferred via ambulance should any possible complications or emergencies arise.

In 2007, the Royal College of Obstetricians and Gynaecologists, in conjunction with the Royal College of Midwives, the Royal College of Anaesthetists and the Royal College of Paediatrics and Child Health, published *Safer Childbirth,* an updated set of standards for obstetric care. This fresh look at the organisation of care in labour introduced minimum staffing levels for consultant and middle grades on labour wards and made recommendations that would make it difficult in the future for smaller units to continue to provide a full range of services safely. Maternity networks were presented as key in helping maternity services to achieve these standards.

A maternity network, which includes births at home, in midwifery units and in obstetric units, should have a common governance structure, including robust systems and clear guidelines for monitoring the safety, quality and performance of the maternity services and transfer arrangements within the network should problems arise.

**How did maternity networks begin?**

Maternity services were faced with government objectives of greater clinical effectiveness, improved quality and increased choice for women and families, plus a demand for higher standards in maternity care, and presented with local alliances of maternity health professionals as the solution. Thus, maternity networks were developed. Without the support of a strategic framework, however, their development has been somewhat restricted. There is no single maternity network model, but somewhat isolated groups of collaborating clinicians with objectives derived from sometimes limited local perspectives, with little opportunity to share their successes on a national stage. Maternity networks were developed in a variety of circumstances but, in many cases, are now struggling for survival.

**What do maternity networks do?**

The nhsnetworks website (see Websites) lists 22 networks with an interest in maternity care. In some cases, this interest has a specialist focus. Fetal medicine research, smoking cessation, maternity risk management, midwifery standards and HIV in pregnancy are among those topics that have networks devoted to them. Twelve of those listed are networks of local maternity services aimed at facilitating collaborative solutions to the challenges of modern day maternity care.

The common themes of work for all of these local networks are:

- obstetric collaboration with neonatal services
- common agreement on care pathways
- shared learning and training.

The Staffordshire, Shropshire and Black Country (SSBC) Maternity Network sits within the SSBC Newborn Network. It covers one-third of the West Midlands, a large region with the highest perinatal mortality rates in the UK. Across the six units that constitute the SSBC Network there are approximately 26 000 births annually. The network was proposed in 2005 following a series of stakeholder consultation events. In 2006, European Working Time Directive money funded a project team which was given the task of scoping the impact of the European Working Time Directive and facilitating the development of clinical care pathways across local maternity services. The project team established working groups which focused on in utero transfer protocol and the patient experience, workforce planning and collaborative work on clinical guidelines and audit.

**How are they funded?**

Unlike their neonatal counterparts, maternity networks are funded in a somewhat ad hoc way. Newborn networks were established following recommendations from the Department of Health’s 2003 National Strategy for Improvement. As the way forward for neonatal care, they were allocated funding through specialist commissioning using national resources. The national recognition that maternity networks are a vital part of perinatal service planning has never been accompanied by allocated resources. When available, funding has, therefore, happened locally, from a variety of sources with a range of interests. There is no standard model of maternity networks and no guarantee that any of the existing networks will continue.
Since 2007, the SSBC Maternity Network has been funded through the SSBC Newborn Network. This has been a temporary arrangement which has enabled the development of the already established network. Future funding, however, is uncertain.

**How should they be funded?**

The concept of a managed clinical network implies a funded clinical network established to meet local maternity needs. This needs to be a locally commissioned service with a service level agreement setting out the expected outcomes and collaborative activities in alignment with the strategic planning of the local strategic health authority. *Maternity Matters* advocates a responsibility to develop high-quality maternity services. The role of primary care trusts (PCTs) is to 'commission high-quality, equitable, integrated maternity services as part of local networks according to local need'. It falls to strategic health authorities to 'provide strategic leadership to assist PCTs in the development of the local vision for local maternity services, the development of networks and of user involvement'.

**What could they do?**

Managed clinical care entails the provision of all maternity services within a network area according to a locally agreed care pathway. In the Staffordshire, Shropshire and Black Country area, for example, this could mean, perhaps, there being one network for directing or managing the care pathways of 26 000 women. A maternity network would be designed according to the needs of the local population. This would, typically, include a number of small units providing local care to most women, with one or two larger units for high-risk cases. Maternity services would be planned according to clear care pathways, ensuring the capability and capacity for high-quality care. Such collaborative work opens up a range of possibilities for workforce planning and solutions to the training of junior doctors. There is also a clear potential for comprehensive data collection and collaborative audit.

**Websites**

nhsnetworks [www.networks.nhs.uk]

**References**


