

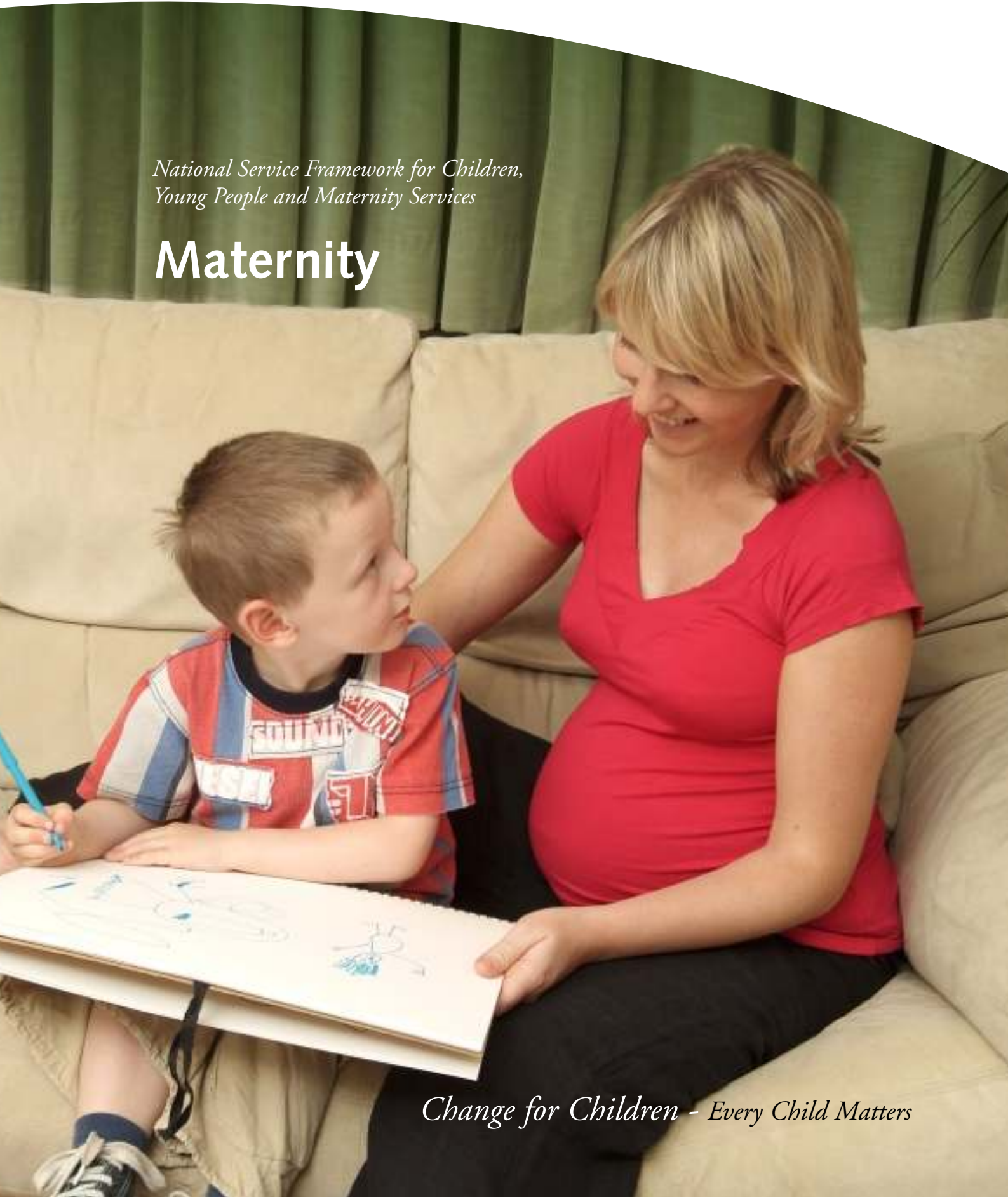
department for

**education and skills**



*National Service Framework for Children,  
Young People and Maternity Services*

# Maternity



*Change for Children - Every Child Matters*

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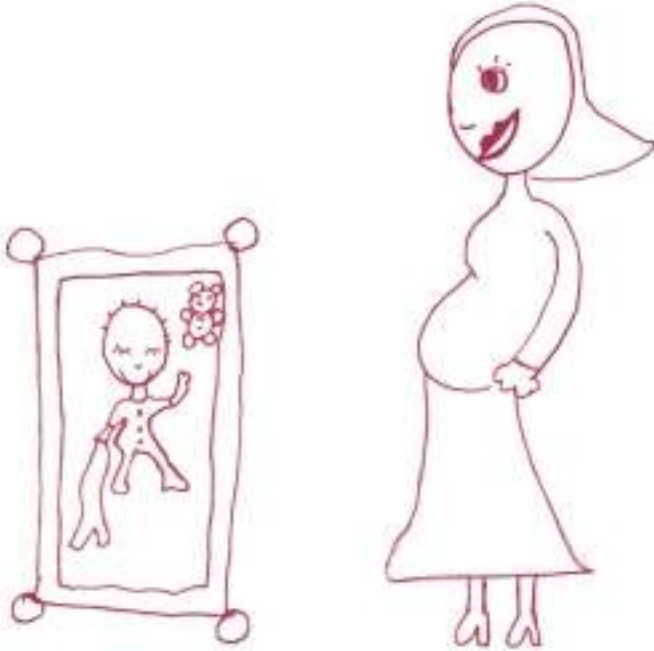
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# Standard 11: Maternity Services

## 1. Introduction

1.1 The National Service Framework for Children, Young People and Maternity Services establishes clear standards for promoting the health and well-being of children, young people and mothers; and for providing high quality services which meet their needs.

1.2 There are eleven standards, of which this is the last. They cover the following areas:

**Standard 1** Promoting Health and Well-being, Identifying Needs and Intervening Early

**Standard 2** Supporting Parenting

**Standard 3** Child, Young Person and Family Centred Services

**Standard 4** Growing Up into Adulthood

**Standard 5** Safeguarding and Promoting the Welfare of Children and Young People

**Standard 6** Children and Young People who are Ill

**Standard 7** Children in Hospital

**Standard 8** Disabled Children Young People and those with Complex Health Needs

**Standard 9** The Mental Health and Psychological Well-being of Children and Young People

**Standard 10** Medicines for Children and Young People

**Standard 11** **Maternity Services**

1.3 This standard addresses the requirements of women and their babies during pregnancy, birth and after birth. It includes women's partners and their families; and it addresses and links to pre- and post-conception health promotion and the Child Health Promotion Programme. It should be read in conjunction with Standards 1 – 5.

### **Vision**

#### **We want to see:**

- > Flexible individualised services designed to fit around the woman and her baby's journey through pregnancy and motherhood, with emphasis on the needs of vulnerable and disadvantaged women.
- > Women being supported and encouraged to have as normal a pregnancy and birth as possible, with medical interventions recommended to them only if they are of benefit to the woman or her baby.
- > Midwifery and obstetric care being based on providing good clinical and psychological outcomes for the woman and baby, while putting equal emphasis on helping new parents prepare for parenthood.

### **Standard:**

**Women have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies.**

### Markers of Good Practice

1. All women are involved in planning their own care with information, advice and support from professionals, including choosing the place they would like to give birth and supported by appropriately qualified professionals who will attend them throughout their pregnancy and after birth.
2. Maternity services are proactive in engaging all women, particularly women from disadvantaged groups and communities, early in their pregnancy and maintaining contact before and after birth.
3. All services facilitate normal childbirth wherever possible, with medical interventions recommended only when they are of benefit to the woman and/or her baby.
4. Maternity services are commissioned within a context of managed care networks and include a range of provision for routine and specialist services for women and their families e.g:
  - > Routine ante-natal and post-natal care services;
  - > Services for women with more complex pregnancies who may require multi disciplinary or multi-agency care;
  - > Services for women who request support for coping with domestic violence;
  - > Services for disabled women;
  - > Services for women and their partners who request support to stop smoking;
  - > Services for women and their partners who are substance misusers; and
  - > Services for women and their partners who have mental health problems.
5. Managed maternity and neonatal care networks include effective arrangements for managing the prompt transfer and treatment of women and their babies experiencing problems or complications.
6. All women and their babies receive treatment from health care professionals competent in resuscitation for both mother and infant, newborn examination and in providing breastfeeding support. Services promote breastfeeding, whilst supporting all women whatever their chosen method of feeding.
7. Women who use local maternity services are involved in improving the delivery of these services, and in planning and reviewing all local hospital and community maternity services.

## **2. Rationale**

- 2.1** This standard recognises that, for the majority of women, pregnancy and childbirth are normal life events; it aims to promote women's experience of having choice and control in giving birth to their baby. The standard seeks to improve equity of access to maternity services, which will increase the survival rates and life chances of children from disadvantaged backgrounds. It also aims to ensure that all mothers and babies receive high quality clinical services.
- 2.2** The care and support provided for mothers and babies during pregnancy, childbirth and the post-natal period has a significant effect on children's healthy development and their resilience to problems encountered later in life.
- 2.3** The quality of the service provided for the half a million babies born in England every year, and their mothers, thus has a long term impact on the future health of the nation.
- 2.4** For the majority of women, pregnancy and childbirth are normal life events requiring minimal medical intervention. These women may choose to have midwifery-led care, including a home birth.
- 2.5** For optimum health and well-being all women require easy access to services, choice and control regarding the care they receive and continuity of support during their pregnancy, childbirth and the post-natal period.
- 2.6** Women living in disadvantaged or minority groups and communities are significantly less likely to access services early or maintain contact throughout their pregnancies. They are also less likely to breastfeed. In consequence, the outcomes for their own and their babies' health and well-being are worse than for the population as a whole. It is important that services are designed to meet their needs.

- 2.7 The Department of Health national target on improving the health of the population sets out some of the current challenges including the need to focus on reductions in smoking in pregnancy (shared with the Department for Education and Skills), improving nutrition in women of childbearing age, particularly those who are pregnant or breastfeeding; increased breastfeeding initiation and duration rates; effective ante-natal care; and providing high quality midwifery, obstetric and neonatal services in a culturally sensitive way, together with effective family support, focussed on those with high needs. Primary Care Trusts, in partnership with local authorities, will wish to focus on some of these in setting local targets.

## **Interventions**

### **3. Woman-focussed Care**

- 3.1 Each pregnancy is different and each woman has different social, physical and emotional needs as well as specific clinical factors that may affect her pregnancy. Good maternity services place the mother and her baby at the centre of care, and plan and provide services to meet their needs.
- 3.2 The majority of women will want to be active participants in planning their care. Most will want to be involved in decisions about which type of care or offers of screening best suits their needs and wishes, and to share responsibility for managing their pregnancy in partnership with their professional care providers.
- 3.3 Promoting the uptake of services involves engaging women and their families in the planning and delivery of services. Inclusiveness can be promoted by ensuring that maternity service planning groups are welcoming, and meeting times and locations take into account womens' access, travel and childcare needs. Maternity Services Liaison Committees provide a useful vehicle for professional interdisciplinary working with informed user input and may play a useful part in monitoring implementation of this National Service Framework. Payment for expenses (including childcare) should be offered to all invited representatives, plus consideration given to remunerating people for attendance in line with other schemes for service user involvement.

- 3.4 Partners, fathers, family and peers, may provide significant influence and support for women using the services. *See section 5*

Primary Care Trusts and maternity service providers design, review and improve maternity services through a programme of consultation with women who use the services, their link-workers and advocates, and their families, building on the work of existing local groups including MSLCs. The programme includes individual feedback and review of complaints, surveys, focus groups, audit and review groups, peer/user group input and community groups. *See also section 11*

Maternity service providers should ensure that:

- > All pregnant women are offered clear information on the following:
  - a) The full range of choices of types of ante-natal and post-natal care and birth environments;
  - b) The full range of screening tests offered and the consequences of these;
  - c) The availability (from 2005) of Healthy Start (the new Welfare Food Scheme), which provides nutritional support, and advice on diet and health to qualifying pregnant women and young families, and
  - d) The new application process for the current Welfare Food Scheme from 10 October 2004;
- > Women are given enough time between receiving information and making choices to reflect upon the information, consider their options and seek additional information and advice where they wish to;
- > All maternity services have policies and procedures which reflect an individualised, flexible, woman-focused approach to care and support, and
- > In addition to providing support and advice for women, maternity services seek to engage fathers.

## **4. Care Pathways and Managed Maternity Care Networks**

### **Care Pathways**

- 4.1** This National Service Framework is based on the care pathway approach. Care pathways are used to illustrate the woman's progress through the variety of services available. They have emerged in the past decade as an important technique for continuous quality improvement in healthcare and are increasingly seen as a key NHS resource for implementing a National Service Framework. Care pathways formalise evidence-based protocols and guidelines into direct, individual women-focused care. The emphasis is on the woman and her child being at the centre of the process rather than meeting the needs of the service providers. They can be used to describe the routine progression of a woman through the ante-natal period as well as illustrating tracer conditions or situations to show how the standards will be implemented in particular circumstances.
- 4.2** The use of these pathways should result in the same high standard of care being provided for all women. More importantly, if the woman is given a copy of her own care pathway or care plan and it is explained to her, it will enable her to understand exactly how to access additional services should the need arise.

### **Managed Maternity and Neonatal Care Networks**

- 4.3** This National Service Framework will integrate services delivered through the care pathway approach by the introduction of Managed Maternity and Neonatal Care Networks. These are linked groups of health professionals and organisations from primary, secondary and tertiary care, and social services and other services, working together in a co-ordinated manner, to ensure an equitable provision of high quality, clinically effective care. Pregnant women may require care from a variety of sources or professionals, provided through such managed care or social services networks, as well as support from peers and local support groups. 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.

- 4.4 An example of a Managed Ante-natal Maternity network is given in Appendix 1.

NHS Maternity care providers and Primary Care Trusts ensure that care pathways and Managed Maternity and Neonatal Care Networks are in place. This is achieved through a multi-disciplinary and multi-agency approach requiring agreement with all those likely to be involved in providing care, including service managers and all relevant health and social care professionals and service user representatives.

## 5. Inclusive Services

- 5.1 All women should have easy access to, and confidence in, the full range of high quality maternity services the NHS offers. However, there are women who do not use or who under-use maternity services, most often those in disadvantaged groups or those who do not understand English or are unfamiliar with the NHS. Services may also be provided in places or at times that make them difficult to access or in a manner that may be considered inappropriate to meeting the cultural needs of some women.
- 5.2 Some women are disadvantaged because they have multiple social problems and may find it difficult to access and maintain contact with maternity services. This applies to homeless or travelling women, refugees and asylum seekers, as well as to those who feel they have stigmatising conditions, such as being HIV positive, misusing drugs, alcohol or other substances or those who are experiencing domestic violence. The inter-agency working required to support these women is underdeveloped and needs addressing.
- 5.3 The needs of women in prison and other custodial settings also need to be addressed and their maternity care delivered in accordance with the standards in both this National Service Framework and the NHS Healthcare Standards<sup>1</sup>.
- 5.4 Disabled women and those with needs requiring specific services, report that current services are not always responsive to their needs; also, that their own knowledge as to what will suit them best is overlooked.

- 5.5 Maternal and neonatal outcomes are poorer for women from disadvantaged, vulnerable or excluded groups. Teenage parents and their babies from these groups face higher risks of poor outcomes than older parents. They have significantly higher rates of infant mortality, low birth weight, smoking during pregnancy and post-natal depression. However, research suggests that these poor outcomes reflect these young women's low uptake of ante-natal and post-natal support *See also Standard 4*
- 5.6 Involvement of prospective and new fathers in a child's life is extremely important for maximising the life-long well-being and outcomes of the child (regardless of whether the father is resident or not). Pregnancy and birth are the first major opportunities to engage fathers in the appropriate care and upbringing of their children.
- 5.7 Young men who become fathers may also come from disadvantaged and vulnerable groups. A positive relationship with the young woman during pregnancy is a key predictor of the father's involvement with his child in the early years. Maternity services can support this relationship through involving and encouraging young fathers but health professionals may know little about teenage fathers and may lack the skills to engage with them.
- 5.8 Sure Start local programmes and Children's Centres are important components in the national strategy to tackle child poverty and social exclusion. *See Box 1*. Staff actively engage families in local communities offering a range of services and activities designed to prepare families for birth and parenthood and deliver key public health targets. When midwives are located in Children's Centres, they tend to be more visible and accessible to the community. Consideration should be given to locating some midwives in Children's Centres, managed as a single service providing both community and hospital-based services.
- 5.9 A report about the experience of Sure Start in involving fathers can be downloaded at [www.surestart.gov.uk/\\_doc/465-6C560D.doc](http://www.surestart.gov.uk/_doc/465-6C560D.doc). This includes recommendations to improve this.  
*See also Standards 1 and 3*

### **Box 1. Sure Start services**

Sure Start local programmes and children's centres are currently developing in the 20% most disadvantaged wards and are expected to offer the following services:

- > Visits for families with newborn babies in the area within the first two months following the birth, with information about services and support;
- > Provision of information and guidance on breastfeeding, nutrition, hygiene and safety, to reduce the number of children aged 0 – 3 years admitted to hospital; and
- > Provision of ante-natal advice and support to all pregnant women and their families in the area.

(See [www.surestart.gov.uk](http://www.surestart.gov.uk))

All NHS maternity care providers and Primary Care Trusts:

- > Plan the provision of maternity services:
  - a) Based on an up-to-date assessment of the needs of the local population e.g. identifying specific vulnerable groups or travellers sites (See section 11), and
  - b) Involving service user groups;
- > Improve the access and effectiveness of maternity services for women from disadvantaged and minority groups and communities by systematically taking account of the reasons why women from these groups find it difficult to access and maintain contact with maternity services, and by actively designing services to overcome these barriers to care.
- > Strengthen services for women from disadvantaged and minority groups and communities by having a staffing profile which, as far as possible, reflects the profile of the local population.

- > With asylum seeker accommodation or a women's prison in their locality, have in place arrangements to link health care services for expectant women and mothers with newborns to local maternity services and ensure that these standards are applied in every setting.
- > Ensure that local maternity services are inclusive for women with learning and physical disabilities taking into account their communication, equipment and support needs.
- > Provide maternity services for teenage parents in line with *Teenage Parents: Who Cares? – a guide to commissioning and delivering maternity services for young parents*<sup>2</sup>. Maternity services staff have the knowledge and skills to engage with teenage mothers and fathers.
- > Make provision for translation, interpreting and advocacy services based on an assessment of the needs of the local population. Provision includes a mixed economy of interpreting and advocacy services – for home visiting, out-of-hours services, ante-natal classes. (See *Committee for Racial Equality, Maternity services code of practice*<sup>3</sup>, particularly in relation to providing translation and interpreting services.)
- > All NHS maternity care providers, Primary Care Trusts and Local Authorities monitor the take-up of services, quality of service user engagement and outcomes for women and their babies from disadvantaged and minority groups and communities; and take action to provide high quality midwifery, obstetric and neonatal services in a culturally sensitive way as part of the broader strategy of improving the health of the population (a Department of Health national target).
- > Develop a directory of local and national agencies who can provide expert advice and support for professionals working with women from disadvantaged and minority groups and communities.

- > Improve take-up of community maternity services and support for all pregnant women and new parents by:
  - a) Ensuring general practitioners, primary care staff and receptionists immediately refer pregnant women to the local maternity services and stress the importance of this care to women they see for reasons other than their pregnancy;
  - b) Extending accessible midwifery services, including some co-location, in Children's Centres where disadvantaged women regularly attend;
  - c) Extending the Sure Start principles across other services i.e. working with parents and children, starting early, being responsive to women's needs, flexible at the point of delivery, providing services for everyone, ensuring services are community-driven, professionally co-ordinated across agencies and outcome focussed, and
  - d) Engaging fathers and partners through services as part of preparation for parenthood.
  
- > Have inter-agency arrangements, including protocols for information sharing and a lead professional, to ensure that women from disadvantaged groups have:
  - a) Adequate support from other agencies which forms part of the package of care needed to promote the health and well-being of the mother and her baby;
  - b) The benefit of health promotion initiatives at every opportunity. (See *Delivering the Best – midwives contribution to the NHS Plan<sup>4</sup>*); and
  - c) The benefit of other agencies (e.g. housing) referring women, with consent, quickly and easily to local maternity services.

All NHS maternity care providers and Primary Care Trusts develop 'community-based continuity of care' schemes for women from disadvantaged and minority groups and communities.

## 6. Pre-Conception Care

- 6.1 Parents who are fit and healthy at the start of pregnancy generally have healthier babies. About half of pregnancies in the United Kingdom are unplanned and some women may delay seeking advice once they know they are pregnant, for a variety of reasons.
- 6.2 Prospective parents do not currently have easy access to information, such as the importance of folic acid supplementation prior to conception and ensuring rubella immunity, as rubella infection in the first eight to ten weeks of pregnancy results in fetal damage in up to 90% of infants.
- 6.3 Some women and prospective parents need specialist pre-conception advice, information and support, including:
- > Women who have conditions treated with medicines that may harm the unborn baby need advice about changes in their medications prior to pregnancy; such conditions include epilepsy, schizophrenia, hypertension and bi-polar affective disorders;
  - > Women with a condition such as heart disease, a history of embolism, epilepsy or diabetes will need information and advice to ensure that their treatment is optimised, about managing their health before conception and during pregnancy, and
  - > Prospective or existing parents with a family history of a genetic disorder, and those who are concerned about familial disease or disabilities.
- 6.4 There are significant risks to the health, and life, of a baby if the mother smokes. These include the risk of miscarriage, premature birth and stillbirth, of placental abnormalities, low birthweight and, after birth, sudden infant deaths. It is estimated that about one third of all perinatal deaths in the UK are caused by smoking. There is also a significant risk to fetal development with women misusing drugs or alcohol (see also paragraph 7.10).

All NHS maternity care providers, Primary Care Trusts and Local Authorities ensure that:

- > Local multi-agency health promotion arrangements include health promotion for pregnancy;
- > Campaigns and materials are targeted towards women in groups and communities who under-use maternity services or who are at greater risk of poor outcomes. (*See Box 2*);

Specific pre-conception services are available within the maternity care network and publicised for all women and their partners who require specialist advice before becoming pregnant, because of pre-existing medical or familial conditions;

The maternity care network works closely with primary health care providers, family planning and sexual health services to identify women with pre-existing medical or familial conditions who may become pregnant and ensure they have pre-pregnancy access to specialist advice should they plan to become pregnant, or appropriate contraception if they do not, and

All pregnant women and their partners who smoke receive clear information about the risks of smoking and the support available to them to stop e.g. the NHS Stop Smoking Service as part of the broader strategy of improving the health of the population (a Department of Health national target).

## Box 2. Pre-conception information for parents

Local health promotion arrangements need to include the provision of the following information for parents:

- > What becoming a parent might be like and the impact on wider family/adult relationships.
- > The importance of:
  - a) pre-conceptual folic acid;
  - b) minimising intake of alcohol;
  - c) not using recreational drugs;
  - d) not smoking during pregnancy and having a smoke-free environment;
  - e) pre-pregnancy rubella immunisation, and
  - f) seeing a healthcare professional as early in pregnancy as possible.

See also Department of Health's *The Pregnancy Book* and Dr Foster local maternity guides - *You're Pregnant*. ([www.drfooster.com](http://www.drfooster.com))

*See also Standard 3*



## 7. Pre-Birth Care

- 7.1 Approachable and supportive ante-natal services in convenient and accessible settings encourage and enable women to engage with maternity services early in their pregnancy and maintain contact throughout the pregnancy, the birth and the early post-birth period. It is recommended in the National Institute for Clinical Excellence (NICE) Ante-natal Care Guidelines<sup>5</sup> that women have access to maternity services at 8 – 10 weeks of pregnancy to give them time to plan their pregnancy effectively and consider early screening options.
- 7.2 Some women, particularly those from more vulnerable and disadvantaged groups, may require more support and access to social or other services, e.g. housing, advice on benefits and, where appropriate, child maintenance and relationship support.
- 7.3 Delivering effective ante-natal care is dependent upon effective and sensitive provision of non-directive information and support. Feedback from parents<sup>6</sup> suggests that they want more information than is currently provided for them, particularly for first-time parents, fathers, young parents, those who are in disadvantaged or minority ethnic groups.
- 7.4 As pregnancy progresses, women's information requirements change. Good ante-natal care for all women and their partners will also include access to parenting education, and preparation for birth as classes or through other means to enable them to make informed choices about the type of birth they would prefer.
- 7.5 Women need general and individual information about taking medicines during their pregnancy.  
*See also Standard 1*

All NHS maternity care providers and Primary Care Trusts ensure that:

- > The option for all women to access a midwife as the first point of contact is widely publicised;
- > Contact details for midwives are easily accessible to all women in the local population, and
- > Each pregnant woman has two visits early in pregnancy with a midwife who can advise her on her options for care on the basis of an in-depth knowledge of local services;

All NHS maternity care providers and Primary Care Trusts ensure that midwives, obstetricians and general practitioners are competent to assist women in considering their options for ante-natal, birth and post-birth care, and the clinical risks and benefits involved. In addition to local information to assist such choices, women are informed of relevant local and national voluntary agencies and websites.

All women are offered the support of a named midwife throughout pregnancy. All women are able to contact a midwife day or night at any stage in pregnancy if they have concerns;

Every woman develops and is encouraged to regularly review, her individual care plan in partnership with a health care professional. The plan is based on an assessment of each woman's clinical and other needs and she and her health care professional are able to discuss changing it at any point in her pregnancy;

Women have access to information and advice about taking any medicines during their pregnancy, and

Every pregnant woman attending an Accident and Emergency department for problems other than obvious minor injuries is seen by a midwife or obstetrician. Where this is not possible, a midwife or obstetrician is consulted by telephone.

- 7.6 Ante-natal care should maximise positive clinical outcomes as well as providing support and reassurance.
- 7.7 Women require information in a medium or language which suits their needs. In early pregnancy, they need to decide which, if any, screening tests they wish to have. It is particularly important that women give properly informed consent to have any tests before these procedures take place. (See the National Screening Committee at [www.nsc.nhs.uk](http://www.nsc.nhs.uk) and [www.nelh.nhs.uk/screening](http://www.nelh.nhs.uk/screening)).

All NHS maternity care providers and Primary Care Trusts ensure that:

- > A comprehensive high quality ante-natal screening and diagnostic service, based on the current recommendations of the National Screening Committee and designed to detect maternal or fetal problems at an early stage, is offered to all women;
- > Ante-natal tests and screening are offered to women as options (with the purpose and consequence of each test explained), rather than as a routine part of the process of being pregnant;
- > Staff working with women in the pre-conception and ante-natal period are competent in recognising, advising and referring women who would benefit from more specialist services, and
- > All relevant clinical guidelines from the National Institute for Clinical Excellence are followed, for example the Guidelines for Routine Ante-natal Care<sup>5</sup>.
- > Where women request or decline services or treatment, their decision is respected.

## **Pre-Birth Mental Health**

- 7.8** The transition to parenthood is associated with psychological change and emotional upheaval. All those concerned with the care of women and their families at this stage in their lives need to be familiar with the normal emotional and psychological changes that take place during pregnancy and in the post-natal period. They also need to be familiar with the signs and symptoms of common crises, the likely causes of these crises, and the states of distress that arise in relation to obstetric and other events.
- 7.9** Mental health problems and mild non-psychotic psychiatric illnesses are common both in pregnancy and following birth. The incidence of serious mental illness is reduced during pregnancy but increased following delivery. A significant minority of women will have a psychiatric disorder during pregnancy which may continue following delivery and compromise their adjustment to motherhood.
- 7.10** Women who have substance misuse problems are at greater risk of problem pregnancies and their care should be provided by an integrated multi-disciplinary and multi-agency team.
- 7.11** Professionals should also consider the effect these problems may have on the woman's ability to meet the needs of her baby. Where there are concerns about the unborn baby's welfare, or the welfare of the baby after birth, a referral should be made to social services for an assessment of the mother and baby's needs, and for social care services to be provided as required.

*See also Standard 2*

All pregnant women have easy access to information about the normal emotional and psychological changes during pregnancy and following birth, advice on promoting well-being and simple coping strategies. It should also include information on mental health problems and how to access appropriate help.

All NHS maternity care providers have in place policies and protocols for identifying and supporting women who are at high risk of developing a serious postpartum mental illness, which will help to deliver the Department of Health national target on improving the health of the population which includes reducing mortality from suicide. These include ensuring that all pregnant women are:

- > Asked about any previous history of psychiatric disorder and/or family history of serious mental illness early in their pregnancy; and
- > Provided with information on pregnancy and mental health which helps them to disclose and discuss mental health issues.

Midwives and obstetricians are competent to elicit the relevant information sensitively and identify serious intercurrent conditions or a potentially serious past psychiatric history.

All NHS maternity care providers and Mental Health trusts have in place joint-working arrangements for maternity and mental health services, including arrangements for direct access by midwives, general practitioners and obstetricians to a perinatal psychiatrist. (See women's mental health guidance: *Women's Mental Health: Into the Mainstream?*).

All women who have a significant problem drug and/or alcohol use should receive their care from a multi-agency team which will include a specialist midwife and/or obstetrician in this area.

Maternity and social services have joint-working arrangements in place to respond to concerns about the welfare of an unborn baby and its future, due to the impact of the mother's needs and circumstances.

## Domestic Violence

- 7.12** Almost a third of domestic violence begins with pregnancy. Feedback from pregnant women already in abusive relationships is that existing abuse often intensifies during pregnancy. The effect of violence on the unborn baby can lead to miscarriage, stillbirth, intra-uterine growth retardation and premature birth as well as to long lasting physical disability. For the mother, violence can cause life-threatening complications and sometimes result in her death.
- 7.13** Furthermore, violence has a major impact on the mental and physical health of the wider family, particularly as violent partners are often violent towards their children as well. See also paragraph 7.11 above.
- 7.14** The recommendations of the two most recent *Confidential Enquiries into Maternal Deaths*<sup>8, 9</sup> (CEMD) reports underline the importance of providing an enabling environment for women to disclose violence, if they so wish, to the health care professional caring for them during pregnancy. This will enable the women to be offered access to the help and support they want.  
*See also Standard 5*



All NHS maternity care providers and Primary Care Trusts ensure that:

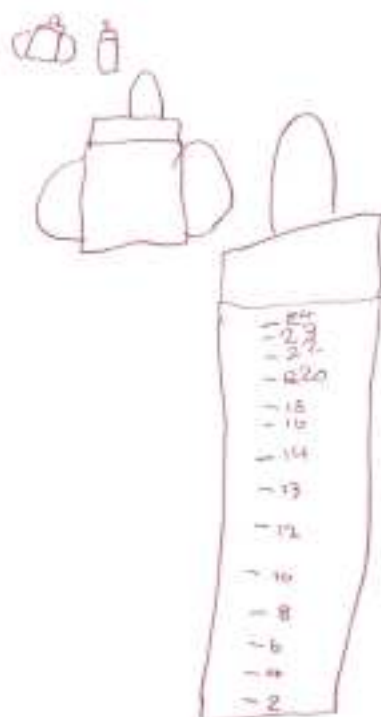
- > All pregnant women are offered a supportive environment and the opportunity to disclose domestic violence; and local support services and networks are developed and midwives and other health professionals involved are trained to respond appropriately.
- > Maternity service staff are aware of the importance of domestic violence in their practice and are competent in recognising the symptoms and presentations. They are able to make a sensitive enquiry if concerned and can provide basic information about, or referral to, local services as required.
- > As part of the local inter-agency domestic violence strategy, joint working arrangements are in place between maternity services and local agencies with responsibility for dealing with domestic violence; information about these services is made available to all pregnant women whether they are affected by violence or not and, if they are, irrespective of whether they choose to disclose it.

Maternity and social services have joint working arrangements in place to respond to concerns about the welfare of an unborn baby and its future, due to the impact of the mother's needs and circumstances.

See also *Domestic Violence: a resource manual for Healthcare Professionals*<sup>10</sup> and [www.northbristol.nhs.uk/midwives/domesticviolence](http://www.northbristol.nhs.uk/midwives/domesticviolence)

## Problems in Early Pregnancy

- 7.15** A significant number of women develop problems in early pregnancy which require quick and sensitive assessment. Up to 20% of pregnancies miscarry and one in a hundred pregnancies will occur outside the womb (ectopic pregnancy). The latter can be life-threatening unless diagnosed early and dealt with quickly.
- 7.16** Successive Confidential Enquiries into Maternal Deaths Reports have highlighted delays in the diagnosis of ectopic pregnancy, sometimes with fatal results. It is therefore crucial that all women with worrying symptoms in early pregnancy can be rapidly assessed and treated as required.
- 7.17** Many hospitals have established Early Pregnancy Units (EPUs) to allow such rapid assessment. However, a clear need exists to enable equitable access to rapid and skilled care for those women currently unable to access these services.



**7.18** For women and their families who experience miscarriage, ectopic pregnancies or other early pregnancy loss, this means the loss of a baby. The Miscarriage Association ([www.miscarriageassociation.org.uk](http://www.miscarriageassociation.org.uk)) provides support for parents and others affected by miscarriage or ectopic pregnancy [www.miscarriageassociation.org.uk](http://www.miscarriageassociation.org.uk) and Ante-natal Results and Choices (ARC) [www.arc.org.uk](http://www.arc.org.uk) provides support and information to parents faced with the choice of whether to continue with a pregnancy where the baby has a congenital anomaly. Both agencies provide training for staff.

Primary Care Trusts and maternity care providers ensure that:

- > Every woman who is experiencing problems in early pregnancy has access to an Early Pregnancy Unit (EPU);
- > Every pregnant woman whose unborn baby is found to have a possible problem has access to high quality, appropriate services in an environment sensitive to her, and her partner's needs;
- > As a minimum, EPUs need to have access to high quality ultrasound equipment and suitable expertise, other methods of assessment and therapeutic expertise, and provide a suitable environment for worried or distressed mothers and their partners, and
- > Diagnostic guidelines are circulated to all health professionals likely to be consulted by a woman who may have an ectopic pregnancy.

There is a clear and consistent local policy about the sensitive disposal of fetal tissues after early pregnancy loss.

Women with three or more miscarriages are offered a referral to a specialist recurrent miscarriage clinic.

## 8. Birth

### Promoting Normality and Choice, and Improving Women's Experiences of Care

- 8.1 Every woman is able to choose the most appropriate place and professional to attend her during childbirth based on her wishes and cultural preferences and any medical and obstetric needs she or her baby may have.
- 8.2 Women's reactions to their birth experiences can influence their emotional well-being, their relationship with their baby and their future parenting relationships.

#### Box 3. What women want

A number of studies have shown that the main things that women want when giving birth are:

- > To have confidence in staff providing care during the birthing process;
- > To have one-to-one care from a named midwife throughout labour and birth, preferably whom they have got to know and trust throughout pregnancy;
- > To receive personalised care, be treated with kindness, support and respect;
- > A pleasant and safe birth environment;
- > To receive adequate information and explanations about their choices for childbirth, including pain relief and hospital practices, and
- > Access to medical help if complications arise

- 8.3 Several large studies on home birth have concluded that it appears safe for women who have been appropriately assessed. Home births should be offered within a risk management framework and with adequate local infrastructure and support.

NHS Maternity care providers and Primary Care Trusts ensure that:

- > The range of ante-natal, birth and post-birth care services available locally constitutes real choice for women (including home births) (See also section 11);
- > Staff actively promote midwife-led care to all women who have been appropriately assessed;
- > Local options for midwife-led care will include midwife-led units in the community or on a hospital site, and births at home for women who have been appropriately assessed. Care should be provided within a framework that enables easy and early transfer of women and babies who unexpectedly require specialist care. As with other options, the outcomes of these types of care should be regularly audited;
- > The capacity of the midwife-led and home birth services are developed to meet the needs of the local population;
- > Staffing levels and competencies on delivery suites comply with *Clinical Negligence Scheme for Trusts*<sup>11</sup> standards;
- > Women have a choices of methods of pain relief during labour, including non-pharmacological options;
- > All staff have up-to-date skills and knowledge to support women who choose to labour without pharmacological intervention, including the use of birthing pools, and in their position of choice;
- > Midwives and doctors who care for women with epidurals have regular updated training from anaesthetic staff;
- > Clinical interventions, including elective caesarean section, are only performed if there is clinical evidence of expected benefits of these to the mother and/or baby;
- > A consultant is involved in the decision to undertake any caesarian section, and
- > Maternity services develop the capacity for every woman to have a designated midwife to provide care for them when in established labour for 100% of the time.

## The Birth Environment

8.4 Feedback from women is that wherever they choose to give birth the environment should:

- > Be quiet, relaxed with comfortable “home-like” surroundings where they can progress through labour with the support of their birth partners;
- > Facilitate companionship, empathy and help as well as skilled professional care, and
- > Enable women to do what feels right for them during labour and delivery with health professionals supporting their wishes wherever possible.

All NHS maternity care providers and Primary Care Trusts ensure that birth environments in all settings:

- > Promote the normality of childbirth i.e. they replicate a home-like ambience;
- > Can have furniture easily re-arranged to allow for mobility and different birth positions;
- > Wherever possible, allow access to a birthing pool with staff competent in facilitating water births; and
- > Are welcoming to fathers and other birthing partners.

(See Health Building Note 21 *Facilities for Maternity Care* NHS Estates website).

All NHS maternity care providers ensure that maternity units and services are:

- > Accessible to disabled women in line with the *Disability Discrimination Act 1995*<sup>12</sup> (including home births where appropriate);
- > Innovative and flexible in meeting the needs of women with communication and other disabilities, and
- > Informed by best practice from settings and regions across the country in caring for disabled women.

### Should Complications Arise

**8.5** Complications, which can arise for both mother and baby, need to be treated quickly and in accordance with best clinical practice. Immediate, safe transfer should be available for any mother or baby who needs to transfer to consultant care in labour or after delivery. These arrangements are an integral part of the local care network.

All NHS maternity care providers and Primary Care Trusts ensure that:

- > All professionals providing maternity care undertake regular, specific, ongoing on-site training on the early identification and referral of women with obstetric or other medical complications. This includes cardiac arrest and haemorrhage procedures for the management of obstetric emergencies on site in the maternity unit;
- > Formal local multi-disciplinary arrangements are in place for emergency situations, including transfer-in labour for all out of hospital or intra-hospital settings;
- > Community-based facilities are fully equipped and staff have the skills for initial management and referral of obstetric and neonatal emergencies;
- > In all out-of-hospital labours/births, the midwife is responsible for transfer and continues to care for the woman on transfer where possible;
- > For all transfers to hospital, midwives refer directly to the most senior obstetrician on call, and
- > Consultant-led services have adequate facilities, expertise, capacity and back-up for timely and comprehensive obstetric emergency care, including transfer to intensive care.

## **9. Post-Birth Care for Mothers**

- 9.1** Women need to be provided with a post-natal care service that identifies and responds in a structured and systematic way, to their individual physical, psychological, emotional and social needs, and which is based on the best available evidence. This should be achieved through a multi-disciplinary team-based approach, with a co-ordinating health professional who has the appropriate clinical skills to ensure that the mother receives the post-natal care she needs, and that the parents are able to care for their child. Within this framework, midwives and health visitors work closely together. When the mother and her baby's post-natal needs have been met, responsibility for her care and support can be transferred to the health visitor.

### **Immediate Post-Birth Care**

- 9.2** All Surveys repeatedly show more negative comments from service users in relation to hospital post-natal services than about any other aspect of maternity care. Many of the complaints focus on women receiving conflicting advice on infant feeding, the availability and quality of hospital food and poor standards of hygiene.
- 9.3** This is an area where maternity support workers could have an important role. They would receive appropriate training and would work under midwife or health visitor supervision in hospital (or community post-natal care teams – see 9.6 below), providing basic care and support for women and their babies. This could include infant feeding advice and general information about the hospital environment including catering, washing and visiting arrangements. Proposals to introduce maternity care support workers as part of the maternity team have been endorsed by women using maternity services.

In hospital settings, each woman receives an initial assessment of her needs and agrees a care plan with the midwife which takes into account the type of birth, expected length of stay in hospital and the timing of her transfer home.

All NHS maternity care providers implement and evaluate innovative models of support services e.g. appropriately trained maternity support workers integrated into both the hospital and community post-natal care teams.

All women leaving hospital or in the community, receive support from a community-based co-ordinating health professional.

#### **Box 4. Information for parents**

Local health promotion strategies need to include the following information for both mothers and fathers:

- > Healthy lifestyles including skills and knowledge of the purchase and preparation of food to form a balanced diet, active lifestyle and the importance of maintaining a healthy weight;
- > The benefits of breast-milk and how to breastfeed and, where this is not possible, how to bottle feed safely; healthy weaning at six months;
- > Reducing the risks of sudden infant death; accident prevention, reducing non-intentional injury and first aid and basic life-saving skills to use with babies and children;
- > What to expect at different ages including, emotional development, growth and child development;
- > How to nurture babies and children, and
- > Services to support parents and children through disrupted relationships and bereavement.

See also Department of Health/Dr Foster local maternity guides and *Birth to Five*<sup>13</sup>, and Standard 3.

## Ongoing Community Care

- 9.4** The current duration of community post-natal care, with routine midwife discharge at 10 to 14 days and routine discharge from maternity care at six to eight weeks, now appears too short for a full assessment of health needs, given the long term nature of many post-delivery health problems. A survey by the National Childbirth Trust found that women reported not having enough help and information between 11 to 30 days after birth, compared with the first ten days. Accordingly, midwifery-led services should provide for the mother and her baby for at least a month after birth or discharge from hospital, and up to three months or longer depending on individual need.
- 9.5** Studies have shown that a new mother's health problems are often not identified or reported prior to post-natal discharge. Many of these health problems can persist in the long term leading to ongoing pain, disability and depression. Their early identification and management is important for the continuing health of the mother and her family.
- 9.6** Additional necessary support can be provided through a maternity support worker service, with midwife or health visitor supervision as part of a community post-natal care team (see 9.3 above). Other support may be provided by peer support initiatives and Sure Start early years services. There is evidence that peer support programmes can have a positive impact in improving breastfeeding rates.
- 9.7** Over a quarter of births conceived to young women aged 17 and 18 are second pregnancies. Although some of these will be planned, many are not. Good quality contraceptive advice and treatment are essential to ensure that young women are able to prevent subsequent pregnancies if they wish to.

All women receive a structured needs assessment in the post-natal period, using a recognised assessment tool which enables health professionals to systematically identify, record and promote the health and well-being of the mother and her baby. As part of this individual care model, the mother, together with professionals, plans for her ongoing care and support needs.

Post-natal care includes provision of information to both mothers and fathers on infant care, parenting skills and accessing local community support groups.

Arrangements are in place for support in the community for teenage parents, with relevant agencies such as Connexions and Sure Start Plus; including the provision of contraceptive advice and treatment.

All NHS maternity care providers, Primary Care Trusts and Local Authorities support voluntary sector agencies in providing local services for parents of babies and young children.

Local policies ensure that women are discharged from the maternity service according to their individual needs and those of their babies.

### **Post-Natal Mental Health Needs**

**9.8** Maternal post-natal depression, with a prevalence of 10 – 15%, has been shown in several studies to have adverse effects on the baby, including insecure attachment, cognitive development deficits and increased likelihood of psychiatric illness, and some of these can persist in the longer term. The identification and management of psychological health therefore is crucial for the child as well as the mother.

9.9 Despite enquiries about previous ill health during the ante-natal period, the majority of women who develop serious mental health problems following birth will probably not have been identified previously as being at risk. The most serious illnesses tend to develop by six to eight weeks after birth. Seriously ill women, whose needs cannot be met by primary care, will require the assistance of Specialist Perinatal Psychiatric Services and sometimes admission to a Specialist Mother and Baby Psychiatric Unit *See also Standard 2*

All professionals involved in the care of women immediately following childbirth need to be able to distinguish normal emotional and psychological changes from significant mental health problems, and to refer women for support according to their needs.

All professionals directly involved in the care of each woman who has been identified as at risk of a recurrence of a severe mental illness following birth, including the woman and her family (as appropriate), are familiar with her individual 'relapse signature' (the early signs of the developing illness).

Each woman who has been identified as at risk of a recurrence of a severe mental illness has a written plan of agreed multi-disciplinary interventions and action to be taken.

Strategic Health Authorities and all NHS Trusts plan for the provision across Strategic Health Authorities boundaries, of sufficient capacity for specialist in-patient psychiatric mother and baby treatment so that all women who require it can be admitted with their baby (unless there is a specific contra-indication) to a Specialist Mother and Baby Psychiatric Unit.

## 10. Post-Birth Care for Babies

### Immediately Following Birth

**10.1** Babies need early and ongoing contact with their mothers and fathers. They may also need care and treatment from health care professionals skilled in appropriate resuscitation methods, examination of the new born to identify problems and in assisting with the chosen method of infant feeding

*See also Standard 1*

All staff who attend a woman in childbirth or who deal with newborn babies, irrespective of the place of delivery, have been trained in neonatal life support and have up-to-date skills in the techniques of neonatal resuscitation and the thermal care of infants at resuscitation.

All appropriate NHS Trusts have in place specialist transport services for transferring babies between hospitals as part of their locally agreed managed maternity and neonatal care network.

### Routine Examination of Newborn Babies

**10.2** All newborn infants should receive a physical examination to detect treatable, but pre-clinical, congenital problems in the early neonatal period. However the current practice of examinations being undertaken by junior doctors has led to significant delays in mothers and babies being discharged from hospital. It is therefore proposed that a range of professionals can undertake the first examination, as long as they are trained and skilled in this procedure.

*See also Standards 1 and 8*

All newborn infants have a clinical examination to detect pre-clinical abnormalities within the first week of life for full term babies, or prior to discharge home from neonatal care.

Professionals are skilled in sharing concerns and choices with parents as part of the emerging diagnosis (see *Right from the Start template*<sup>14</sup>).

Both parents are encouraged to be present at the first examination.

Professional staff examining newborn babies have up-to-date training in neonatal examination techniques. Prompt referral for further medical investigation or treatment is provided through agreed clinical care pathways.

### **Infant Feeding**

**10.3** There is clear evidence that breastfeeding has positive health benefits for both mother and baby in the short and longer term. Breastfeeding has an important contribution to make towards meeting the national target to reduce infant mortality and health inequalities. Women from lower socio-economic groups have lower breastfeeding rates than those from higher socio-economic groups, and teenage mothers are half as likely to breastfeed as older women.

**10.4** The infant feeding survey showed that 90% of mothers who gave up breastfeeding within six weeks of birth would like to have breastfed for longer. Some of the reasons for stopping breastfeeding were found to include a lack of ante-natal information concerning breastfeeding, delays in the first feed and a lack of post-natal help with breastfeeding problems.

- 10.5** Mothers who are taking medicines need particular advice about breastfeeding. Current information sources available to health professionals may lead to women being advised, unnecessarily, not to breastfeed, because of the medicines which they are taking.

Information on breastfeeding is timely, consistent and reflects best practice standards; this will help to deliver the Department of Health PSA target on improving the health of the population.

Support for breastfeeding is a routine part of ante-natal care, birth and post-natal care, with particular support for mothers who have had a multiple birth or have a premature or sick baby.

NHS Trusts have, as a minimum standard for breastfeeding support, the best practice guide *Good Practice and Innovation in Breastfeeding*<sup>15</sup>.

Arrangements are in place for women to easily access breast-feeding support services e.g. community-based networks offering mother-to-mother support and trained breastfeeding counsellors working within, or closely with, the health care system.

Women who are taking medicines receive specialist advice, based on best available evidence, in relation to breastfeeding.

### **Stillbirths and Early Neonatal Deaths**

- 10.6** Despite improvements in all aspects of care for pregnant women, some still lose babies through stillbirths and death in the first week of life (in 2003 the figure was 8.5 stillbirths and deaths under one week, per thousand live births and stillbirths in England).

**10.7** Women, their partners and sibling children who have suffered a bereavement arising from a pregnancy, whether a miscarriage, termination, stillbirth, neonatal and infant death or the death of the mother herself, will need supportive information and choices which are:

- > Responsive to their individual needs and those of the family;
- > Easily accessible for as long as required;
- > Consistent in content across all sectors of the health service;
- > Appropriate and based on the relevant guidelines, and
- > Respectful of culture and diversity.

**10.8** The Child Bereavement Trust provides a range of resources for professionals and bereaved families. A particular concern is support to siblings when a child dies [www.childbereavement.org.uk](http://www.childbereavement.org.uk); The Compassionate Friends is a peer support group for those bereaved by the death of a child or children [www.tcf.org.uk](http://www.tcf.org.uk) and CRUSE provides training in bereavement for professionals, written information for the bereaved including for children of various ages [www.crusebereavementcare.org.uk](http://www.crusebereavementcare.org.uk). See also Guidelines issued by the *Stillbirth and Neonatal Death Society*.

*See also Standard 8*

All NHS maternity care providers ensure that all health services have comprehensive, culturally sensitive, multi-disciplinary policies, services and facilities for the management and support of families who have experienced a maternal or neonatal death or stillbirth.

Skilled staff are available to support parents following maternal or neonatal death, stillbirth or miscarriage.

Information is available in different languages, with particular cultural beliefs or sensitivities appropriately reflected.

## 11. Quality of Care

*See also Standard 3 and Standard 7, Children in Hospital*

- 11.1** Clinical governance is the framework through which organisations providing maternity services can manage their accountability for maintaining high standards and continuously improving the quality of their services.

Women who are assessed as needing clinical interventions during their pregnancy, through birth and in post-birth care receive high quality, evidence-based care in line with the Department of Health national target on improving the health of the population.

Maternity services comply with the National Institute for Clinical Excellence (NICE) guidelines for the provision of high quality clinical care including the provision of ante-natal, intrapartum and postpartum care and caesarean sections, as and when they are available and updated.

### **Routine Data Collection and Analysis**

- 11.2** The Government recognises that data from NHS maternity care providers is important as it provides a measure, not only of the health of pregnant women, but also of their babies. Data on the mother's health plays an important part in the child's health record, so maternal and child health should be linked. Such information, on processes and outcomes, also informs continuous improvement in local maternity services to best address local needs.

Primary Care Trusts and NHS Trusts ensure that maternity data is collected and made available in accordance with recognised best practice, and agreed national datasets once published.

## Learning from Adverse Events and Research

**11.3** High quality care requires an evidence-based culture which relies on well-designed clinical research.

All maternity care providers and Primary Care Trusts ensure that:

- > Multidisciplinary review of critical incidents are a routine learning exercise for staff;
- > All staff participate in the relevant Confidential Enquiries into maternal, perinatal or infant deaths, and
- > Maternity units actively engage in well-designed, ethical, clinical research that aim to improve care for pregnant and recently pregnant women and their babies.



## 12. Training and Development

- 12.1 The delivery of maternity services to this standard is dependent on all maternity services staff being trained and supported to work within the full range of their competences. This may include the development of new roles, for example:
- > Appropriately trained maternity support workers, integrated into both the hospital and community post-natal care teams;
  - > New advocate and link worker roles; and
  - > New Consultant Midwife roles.
- 12.2 Although not all the core competencies set out under Standard 3 are applicable to staff providing maternity services, some are relevant, such as those regarding equality and diversity, communicating with parents (mothers and fathers) and safeguarding children.
- 12.3 Competencies or national occupational standards relating to maternity and neonatal services are being developed by *Skills for Health* as part of the Children's National Workforce Competence Framework for Children's Services<sup>16</sup>.

Maternity services staff have the core competencies set out under Standard 3 which are relevant to maternity services.

Clinical staff have appropriate, multi-disciplinary training to ensure that they work in partnership, including inter-agency, with a shared philosophy of care.

In addition, specific training is needed so that advocates and translators understand the provision of maternity care and social services so that they can effectively help to guide women around the system.

All maternity care providers and Primary Care Trusts ensure the implementation of the anticipated national occupational standards relating to maternity and neonatal services.

### 13. Planning and Commissioning Maternity Services

13.1 All NHS Trusts, together with their neighbouring NHS Trusts and social service departments and, if necessary Local Strategic Health Authorities, should plan and commission maternity services as part of a locally agreed and managed network of maternity and neonatal care appropriate and accessible for all women. *See also Standard 3*

Any reconfiguration of maternity services provides services which:

- > Are more woman-focussed and family-centred;
- > Expand community based provision; and
- > Enhance the network of care for women requiring specialist, particularly tertiary care.

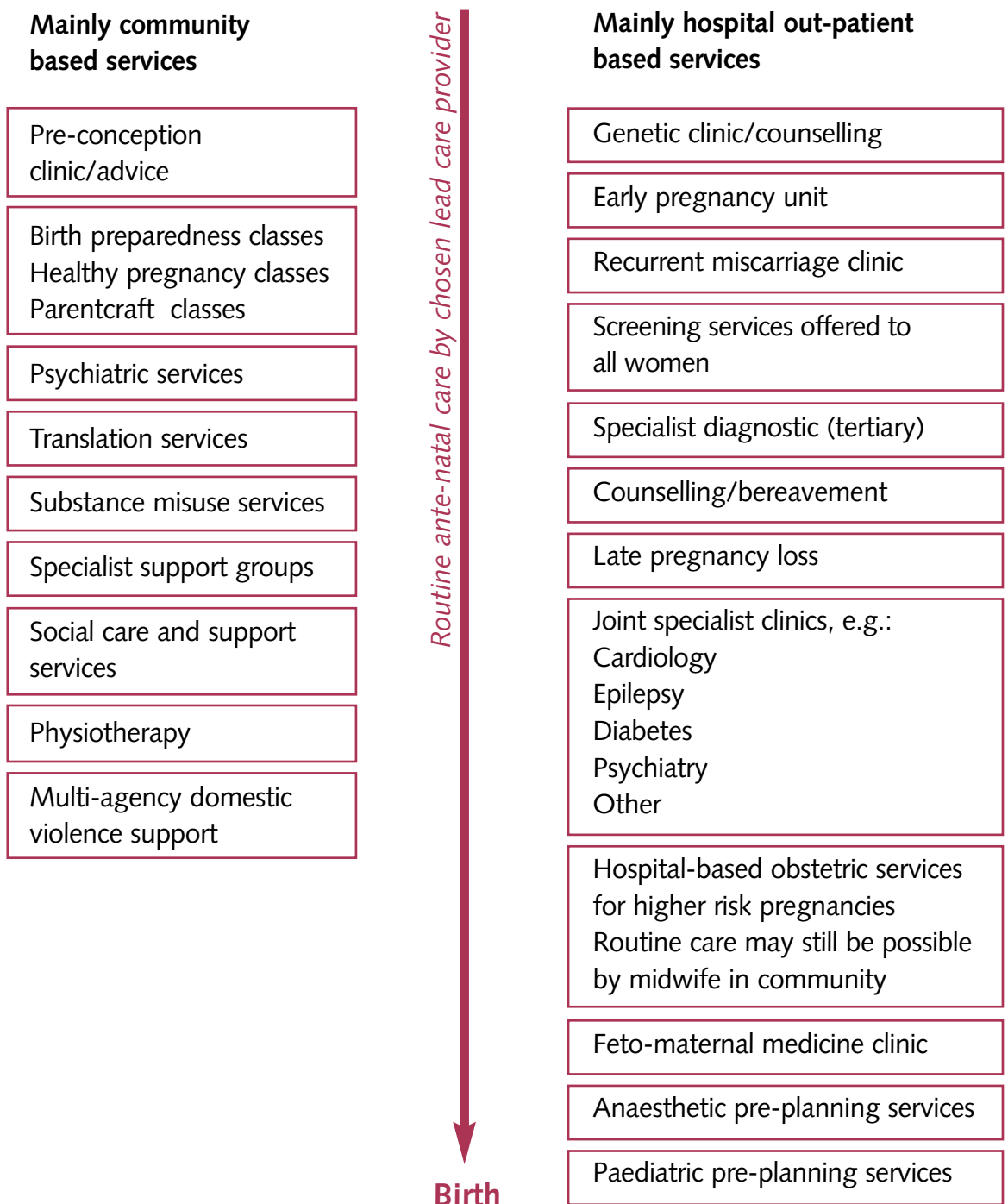
The assessment and planning of services takes into account the availability of IT equipment and networks, local transport services, access to facilities for wheelchairs or baby buggies and for women with physical, sensory or learning disabilities; and access for women from disadvantaged or minority groups.

Strategic Health Authorities, Primary Care Trusts and NHS Trusts implement a service user involvement programme for maternity services and ensure that the local population has representation on a Maternity Services Liaison Committee (MSLC), within a clinical network.

Primary Care Trusts and NHS Trusts have local interagency information sharing and working arrangements between all agencies providing care to women and their families. The arrangements reflect recent guidance on information.

**Appendix 1:**

**An example of a possible managed care network for ante-natal care**



## **In-patient services**

In-patient or day care gynaecology/ termination of pregnancy

Referrals to and between services are managed through agreed and understood multidisciplinary protocols. The woman's lead carer refers direct and acts as gateway and keeps in regular touch with the woman and the services she receives

In-patient ante-natal services

Tertiary in-patient services

- <sup>1</sup> Department of Health *National Standards, Local Action Health and Social Care Standards and Planning Framework 2005/06 – 2007/08* 2004
- <sup>2</sup> Teenage Pregnancy Unit/ Royal College of Midwives/Department of Health *Teenage Parents: Who Cares? – a guide to commissioning and delivering maternity services for young parents* February 2004
- <sup>3</sup> Committee for Racial Equality *Maternity services code of practice* [www.cre.gov.uk/gdpract/health\\_maternity\\_cop.html](http://www.cre.gov.uk/gdpract/health_maternity_cop.html)
- <sup>4</sup> Department of Health *Delivering the Best – midwives contribution to the NHS Plan* 2003 [www.dh.gov.uk](http://www.dh.gov.uk)
- <sup>5</sup> National Institute for Clinical Excellence *Clinical Guideline Antenatal care; routine care for the healthy pregnant woman* London RCOG press October 2003
- <sup>6</sup> Singh D, Newburn M *Access to maternity information and support: the experiences and needs of women before and after giving birth* London: National Childbirth Trust 2000
- <sup>7</sup> Department of Health *Women's Mental Health: Into the Mainstream* 2002
- <sup>8</sup> Department of Health *Why Mothers Die* Report on the Confidential Enquiries into Maternal Deaths in the United Kingdom 1994-1996 London HMSO 1998
- <sup>9</sup> National Institute of Clinical Excellence *Why Mothers Die* The Confidential Enquiries into Maternal Deaths in the United Kingdom London RCOG Press 2001 ISBN 1-900364-65-4 <http://www.cemach.org.uk/publications.htm>
- <sup>10</sup> Department of Health *Domestic Violence: a resource manual for Healthcare Professionals* Department of Health March 2000

- <sup>11</sup> NHS Litigation Authority *Clinical Negligence Scheme for Trusts: General – Clinical Risk Management Standards* April 2004 edition [www.nhsia.com](http://www.nhsia.com)
- <sup>12</sup> Disability Discrimination Act 1995 The Stationery Office 1995
- <sup>13</sup> Department of Health *Birth to Five* 2004  
<http://www.publications.doh.gov.uk/birthtofive/>
- <sup>14</sup> SCOPE *Right From The Start Report 1994 The Template* Right from the Start Working Group 2003 edition
- <sup>15</sup> Department of Health *Good Practice and Innovation in Breastfeeding* Forthcoming publication 2004
- <sup>16</sup> Skills for Health *Children's National Workforce Competence Framework for Children's Services* April 2004 [www.skillsforhealth.org.uk](http://www.skillsforhealth.org.uk)

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Notes







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