



> Postnatal care funding

The case for better resourced maternity care



The message we are getting from our members is clear. We must do something to address the state of postnatal care. That's what our campaign Pressure Points is all about. Presenting the evidence and making a case for better provision of postnatal care – enabling midwives, maternity support workers and student midwives to give women and their families the care that they deserve.

This report focuses on **postnatal care funding**. Over the last year, we've been focusing on different Pressure Points and demonstrating how they can be eased by funding more midwives. This report is the final in the campaign, so also summarises the main issues in the previous four reports. One thing is certain – our members cannot continue to paper over the cracks in an underfunded and under-resourced postnatal environment, without there being detrimental effects on the health of women, children and the over-stretched maternity teams who are crying out to be given the tools to support them.

Cathy Wannick

Chief Executive,
Royal College of Midwives

Pressure Point 5 Postnatal care funding; the background

The Pressure Points campaign has highlighted shortcomings in postnatal care across the UK in four key areas - maternal mental health, 24 hour signs & symptoms, infant feeding and postnatal care planning.

Throughout each report we have demonstrated that services are poor in each area because of a lack of resources. This report explores this theme in more depth. It argues that there are too few midwives to deliver high quality care across maternity services and that a lack of funding is preventing providers from addressing this.

The lack of resources for postnatal care has two aspects. The first is the underfunding of maternity services and the NHS more generally. The second is how the resources that are available are divided up between the different parts of maternity care.

Both of these must be addressed to ensure that there are enough midwives to provide women with the care they need in the crucial postnatal period.

Maternity care is funded differently across England, Wales, Scotland and Northern Ireland. How, and the extent to which, postnatal care is underfunded, therefore varies across these countries. This report briefly reviews the four pressure points in postnatal care previously identified by the RCM, then focuses on England, where the lack of funding and the shortage of midwives are most acute.

Reviewing the pressure points

Between September and November 2013 the RCM surveyed our midwife, maternity support worker and student midwife members across the UK. We then asked the mothers at www.netmums.com for their experiences within the postnatal care period. These are the results.



Midwives



MSWs



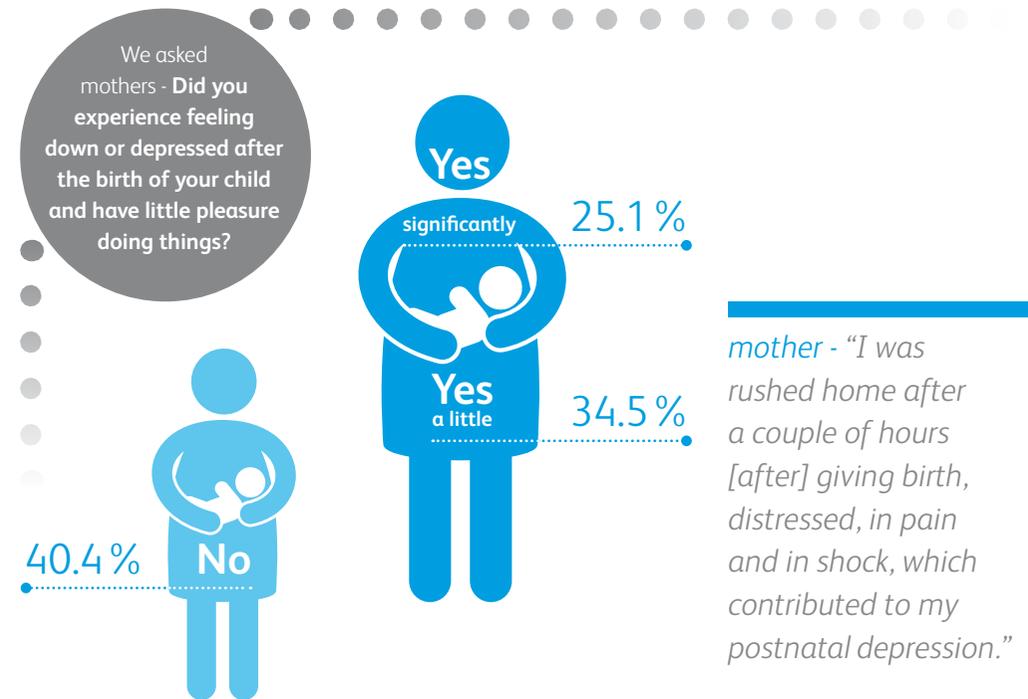
Student Midwives



Mothers

> Pressure Point 1: Maternal mental health

Most women (60%) experience feeling down or depressed after giving birth. Midwives need to assess the emotional wellbeing of women and be on hand to provide support, and interventions where needed. However, only 40% of midwives and MSWs thought that there is usually enough time and resources to support women with their emotional wellbeing. 40.6% said they find it quite or very difficult to make a referral to maternal mental health services.

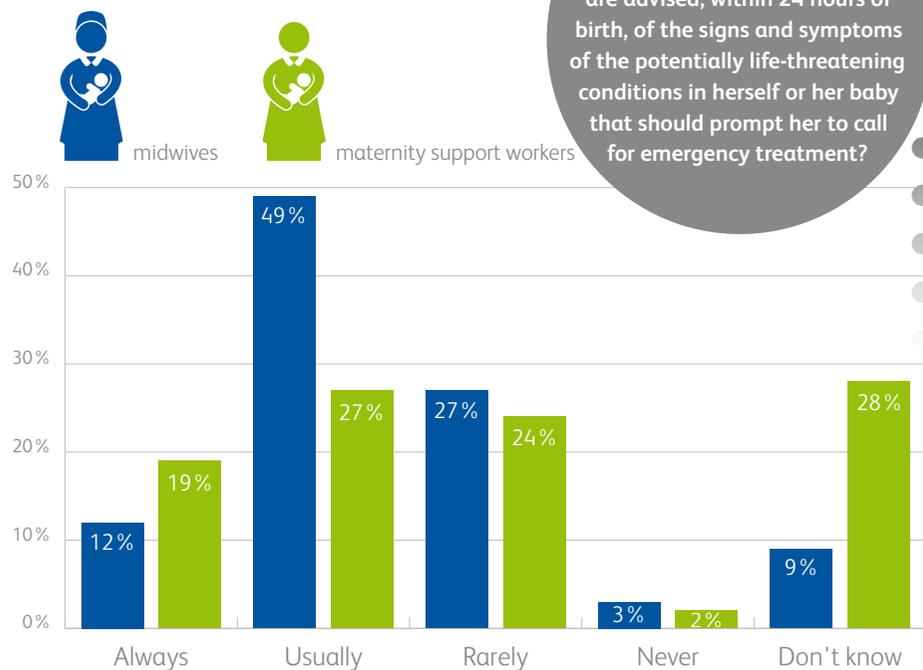


Our recommendations:

- Education commissioners and providers should review pre-registration and CPD courses for appropriate coverage of perinatal mental health issues.
- Commissioners and providers should develop perinatal mental health strategies.
- Providers should employ at least one specialist perinatal mental health midwife per unit.
- More 'mother and baby units' should be established.

> Pressure Point 2: 24 hour signs & symptoms

The first 24 hours after birth is a crucial time for mothers and babies. Women must know how to spot any signs and symptoms that could indicate a life threatening condition, and who to contact if they see anything wrong. Unfortunately, 30% of midwives thought that women were never or rarely advised of potentially life-threatening signs and symptoms within 24 hours of birth. Only 24% of women were confident that they had been told about these signs and symptoms.

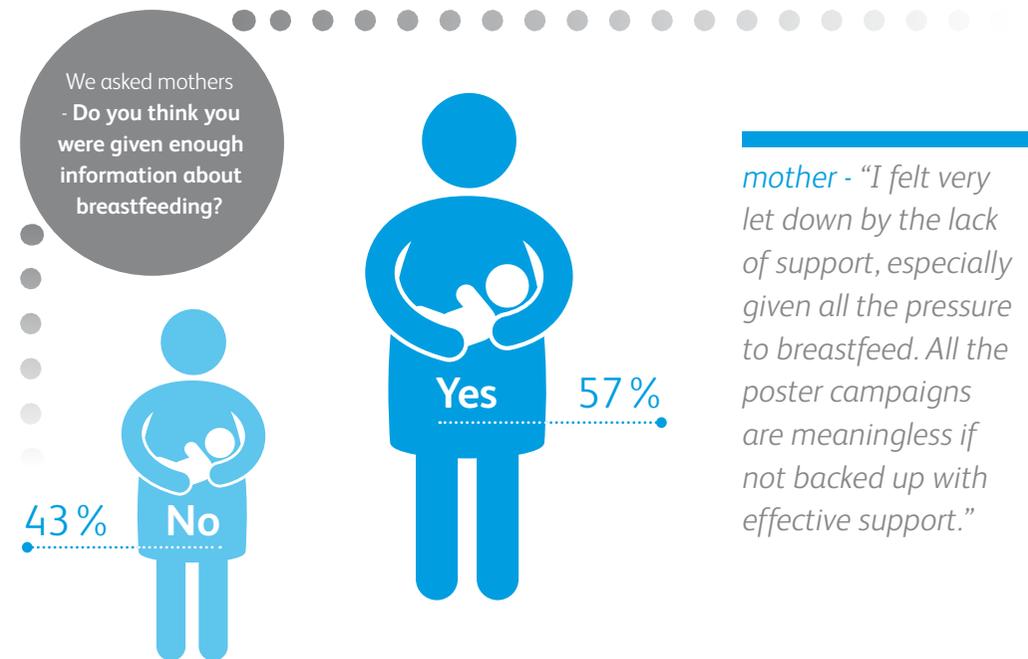


Our recommendations:

- Providers need to recruit enough midwives and MSWs to reduce shortages and to ensure staff have the time to give women vital information.
- Providers must ensure that midwives have 'protected time' to keep updated on national standards and guidelines.
- Midwives should be entrusted to make clinical decisions about the most appropriate level of postnatal visiting.

> Pressure Point 3: Infant feeding

Women should be encouraged to initiate breastfeeding as soon as possible, and be offered skilled breastfeeding support. Women who want to use formula milk should be taught how to do this correctly. However, only around 70% of midwives thought that there was usually enough time to support mothers with latching on and positioning for breastfeeding. Only 57% of mothers thought that they were given enough information about breastfeeding.

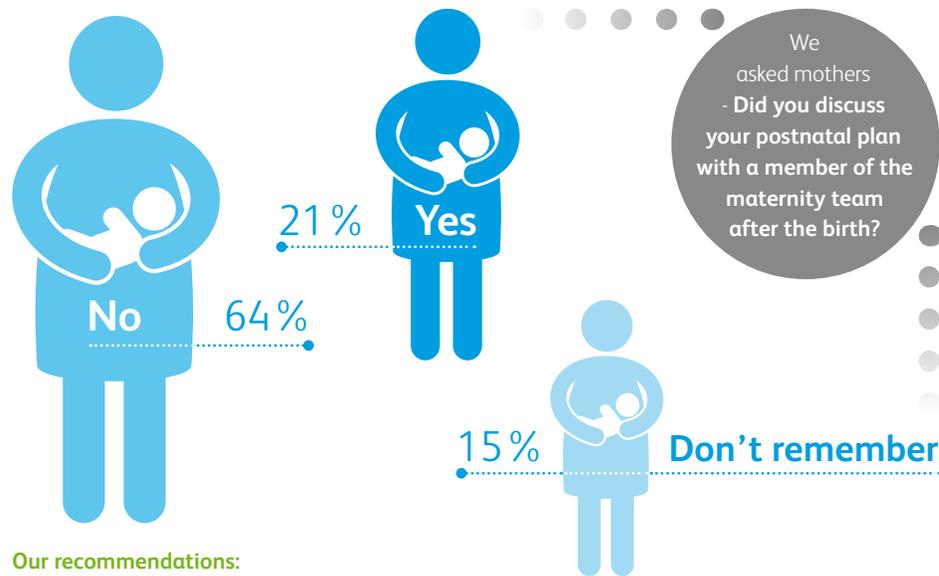


Our recommendations:

- Providers and commissioners should recruit more midwives.
- Providers and commissioners must ensure all parents who have chosen to bottle-feed are shown how to make up formula feed safely.
- Providers and commissioners should support all women equally regardless of their infant feeding method.
- Midwifery education institutions should ensure that student midwives have the competencies needed to help women feed their babies.
- Midwifery education institutions should ensure that course content clarifies the Unicef Baby Friendly Initiative standards.

> Pressure Point 4: Postnatal care planning

For each woman an individualised and documented postnatal care plan should be developed. This should address relevant factors in her care to date, details of the professionals involved in her care, and plans for care in the postnatal period. The plan should be reviewed at each postnatal contact. However, only 21% of mothers said that they discussed their postnatal plan with a member of the maternity team after their birth. Only 35% of midwives and MSWs think that there is usually enough time to review a woman's postnatal care plan.



Our recommendations:

- Providers and commissioners must ensure postnatal services are consistent with NICE quality standards.
- Providers must ensure that midwives and MSWs are given time to prioritise postnatal care planning with women.
- Postnatal care planning should enable women to take part in the decision and to make genuinely informed choices.
- Midwives should be entrusted to make clinical decisions about the number of postnatal contacts, in line with women's and babies' needs.
- Commissioners must enable midwives and MSWs to prioritise continuity of care.
- Providers must adequately disseminate relevant NICE guidance and ensure that midwives are absorbing the key recommendations.

> Pressure Point 5: Postnatal care funding

Maternity care is funded differently in England, Wales, Scotland and Northern Ireland. Only England publishes detailed information about how services are funded. Evidence, such as our RCM State of Maternity Service report, shows that staffing shortages are most severe in England. For this reason, the remainder of this report focuses specifically on England.

Since 2008, poor economic performance in the United Kingdom has hit government finances. This means that the governments in England, Wales, Scotland and Northern Ireland have had less income to spend on public services. Funding for the NHS has, however, remained relatively stable and has even increased a little. Across the UK, spending on the NHS is a little over £130 billion per year.

Although funding has remained at a similar level, the demands on the NHS continue to grow. People are living longer with more complex conditions. New treatments are constantly being developed and the NHS must keep up with these. In maternity services, the number of babies being born has increased rapidly and women have increasingly complex care needs.

The proportion of NHS funding that goes to maternity has also remained largely consistent, at just under 3%. In 2012/13, Primary Care Trusts in England (the predecessors of Clinical Commissioning Groups) paid £2.58 billion for maternity services, or £3,500 per birth. However, there are worrying signs that this money is not enough to meet the demands on maternity services.

2012/13

Maternity services funding

NHS

Primary Care Trusts in England in 2012/13



just under 3%

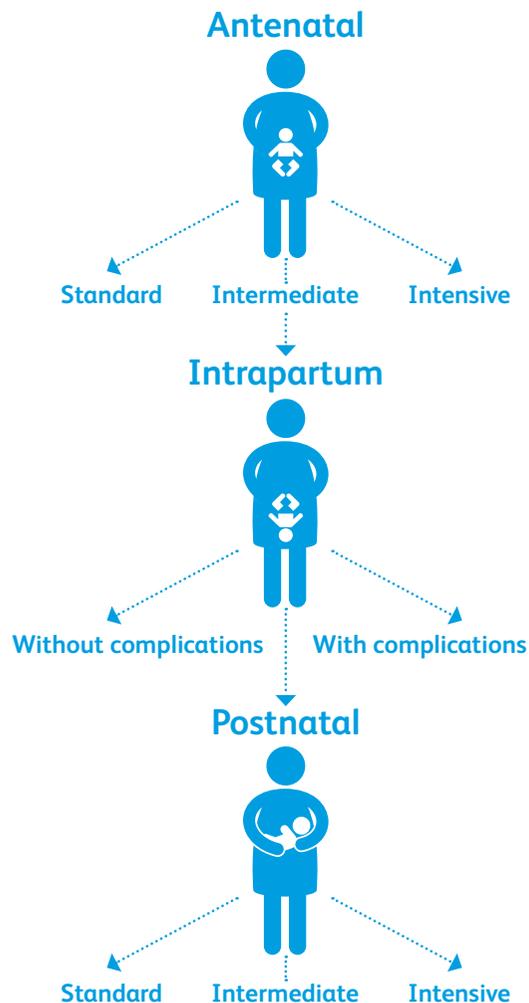
£2.58 billion
or £3,500 per birth

Maternity services funding in England

In England, maternity services are funded under the 'maternity pathway payment system', which is part of Payment by Results. Clinical commissioning groups pay providers (predominantly NHS and Foundation trusts) separately for the antenatal, intrapartum and postnatal aspects of each woman's care.

The maternity pathway payment system has a tariff which pays providers depending on the specific care needs of women. Commissioners pay providers more for women who have more complex care needs.

There are additional complicating factors in how maternity services are funded. For example, commissioners are able to negotiate 'local variations' with their providers to reflect specific local circumstances. Additional funds for specialist, capital and public health services related to maternity care reach providers by other channels. However, the tariff is by far the largest and most important element of maternity service funding.



Are maternity services and postnatal care underfunded?

Because of the complexities of healthcare funding and accounting, there is a lack of unambiguous evidence that there is not enough money in maternity services. However, there are numerous indicators that strongly suggest that maternity services, and postnatal care in particular, are underfunded.

> Indicator 1: there are not enough midwives

More births and more demands on midwives' time have created a large shortage of midwives in England. Training more midwives and deploying staff more effectively has reduced this shortage in recent years. But the RCM's latest estimate is that England still needs 3,200 more midwives working in the NHS to provide every woman with high quality maternity care. Making matters worse, the midwifery profession is facing an upcoming 'retirement bulge' in the coming decades. This will see the rate at which highly skilled and experienced midwives leave the profession accelerate.

Number of live births in England

Year	Live births
2001	563,744
2002	565,709
2003	589,851
2004	607,184
2005	613,028
2006	635,748
2007	655,357
2008	672,809
2009	671,058
2010	687,007
2011	688,120
2012	694,241
2013	664,517

One of the key constraints on the midwifery workforce is a lack of funding. Although it is commissioners that pay for training places at universities, it is providers who must pay to hire midwives when they graduate. When the RCM surveyed heads of midwifery in 2012/13, 34% reported that a lack of money was locking in staff shortages.

As an illustrative example, in April 2014, the CQC made an unannounced inspection of maternity services at Liverpool Women’s NHS Foundation Trust. The CQC issued the trust with a warning notice on the grounds that there were not enough midwives to provide 1:1 support to women in labour. The trust had previously been aware of this issue – five days before the inspection the trust’s Board of Directors had received an internal report raising the same concerns. However, this report stated that the needed level of staffing is “unaffordable within [the maternity] tariff”.

student midwife - “The discharge chat is always rushed as the midwives are always pressed for time.”

mother - “Definitely feel that staff are under huge stress and the quality of care is affected.”

midwife - “I always feel I’m pushed for time. I am frustrated that I’m not always able to deliver the standard of care that women require and deserve.”

mother - “I feel that it wasn’t the midwives’ fault that I didn’t receive much help but the fact is the hospital was so short on midwives they were pulled in all directions.”

> Indicator 2: providers spend more than commissioners pay

For the 2012/13 financial year, commissioners (then primary care trusts) reported spending £2.58 billion on maternity services. For the same year, providers reported spending £2.92 billion. The gap between these – at £340 million – is the largest it has been in the four years of data we have. Because the figures come from different sources and use different accounting systems, we cannot make strong conclusions from this. However, the figures do suggest that providers have to spend more on maternity care than they are being paid. Some providers – for example those delivering expensive specialist fetal medicine – will be taking on a bigger share of this burden than others.

Commissioning and spending on maternity from 2009/10 to 2012/13

	Maternity expenditure (at 2012/13 prices)	Maternity commissioning (at 2012/13 prices)	Difference
2009/10	£2,778,383,326	£2,553,100,163	£225,283,162
2010/11	£2,856,184,502	£2,617,583,559	£238,600,944
2011/12	£2,939,104,045	£2,649,297,260	£289,806,786
2012/13	£2,922,608,761	£2,583,000,000	£339,608,761

Maternity underfunding is one aspect of wider underfunding in the NHS. Rising deficits amongst NHS providers indicate that across all areas of care, trusts have to spend more than they are being paid to keep up services. In the first quarter of 2014/15, for example, trusts ran up a deficit of almost £500 million. Over two-thirds of hospital trusts were in deficit over this time.

> Indicator 3: funding per birth is not increasing

Maternity services are facing growing demands in terms of more complex births and are expected to deliver a wider range of interventions. Despite these demands, the amount of funding going to maternity services has not increased. In fact, the amount of funding fell in real terms by about £33 pounds per delivery – that’s the equivalent of one less postnatal care visit for every second women. Providers are spending a little bit more on maternity care, but most of this is being spent on the delivery – and not on postnatal care.

midwife - “Lack of staff and money has led to a fragmented service.”

Commissioning and spending on maternity, per birth

	Maternity expenditure (at 2012/13 prices)	Maternity commissioning (at 2012/13 prices)
2010/11	£4,304	£3,944
2011/12	£4,361	£3,931
2012/13	£4,426	£3,912

mother - “During labour and birth the midwives were fantastic. Once on the ward though I was left to it.”

midwife - “Women are discharged inadequately prepared because the hospital is grossly understaffed.”

> Indicator 4: only a small proportion of funding goes to postnatal care

On the face of it, the amount that commissioners are paying for postnatal care seems very small. For a woman with the most routine care needs, a commissioner pays a provider only £237 for her postnatal care. This is only 8.5% of the total amount paid for her maternity care. This increases to 13.8%, or £805, for a woman with the most complex care needs throughout her maternity. Certainly, when compared against what is expected of midwives and MSWs in NICE and other guidance, the amount seems woefully inadequate.

How much do commissioners pay for maternity care?

	For a woman with the most basic needs	For a woman with the most complex needs
Antenatal	£1,060	£2,822
Labour & delivery	£1,496	£2,188
Postnatal	£237	£805

It is not possible to tell precisely how much providers are actually spending on postnatal care relative to other parts of maternity care. However, on average, at least 7.5% of trusts’ spending is on postnatal care.

How much do trusts spend on maternity care?

	Spending per birth
Other maternity (spent across all aspects of maternity care)	£877
Intrapartum	£2,203
Antenatal	£1,015
Postnatal	£331

Can maternity services cope with less funding?

Many public services are facing reduced funding. In the so-called era of austerity, services need to ‘find efficiency savings’ or ‘improve productivity’. It is undoubtedly true that maternity services need to become more efficient.

The RCM strongly supports efforts to make this happen. We support moving more care to the community. We support reforming insurance arrangements for maternity care providers, which make up nearly one-fifth of their costs. We support delivering more public health interventions that reduce treatment costs in the future. We support moving care to midwife-led models of care which deliver excellent outcomes and are much more cost efficient.

But there are limits on how quickly maternity services can become more efficient. Shifting care into the community and opening new midwife-led units takes many years of planning, public consultation and service reconfiguration. The opportunities for ‘quick-wins’ are slim. There are also the ‘red herrings’ of apparent savings that shift the costs of provision onto others, lower care quality and do long term damage to the NHS. This includes the reallocation of staff away from postnatal wards, birth centres and home birth services to ensure essential cover on labour wards. This in particular is a major driver of the problems in postnatal care that have been identified in this campaign.

It includes sending women home too early, only for them to be readmitted with preventable problems later on. It includes making staff skip their breaks and work unpaid overtime. It includes not giving NHS staff pay rises that cover the increasing costs of living. These changes save money for trusts and the government, but they do so at a tremendous cost for staff and the women they care for.

Unfortunately, the way maternity services are funded is driving providers to pursue these false economies instead of investing in long-term sustainable solutions. A particular problem is the use of an ‘efficiency factor’ in the annual calculation of the maternity tariff. The efficiency factor is a set percentage by which the amount of funding decreases each year. This drives providers to find short-term cost-reductions rather than long-term productivity gains. The King’s Fund has recently labelled the efficiency factor as a ‘shoot first, ask questions later’ approach. What is needed instead, is funding that is sufficient to meet the on-going costs of delivering high quality care and new capital investment to support service

How do we fix this?

There is no magic amount of money that would make everything better.

A concerted effort across the system is needed to ensure that midwives and MSWs have the resources and time needed to deliver excellent postnatal care.

- NHS England and Monitor (an NHS regulator) must review the costs of maternity care and adjust the size and allocation of the maternity payment tariff in England. Our evidence clearly shows that current funding levels are not sufficient to meet the demands on maternity services. Similar recommendations have been made by the National Audit Office and the House of Commons Committee of Public Accounts.
- Providers must employ more midwives and maternity support workers to ensure that they meet recommended staffing levels. These staffing levels should be in line with Birthrate Plus workforce planning tool and the upcoming NICE guideline on midwifery staffing. Where the maternity tariff is insufficient to fund these staffing levels, providers should work with commissioners, NHS England and Monitor to find additional resources.
- Providers and commissioners must invest in long-term service reconfigurations that will deliver high-quality maternity care more efficiently. A greater focus on midwifery-led and community-based models of care is particularly important to meet the financial challenges of the future.

The RCM's Pressure Points campaign has highlighted the shortcomings in postnatal care. These shortcomings are particularly clear in the lack of support for maternal mental health, the 24 hour signs and symptoms, infant feeding and a lack of focus on postnatal care planning. Underpinning these is the need for more midwives, MSWs and funding, particularly in England. Attempts at improving care will always fall down in a service struggling to deliver many of the basic aspects of maternity care. Our latest estimate is that the NHS in England is short of around 3,200 midwives. Progress must be made if we want to drive the improvements in postnatal care the RCM wants to see, midwives believe are important and which women and their families are desperate for.

Get involved with our campaign at
www.rcm.org.uk/pressurepoints

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The Royal College of Midwives
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