

Commissioning strategy for maternity services 2014 - 2019

Change Cornwall picture



Delivering “*Excellence in Maternity Care*”

(NHS Institute Maternity Improvement Programme, 2011-12)

Our shared vision for maternity services in the South West Peninsula is a service where all maternity related services work closely together to promote pregnancy and childbirth as an event of social and emotional significance where women and their families are treated with dignity, respect and compassion.

For every mother wherever they live and whatever their circumstances, pregnancy and childbirth will be a safe and positive experience so that mother and their partner can begin parenting feeling confident, capable, well supported and able to give their child a secure start to life.



Foreword

Maternity services and the care they provide to women, babies and families are of the utmost importance to society. It is key that women have a safe and emotionally satisfying experience during pregnancy, having their child and the postnatal period.

The coming together of the three Clinical Commissioning Groups (CCGs) with service providers, clinicians, children's centres, voluntary organisations and most importantly service users to develop this commissioning strategy clearly underlines our commitment to the maternity service in the wider context of maternity care.

The coming two - five years will present new challenges and opportunities for the services to develop and shape the future whilst consolidating existing good practice.

We hope etc

Signatures

.....

.....

.....



Individuals
at the centre

Executive summary

This maternity services commissioning strategy strives to ensure responsive NHS maternity services are available within Northern, Eastern and Western (NEW) Devon, South Devon and Torbay and Kernow CCGs, that are centred on the needs of women and their families.

It sets out the strategic direction for the next five years and places maternity services within the wider context of maternity care.

The strategy links needs assessment work with national policy, statutory obligations, evidence bases and commissioning intentions of all three CCGs.

There is a considerable body of evidence that has highlighted the enormous influence that the earliest experiences in a baby's life can have on later life chances. It is key therefore that all of those services working with mothers and families work towards the over-riding aim of continuing to improve the quality of services, concentrating on safety, better outcomes and satisfaction for all women and their babies.

This aim is supported by the following four key principles:

1. **Pregnancy and birth:** These are essentially normal physiological processes, therefore for the majority of women a culture of normalisation of pregnancy and birth offer the best chance of a successful outcome and positive experience.

The majority of healthy women can give birth with a minimum of medical procedures and most women prefer this provided they and their baby are safe.

To this end midwives will take a key role in maternity care by encouraging early and direct access, and risk assessment throughout pregnancy and postnatal period to ensure that women who are at a higher risk are detected as early as possible to ensure that specialist care appropriate to their needs is provided.

2. **The National Choice Guarantee:** We will aim through this commissioning strategy to support the importance of the National Choice Guarantee providing choice of how to access maternity care, choice of antenatal care, and choice of place of birth whenever possible, practical and safe.

3. **Continuity of care:** All women and their partners, however complex the pregnancy, need to know and trust the midwives who are caring for them. We will work towards every woman being

supported by a midwife she knows and trusts throughout her pregnancy and after birth, and to strive to achieve one-to-one midwifery care in established labour.



4. **Safety:** It is of paramount importance that services are available to secure the safety and wellbeing of women, their family and baby.

This commissioning strategy will aim to ensure that all services commissioned will deliver the most equitable outcomes in areas of deprivation. It will be responsive to, and targeted at the specific needs of mothers, partners and babies known to be at risk of poor outcomes

This strategy has five key measurable outcomes linking to the NHS outcomes

framework indicators and national public health outcomes framework. They will be delivered through the maternity services implementation plan, an example of which can be found in [Appendix 1](#). (NHS outcomes framework indicators and national public health outcomes framework)

- An improvement in maternal health – this includes improvements in rates of early access to midwifery care, reduction in maternal obesity and rates of smoking
- A reduction in infant mortality
- A reduction in infant morbidity
- An improvement in women and their families' experience of maternity services.

Details of how the commissioning intentions of this strategy will be achieved will be detailed in a comprehensive implementation plan.

Vitaly important also is that services recognise the need to listen empathically and sensitively to service users to ensure they become true partners in deciding and agreeing on their care throughout the maternity pathway.

This strategy has been written with the aim that the voice of women and their families are key to delivering future service provision.

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1.0 Glossary / abbreviations

BME	Black, Minority and Ethnic
BMI	Body Mass Index
CC	County Councils
CC	Complications and Co-morbidity
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CMACE	Centre for Maternal and Child Enquiries
CNST	Clinical negligence scheme for trusts
CO	carbon monoxide
CPD	Continuing Professional Development
CYP	Children and young people
DCC	Devon County Council
DERRIFORD	Derriford Hospital, Plymouth
DOH	Department of Health
FGM	Female Genital Mutilation
GOV	Government
GP	General practitioners
HCP	Healthy child programme
HRG	healthcare resource groups
HSCIC	health and social care information centre
HV	Health Visitors
IMD	index of multiple deprivation
IQ	intelligence quotient
LA	Local Authorities
MLU	Midwifery led units
MSLC	Maternity Services Liaison Committee
NCT	National Childbirth Trust
NEW Devon	Northern, Eastern and Western Devon

NDDH	North Devon District Hospital
NDHCT	Northern Devon Healthcare NHS Trust
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NMC	Nursing and midwifery council
NRT	Nicotine Replacement Therapy
NSF	National Service framework
ONS	office for national statistics
PBR	Payment by Results
PHAST	Public Health Action Support Team
PHE	Public Health England
PHN	Public Health Nurses
PHNT	Plymouth Hospitals NHS Trust
PMIMH	Perinatal Maternal and Infant Mental Health
RCHT	Royal Cornwall Hospital Trust
RCM	Royal College of Midwives
RCP	Royal College of Physicians
RD&E	Royal Devon & Exeter Hospital
RGOC	Royal College of Obstetricians & Gynaecologists
SD&T	South Devon & Torbay
UCL	University College of London
UK	United Kingdom
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organisation
YTD	Year to Date
<	less than
>	more than

2.0 Introduction

This commissioning strategy sets out the strategic plans for the commissioning of maternity services for the period 2014 to 2019.

The birth of a baby is a significant event and in the South West Peninsula women and their families generally experience high quality safe maternity care.

A new born baby deserves the best start in life that its parents and society can give it.

This commissioning strategy recognises the wider determinants of health and the links between maternity and the broader social and public health agenda.

There is strong evidence that good maternal and paternal health contributes to positive health outcomes in babies and onwards throughout their childhood into later life (*Delivery Excellence in Maternity Care and Kuh Dt, Ben-Schlomo, Y1997¹*). The promotion of healthy lifestyle behaviours around the time of a pregnancy is therefore particularly important.

An integrated approach to public health, pre-conception and maternity care is vital to improve pregnancy outcomes and reduce health inequalities.

Through the provision of universal information, early intervention and support, parents and their families can make better life choices. This will ensure they are better prepared for pregnancy, for birth, and the continued care of their baby.



Commissioners and providers of health services are committed to ensuring that women and their families are at the heart of this commissioning strategy. The need to place women in control of their own pregnancy and support proactive choice underpins its direction.

We are committed to promoting the 'Normalisation Agenda'. (*Promoting Normal Childbirth, NCT 2010²*) However, some women, particularly those with more complex needs, will require midwifery care and care from a consultant and from specialist midwives.

Women told us that the key to a positive experience was being treated with dignity, empathy and respect, being listened to - whatever their situation or age - and being enabled to feel 'in control'.

This maternity services commissioning strategy will aim to ensure maternity services meet both local and national guidance and requirements. The strategy links needs assessment work with national policy, statutory obligations, evidence based commissioning intentions and importantly, reflect the views of service users and stakeholders. The NHS England *Mandate for Maternity³* and its focus on personalised maternity care is embedded in this strategy.

It should be noted that the context for future commissioning is set by the significantly challenging financial environment being faced by the NHS.

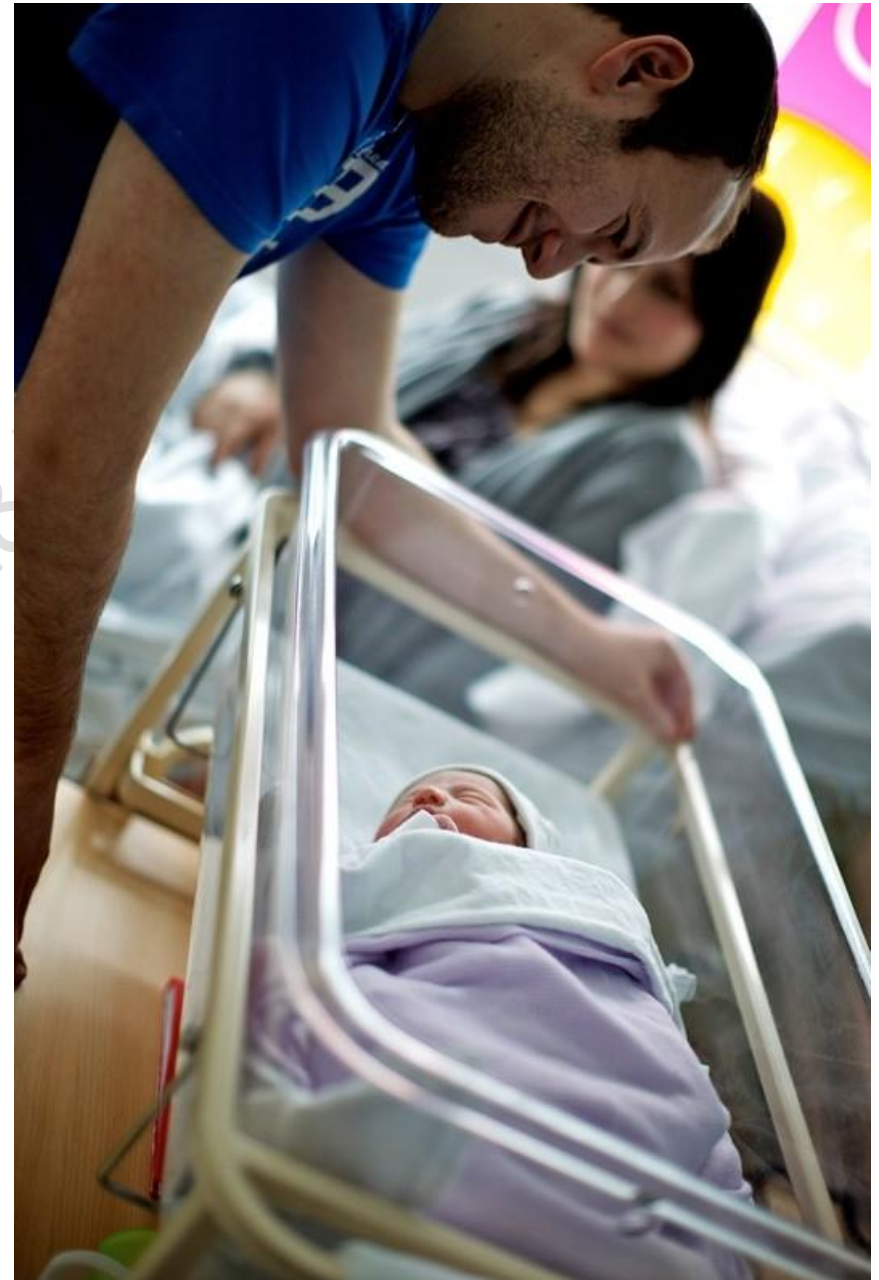
In addition, in 2013/14 the National Payment by Results (PbR) guidance changed the funding for maternity services.

It will be vital for maternity services to ensure the resource is used effectively with highly skilled clinicians managing their resources by doing what only midwives and doctors can do.

This will lead to commissioners considering options for future service models that make full use of an integrated approach to the wider concept of maternity care and all appropriate services in the community.

Commissioners from the three CCGs were supported by a number of task and finish groups to produce this overarching commissioning strategy.

This strategy aims to ensure women receive an equitable service and service outcomes, whilst recognising there will be a need to reflect local variation within the area of each CCG's own strategy.



What you told us about maternity services

Add Cornwall

The surgeon who performed my caesarean section was fantastic, he came and saw me after surgery, which was nice.
Torbay

"Baby groups at Children's Centres are brilliant"
Devon

My midwife kept me informed, was supportive of breast feeding, and gave useful techniques - I am still breast feeding now
Torbay

Cornwall



Specialist perinatal team really helped me when I started to get depressed.
Devon

Good being able to contact midwives by 'phone.
Devon

I loved my midwife – she explained everything to me – she knew I was worried about being judged because of my age.
Torbay

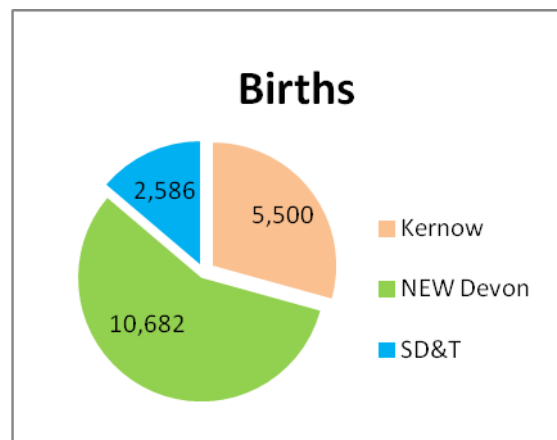
Cornwall

3.0 Current service provision

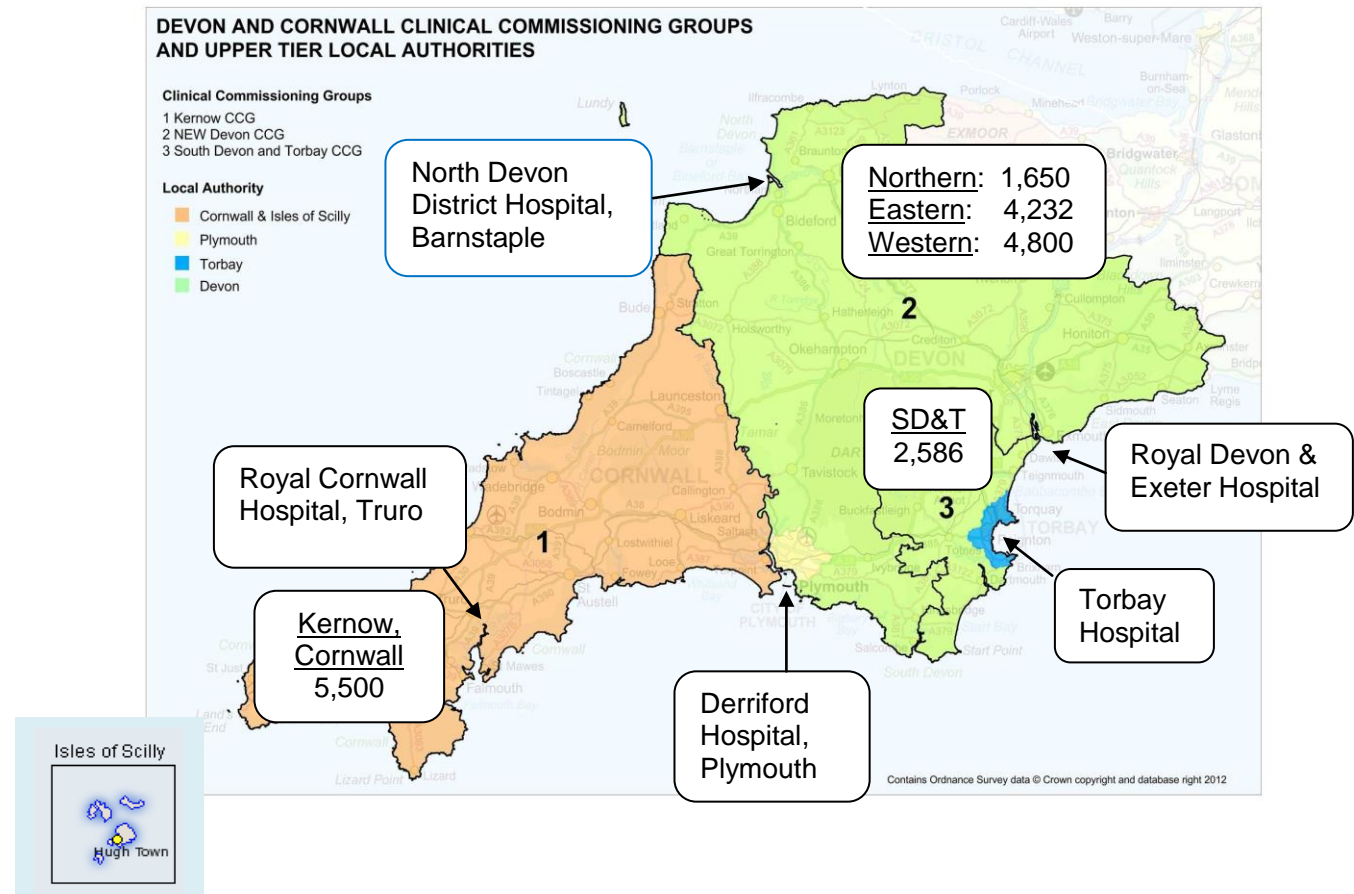
Maternity services provide care for women once they become pregnant until transfer to the Public Health Nursing Service.

In Devon, Torbay and Cornwall, midwifery services are provided by midwives and doctors based within District General Hospitals/ Teaching Hospitals, and with services provided by midwives in the community, within midwifery led units, children's centres, GP practices, and in the home.

For a synopsis of maternity services provided across the three CCGs, (see [Appendix 2](#))



Number of births 2012/13



All five maternity units in the South West Peninsula are commissioned by one or more of the Peninsula's three CCGs. In addition, whilst Cornwall CCG is coterminous with Cornwall Council, the geographical county of Devon has two CCGs that are not conterminous with the Local Authority boundaries of Plymouth City Council, Torbay Council and Devon County Council. By working together to produce this commissioning strategy the three CCGs wish to provide consistency in provision wherever possible.

4.0 Commissioning principles

The key values and principles for commissioners and providers of maternity services are based on the commitment of putting women, their partners and babies at the heart of this commissioning strategy, we will work together to ensure that services:

- Are of a high quality, providing safe, accessible, equitable and sustainable service outcomes for women and their families
- Place the woman and their family at the centre of care and supporting the principal of normalisation (*Promoting Normal Birth (DHS 2011)*)⁴
- Are based upon best practice and national guidance
- Are commissioned and delivered, reflecting and listening to service users throughout the process
- Are responsive to change, recognising the need to be open and transparent and reflecting the lessons learnt from incidents and events (*Introducing the Duty of Candour (Gov.uk, 2014)*)⁵
- Uphold the six fundamental values identified in *Compassion in Practice (DoH 2012)*⁶ recognising the unique midwifery and nursing contribution.



**Care
Compassion
Competence
Communication
Courage
Commitment**

5.0 Scope / definition of commissioning strategy

For the purposes of this document, 'maternity services' refers to professional care delivered to women, and the support provided to their partners in the pre-conceptual, antenatal, labour and birth (intrapartum), and the postnatal period (up to 28 days). These include midwives, obstetricians, anaesthetists and neonatologists / paediatricians, all working collaboratively with other specialties as required.

'Maternity care', on the other hand, is a broader concept and refers to care provided throughout the maternity pathway. This can be delivered through various models of care: by maternity professionals (as identified above), primary care professionals (including general practitioners), public health nurses (health visitors), and colleagues from mental health services, children's centres, social care and the voluntary sector.

This commissioning strategy defines the strategic commissioning direction for maternity services whilst recognising the need for the wider maternity care agenda to be considered.

6.0 Service user / stakeholder / clinical engagement

We recognise that strengthening and enhancing the contribution and involvement from women and their families in the design, planning and decision-making process will result in service users working as partners, ensuring their experiences of maternity services are taken into account.

The commitment that has been shown by service users, stakeholders and commissioners has provided an excellent foundation for this strategy.

All three CCGs already support locality-based Maternity Services Liaison Committees (MSLCs) which provide an important link of maternity services with local communities and voluntary organisations. The key element here is that there will be on-going commitment for the continuation of MSLCs in the coming years.

We are committed to ensuring that women and their families are at the heart of developing maternity services.

We will therefore work together in a meaningful way to support local MSLCs and ensure service user participation in the commissioning process.

The outcomes of this commissioning strategy will enable women and their families to say:



For detailed analysis of stakeholder involvement [\(see appendix 3\)](#)

7.0 Commissioning context

There are a number of commissioning organisations involved in commissioning the maternity care pathway.

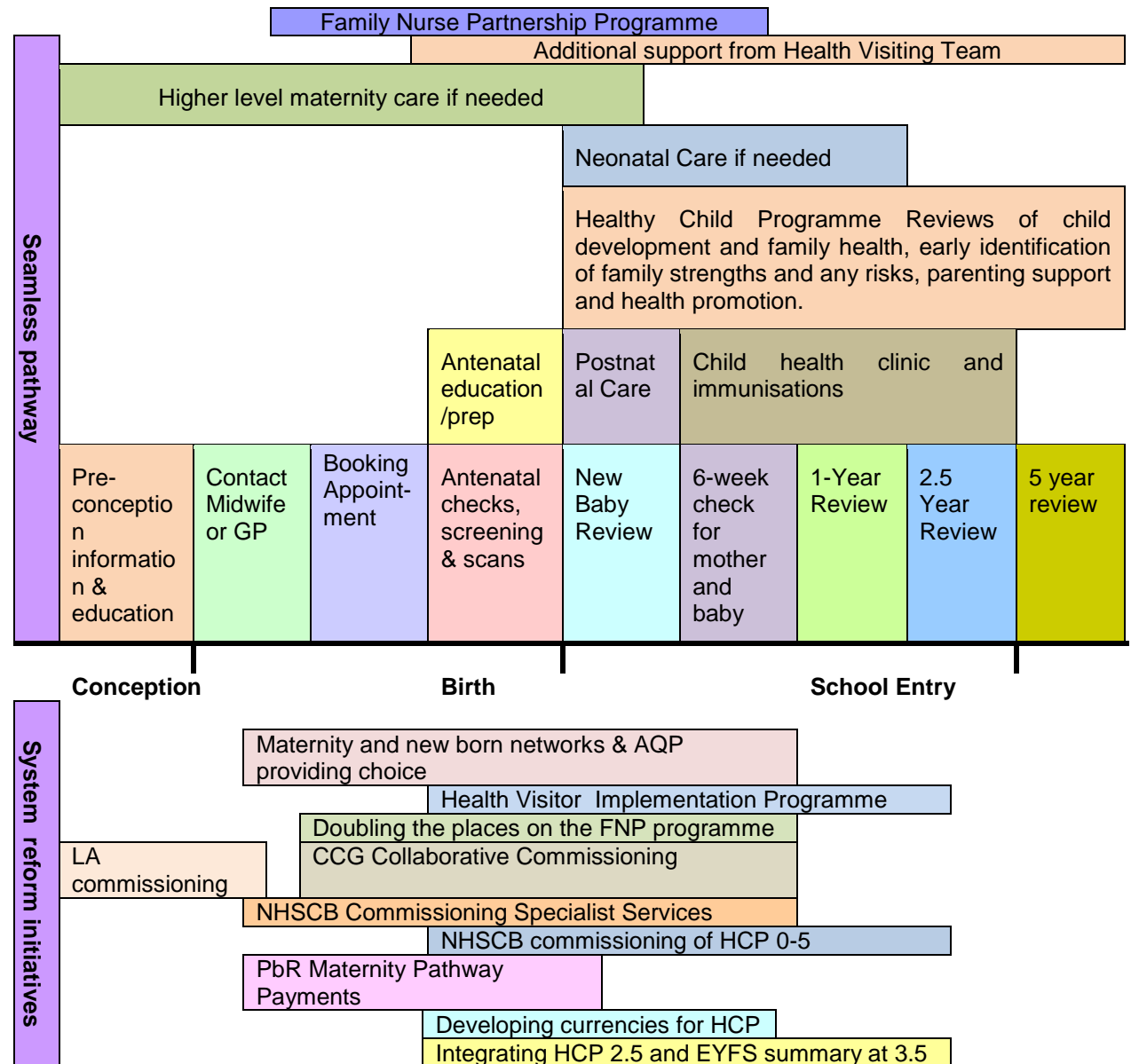
Whilst the CCGs are responsible for much of this pathway, Local Authorities, County Councils and until 2015 NHS England, are responsible for commissioning specialised maternity services, general practitioners, health visitors, education support, children's centres and Public Health services.

We will aim to work with our commissioning colleagues across the pathway to develop seamless co-ordinated maternity care.



Commissioning framework

(Commissioning Maternity Services, 2012)⁷



8.0 List of commissioning intentions

Stakeholder engagement (p.11)

Women and their families will be at the heart of developing maternity services.

We will develop and support local MSLCs

Commissioning context (p.12)

We will aim to work with our commissioning colleagues across the pathway to develop seamless co-ordinated maternity care

Partnership working (p.16)

The maternity pathway will include all disciplines to work towards achieving the best outcomes for parents and babies.

We will:

- work with GPs to discuss the role of primary care
- ensure that GPs are involved in line with local and national guidance
- work with all our partners to develop a strategic approach to children's centres, and ensure commitment to each area's Early Years Offer.



The pronoun "We" used throughout this document describes the three commissioning organisations

Maternity networks and Public Health (p.18)

We will work with:

- the South West Maternity and Children's Strategic Clinical Network to develop best practice
- Public Health to promote a whole systems approach, ensuring relevant Public Health initiatives including the midwifery contribution.

Strategic national framework (p.19)

We will work to ensure services are delivered in line with national directives and regulatory standards and local requirements.

Changes in demand for maternity services (p.20)

We will ensure services are non-stigmatising, equitable, fair and accessible.

Reducing health inequalities and promoting health (p.21-25)

We will work with:

- all relevant providers to reduce health inequalities and promote health and wellbeing
- colleagues to ensure the 'Quit Smoking' programme is a high priority for maternity services
- service providers to develop, support and implement the principles of the UNICEF Baby Friendly initiative
- providers to ensure there is an equitable and seamless pathway of care for all women who require perinatal infant health services
- all appropriate organisations to ensure the safeguarding needs of children and young adults are met, including girls and women at risk of FGM
- providers to ensure all midwives are trained to recognise and act on domestic abuse
- our providers to ensure a regional wide dashboard will be implemented.

Substance misuse in pregnancy (p.22)

We will work with providers to ensure better recording of data on BMI.

Then we will work with colleagues to ensure an audit of compliance against the recommendations in NICE guidance PH27, 'weight management before, during and after pregnancy' is undertaken and the findings used to inform our action plan.

Enabling choice (p.26)

We will work with local providers to ensure the development and implementation of the Choice Guarantee.

Pre-conceptual care (p.27)

We will work with the relevant providers to scope the current arrangements for pre-conceptual care to inform future service provision.

Antenatal care (p.28-30)

We will work:

- with our providers to reduce the number of women who access services later than 12 weeks and six days
- to ensure women receive individualised / personalised care during their pregnancy, including women with complex medical problems
- with providers to ensure access to appropriate fetal medicine services
- to ensure those women and their families experiencing loss in early or late pregnancy, receive the support they need
- with service providers to ensure there is a parent-centred approach to the provision of parent education.



Intrapartum care (p.31)

We will work with our service providers to address the challenge of meeting the Choice Agenda regarding place of birth and to ensure all women receive one-to-one care where possible, enabling a positive birth experience.

Postnatal care, new born and neonatal care (p.32)

We are committed to ensure that postnatal care gives a positive experience for women, their partners and babies, including vulnerable families, and that there is a safe transfer process to public health nursing services.

Workforce (p.33)

We will work with our service providers to ensure the long-term sustainability of maternity services which are flexible to meet changing demands.

Public Sector Duty (p.34)

We will seek assurance that providers follow Public Sector Quality duty (EHRC 2011)



Please note

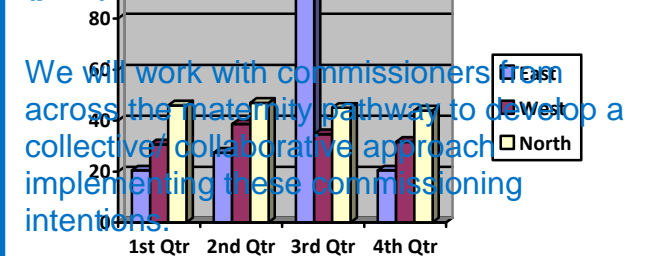
High level commissioning intentions can be found in boxes throughout the document. These will be supported by a more detailed action plan identifying the actions, outcomes and monitoring arrangements.

Data collection (p.35)

We will continue to work with the South West Maternity and Children's Strategic Clinical Network, County Council, Public Health colleagues and provider units to ensure there is a consistent methodology for collecting, monitoring, utilising and sharing maternity data.

There is an expectation that a regional-wide dashboard will be implemented.

Way forward / implementation plan (p.35)



9.0 Partnership working

It is recognised that the health and wellbeing of parents and babies is a shared endeavour. This involves working in full partnership with parents and families, communities, community and voluntary services, early years and primary care services, and other statutory services to deliver the best outcomes for parents and babies.

We will work collaboratively to ensure the maternity pathway includes all disciplines and provides clarity regarding their individual contribution, and work towards achieving the best outcomes for parents and babies.

Public Health nursing (health visiting)

Health visitors link with midwifery services in the antenatal and postnatal periods to provide additional and on-going support to families contributing to early help, including intervention support and referral ensuring readiness for parenthood through working with mothers and their babies and families (as recommended in the *Healthy Child Programme*).

General practice

General practitioners (GPs) are well placed to know individual patients and their families, and may be managing women for certain clinical conditions such as diabetes and high blood pressure, which could have a significant impact on pregnancy and may share care with the midwives.

GPs are also in a key position in identifying those women who may be socially isolated or vulnerable for whatever reason.

GPs may also be involved in:

- pre-conceptual care (e.g. staying healthy, folic acid supplement, obesity, smoking, rubella, amniotic fluid screening, genetic counselling, etc.)
- some antenatal care (e.g. sharing of relevant medical history, continuity of care especially for those women with complex medical conditions / family history)
- some postnatal care.

“Nationally the role of the GP has reduced due to the development of more midwifery-led services.” (*The role of GPs in maternity care – what does the future hold? - Kings Fund 2010*)⁸.

We will work with service providers to identify and clarify the primary care role in the provision of maternity care locally.

We will ensure that where GP's are involved in the provision of maternity care that they provide care according to local and national guidelines.



Children's centres

Children's centres (commissioned by County / City Councils) provide early childhood services to prospective parents during pregnancy and until a child is five years old. They are at the heart of delivering the early help and other related strategies.

The All Party Partnership Survey Strategy Groups '*Best Practice for a Sure Start: The Way Forward for Children's Centres*' (2013)⁹ makes a number of recommendations that reflect on maternity services (Appendix 4).

Currently children's centres both nationally and locally are subject to review the outcomes of which may affect their model of delivery with a reduction in the number of buildings.

We will work with our partners in Local Authorities / County Councils and the voluntary sector to:

- develop a strategic approach to services through children's centres where it is possible and appropriate
- ensure commitment to each area's early years offer



Working with maternity networks

*The Way Forward: Strategic Clinical Networks (NHS England, 2012)*¹⁰ states that:

“Clinical networks combine the experience of clinicians and the input of patients. They have supported and improved the way we deliver care to patients.

We are committed to the South West Maternity and Children’s Strategic Clinical Network to work with maternity services across the South West to contribute to and develop best practice.



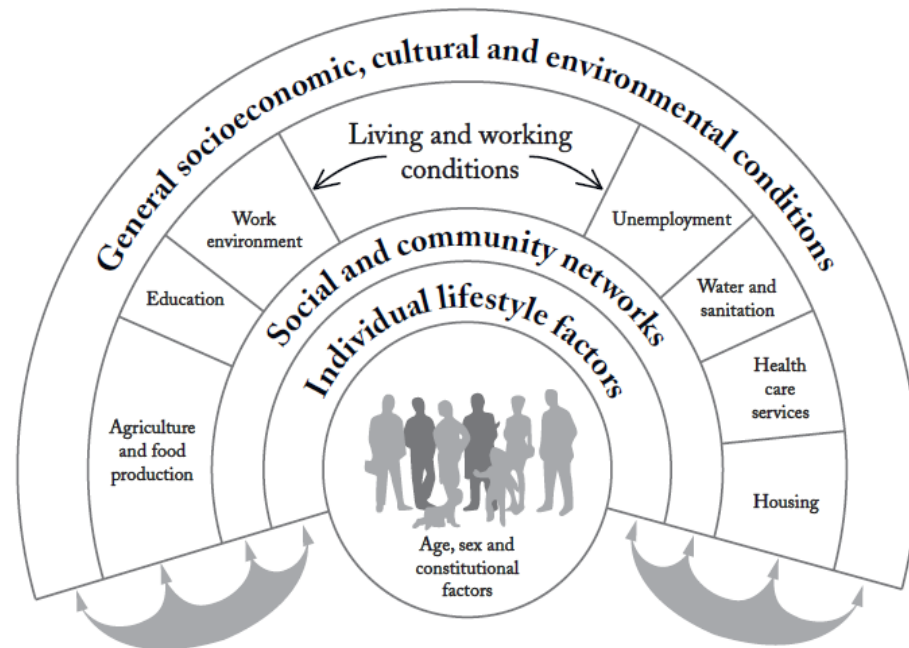
Working with Public Health

The *Department of Health Mandate April 2013-2015*³ has identified that improving Public Health is one of their key priorities and that it is the business of every nurse and midwife. There are two clear directives with relevance to midwives. These are:

- develop the nursing and midwifery contribution to “No health without mental health”
- developing a new model for the public health role of midwives.

Public Health as a whole system approach

(Health Knowledge Education CPD and revalidation from PHAST)



We will work with partners in Public Health to promote a whole systems approach to ensure the midwifery contribution is included within relevant Public Health initiatives.

10.0 Strategic National Framework

The national policy context on the improvement and development of maternity services is detailed in *Midwifery 2020 (DoH 2010)*¹¹, *Towards Better Births (2008)*¹², *Standards for Maternity Care (RCOG 2008)*¹³, *Safe Births : Everybody's Business (Kings Fund 2008)*¹⁴, *Maternity Matters (2007)*¹⁵, the *NSF for Children, Young People and Maternity Services (2004)*¹⁶, *Choosing Health (DoH, 2004)*¹⁷, *CNST (litigation for maternity cases)*¹⁸, NICE guidance on place of birth, and other NICE clinical guidelines.

The national policies including *'No Health without Mental health (2011)*¹⁹ recognises that maternal mental health problems during pregnancy increase the risk of adverse pregnancy outcomes as well as neuro-developmental problems for the child both before and after birth.

*Maternity Matters (DH, 2007)*¹⁵ outlines the focus on commissioning high quality, safe and accessible maternity services through the implementation of a choice guarantee for all women and their families, ensuring that women will have choice about the type of maternity care that they receive. This remains the Department of Health current position.

The National Choice Guarantee is to offer all women:

- choice of how to access maternity care (direct booking with midwife or via GP)
- choice of type of antenatal care
- choice of place of birth: depending on their circumstances
- choice of place of postnatal care.

The *Joint Planning and Commissioning Framework for Children, Young People and Maternity Services (2006)*²⁰ has been designed for people working in all sectors of children, young people and maternity services and aims to help local planners and commissioners design a unified system making the best use of resources and joining services where appropriate to provide better outcomes.

Additionally, *Our Health Our Care Our Say (2006)*²¹ sets out a vision of an individualised maternity service comparable with other maternity policies with a focus on access, choice and information.

*Promoting normal Childbirth (NCT 2010)*² showed that a focus on promoting normality and birth is associated with a lower rate of medical intervention such as instrumental deliveries and caesarean sections. This results in better quality and care for mother

and baby allowing midwives to spend more time caring for them.

*Making Normal Birth a Reality (RCM, RCOG, NCT 2010)*²² confirmed a shared view about the need to recognise, facilitate and audit normal birth.

The NHS Outcomes Framework acts as a catalyst for driving up quality of care and encouraging a change in culture and behaviour **(See appendix 5)**.

*The Pledge for better health outcomes for children and young people, (2013)*²³ sets out shared ambitions to improve physical and mental health outcomes for all children and young people. It commits signatories to putting children, young people and families at the heart of decision-making and improving every aspect of health services – from pregnancy through to adolescence and beyond.

The Government, NHS England, Public Health England (PHE), Royal Colleges, local government organisations and others have signed up to The Pledge.

We will work collaboratively with providers to commission a service that will be delivered in accordance with national directives, relevant clinical and regulatory standards and local requirements.

11.0 Changes in demand for maternity services

The number of births nationally has increased by almost a quarter in the last decade and is currently at its highest level for 40 years, placing increasing demands on NHS maternity services.

In Cornwall & Isles of Scilly (CIOS), Torbay and Plymouth the number of births are expected to remain static over the next seven years (see Figure 1, Appendix 6).

In Devon numbers of projected births in Exeter and North Devon are expected to rise over the next 10 years before a gradual decline towards 2030, with other district areas static or showing a gradual decline in numbers of expected births (see Figure 2, Appendix 6).

There is a substantial variation in fertility rates (see Figure 3, Appendix 6) across the Peninsula. Rates in Exeter and South Hams are statistically lower than National and South Western rates. Rates in Torbay and Mid Devon are above the South West average.

Over recent years there has also been an increase in the proportion of 'complex' births, such as multiple births (for example twins) and those involving women over the age of 40 years.

Nationally the number of babies born to women aged 40 or over rose by 85 per cent between 2001 and 2012. This pattern is mirrored locally (see Figure 4, Appendix 7).

Teenage pregnancy rates are declining across the South West Peninsula although rates in Plymouth and Torbay are still above the South West and England average (see Figures 5, Appendix 7).

We know that pregnant teenagers and young families often have complex needs outside the remit of maternity services. We will need professionals to take innovative approaches to developing care to promote enjoyment, rapport and engagement when working with young families.

Women who were previously not having babies because of their complex pre-existing medical conditions are also now embarking on pregnancy. These women often require sub-specialized clinical involvement in their maternity care adding extra demands on maternity services.

Maternity services should be responsive to the needs of:

- ethnic minorities
- recently arrived families
- travelling families
- substance abusing women and their families

- Children in need of protection.

The ethnicity of mothers in a local area has an impact on the kinds of services needed - for instance certain conditions are known to be more common in particular ethnic groups. Families who have recently moved to the UK may have difficulties reading or speaking English, and therefore require additional support.

The Peninsula, when compared to the rest of the UK, has a very low representation of black and minority ethnic (BME) groups.

A table outlining the percentage of deliveries by the ethnicity of the mother is in (Appendix 8). This information does not however capture diversity within ethnic categories. For example the ethnic category 'White' would include mothers from Eastern Europe some of whom may not speak English and therefore need support with translation services.

We will work with partner organisations to deliver non-stigmatising, age-appropriate, equitable, fair and accessible services that meet the needs of parents and their families.

12.0 Reducing health inequalities and promoting health

“It is clear that a good start make a crucial difference in securing good outcomes for children / adults.” (Best Practice for a Sure Start 2013)⁹

Giving every child the best start to life is crucial for securing health and reducing inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid down in early childhood.

What happens during these early years, starting in utero, has life-long effects on many aspects of health and wellbeing from obesity, heart disease and mental health, to educational achievement and economic status.

The Marmot Review reflects the above in six key statements referring to children and young people (See Appendix 9). *Fair Society, Healthy Lives (2010) – the Marmot review of health inequalities in England²⁴.*



Health inequalities

Socio-economic status is strongly associated with health outcomes for mothers and their babies. Babies born to mothers living in the most deprived areas have around twice the rate of still birth and neonatal death than those born to mothers living in the least deprived areas. (ONS 2012)

The maternal death rate amongst women living in families where both partners are unemployed is up to 20 times higher than for women in the highest two social classes.

“Each midwife has the opportunity to influence the woman and the subsequent life chances for her child from pre-conception to the postnatal period”. (Midwifery 2020)¹¹

Deprivation varies across the CCGs. CIOS, Torbay and Plymouth have above the national average levels of urban deprivation. All rural areas of the peninsula, with the exception of East Devon and Teignbridge, have above the national average score for rural deprivation, which is associated with issues of social isolation, a low wage economy, high housing and living costs and greater distance to travel to services (see Figure 7 & 8, Appendix 10).

Within NHS NEW Devon CCG, more than half (six) of the top 10 most deprived wards are found in the Western Locality (See Appendix 10). We know that women affected by social deprivation find services hard to access.

We will take a collaborative approach with all relevant providers to reduce health inequalities and promote health and wellbeing.

Substance misuse in pregnancy

There is no reliable data locally or nationally on the proportion of women consuming alcohol or using drugs during their pregnancy, pre-pregnancy or pre-pregnancy recognition.

There are clearly significant problems associated with substance misuse during pregnancy but there are many difficulties in determining the most appropriate and affective response to these problems.

We will work with providers to audit the provision of advice about alcohol and drug use during pregnancy, the screening of women for substance misuse and the provision of services to support those identified with substance misuse problems before, during and after their pregnancy.



Maternal obesity

There is substantial evidence that obesity in pregnancy contributes to increased morbidity and mortality for both mother and baby.

Women who are obese when they become pregnant are more likely to experience complications and adverse outcomes during pregnancy and childbirth, including maternal death, miscarriage, pre-eclampsia and

gestational diabetes (CMACE/ RCOG 2010)²⁵.

Women who are obese are more likely to have a longer or induced labour and an instrumental delivery or caesarean section (Yu et al, 2006)²⁶.

Obese women are likely to spend longer in hospital than those with a healthy weight because of morbidity during pregnancy and labour related to their weight (Chu et al, 2008)²⁷.

Babies born to obese women also face several health risks, including fetal death, still birth, congenital abnormality and subsequent obesity (Ramachenderan et al, 2008)²⁸.

Women with a high BMI need to be supported to lose weight before, during and after pregnancy. Better recording of BMI status is important to support the development and provision of appropriate services. (See Appendix 11)

We will work with providers to ensure better recording of data on BMI.

Then we will work with colleagues to ensure an audit of compliance against the recommendations in NICE guidance PH27, 'weight management before, during and after pregnancy' is undertaken and the findings used to inform our action plan.

Smoking in pregnancy

- It remains one of the few preventable risk factors associated with complications in pregnancy.
- It causes an increased risk of miscarriage, still birth, low birth weight and sudden unexpected death in infancy (RCP, 1992)²⁹. (tables 1 & 2, Appendix 12)
- It is associated with psychological problems in childhood such as attention and hyperactivity problems and disruptive and negative behaviour. (Button et al, 2007)³⁰

There are significant variations in smoking rates across the Peninsula (see Figure 11, Appendix 12). Plymouth, Torbay and Cornwall & Isles of Scilly have higher rates of smoking at delivery when compared with the South West and England averages.

All areas have seen a decline in the rates since 2006, although in Devon the rates have remained static since 2010.

The proportion of mothers smoking at delivery varies dramatically according to socio-economic status from nearly 26 per cent in the most deprived group to 5 per cent in the least deprived group (see Figure 12, Appendix 12).

We will work alongside colleagues from Public Health England to ensure the 'Quit Smoking Programme' is a high priority for Maternity Services. This will include auditing compliance against the eight NICE guidance Smoking Recommendations (see Appendix 13).



Infant feeding

The benefits of breast feeding are widely evidenced and include for the infant:

- a reduction in infection, including gastroenteritis, respiratory and ear infections leading to hospitalisation (*Ip S. et al, 2007*)³¹
- a reduction in childhood obesity increasing the risk of developing type-2 diabetes
- reduction of blood pressure and cholesterol in adulthood. (*Horta, B. et al, 2007*)³²

For mothers:

- breastfeeding is associated with a reduction in the risk of breast and ovarian cancers. (*Beral, V. 2002*)³³

Rates of breastfeeding vary widely between different socio-economic groups, (see **Figure 13/14, Appendix 14**), with mothers from professional and managerial groups much more likely to initiate breastfeeding than mothers from the most deprived groups.

Plymouth, Torbay and North Devon, which all have high rates of deprivation, have lower than the Peninsula's average rates of breastfeeding initiation.

On the other hand South Hams and West Devon, relatively affluent areas, have higher rates of breastfeeding initiation than the cluster average as well as the England and South West average.



The United Nations International Children's Emergency Fund (UNICEF) UK Baby Friendly Initiative (2012) supported by the World Health Organisation (2001) and the Royal College of Midwives provides a

framework for the implementation of best practice by NHS trusts and other healthcare facilities with the aim of ensuring that all parents are helped to make informed decisions about feeding their babies and that they are supported in their chosen feeding method.

Implementing the Baby Friendly best practice standards is a proven way of increasing breastfeeding rates (*NICE, 2006; Broadfoot, M., 2005; Tappin, D.M. et al, 2001; UNICEF, 2012; Kramer M.S. et al, 2001*)³⁴.

The aim is to create a culture in which breastfeeding is a routinely accepted way in feeding a baby in the Peninsula.

We are fully committed to supporting the principals of the 'UNICEF UK Baby Friendly initiative' and will work with our service providers to ensure women and their families are supported to make an informed choice regarding their method of feeding, both initially and throughout the postnatal period.

We will seek to establish an infant feeding alliance to monitor progress towards achieving the principles of the UNICEF UK Baby Friendly initiative.

Perinatal maternal / infant mental health

During pregnancy and the year after birth women can be affected by a range of mental / emotional wellbeing problems which can affect at least 20 per cent of women. If untreated the impact can be devastating to the woman and her child, and also the whole family.

Better perinatal mental health is associated with better outcomes for children, including behaviour, and the development of better relationships.

For these reasons we are committed to ensuring that women and their families receive effective prevention, detection and treatment through the development and support of specialist perinatal mental health care services.

We are committed to work with perinatal maternal / infant mental health providers and the South West Maternity and Children's Strategic Clinical Network to ensure there is an equitable, seamless and consistent pathway of care for all women.

Safeguarding / domestic violence

Domestic violence is any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 years who are or have been intimate partners or family members.

Evidence tells us that 30 per cent of domestic violence starts in pregnancy (*Women's Aid 2005*)³⁵ with between four and nine women in every 100 being abused during and or after their pregnancy.

Domestic abuse has been identified as a prime cause of miscarrying or stillbirth and of maternal deaths in pregnancy.

The ability to recognise potential indicators and signs of abuse to both the pregnant woman and her child is imperative. Early intervention for mothers and babies in securing additional support is vital.

All services will work to the appropriate evidence based Assessment Framework for their area. Early assessment is a key part of delivering frontline services that are integrated and focused around the needs of children and young people. The aim is to identify, at the earliest opportunity, a baby, child or young person's additional needs which are not being met by the universal services they are receiving and provide

timely and co-ordinated support to meet those needs.

We are committed to compliance with National Guidance to ensure the safeguarding needs for children, young people and adults are met. The principals outlined within this document must underpin all service provision.

To work with midwifery service providers with the aim of ensuring all midwives are appropriately trained to recognise domestic abuse and have systems in place to support women and signpost on for further help with their agreement.

Female Genital Mutilation (FGM)

Female genital mutilation is estimated to have affected 66,000 women nationally (this is a conservative estimate in Britain). FGM is a violation of the human rights of girls and women, and as such must be treated as child abuse. (*WHO Fact Sheet 241*)³⁶

This is an important issue for commissioners. We will collaborate with appropriate relevant partners to ensure that girls and women at risk of FGM are not overlooked.

13.0 Enabling choice

(as defined in Maternity Matters 2007 ¹⁵)

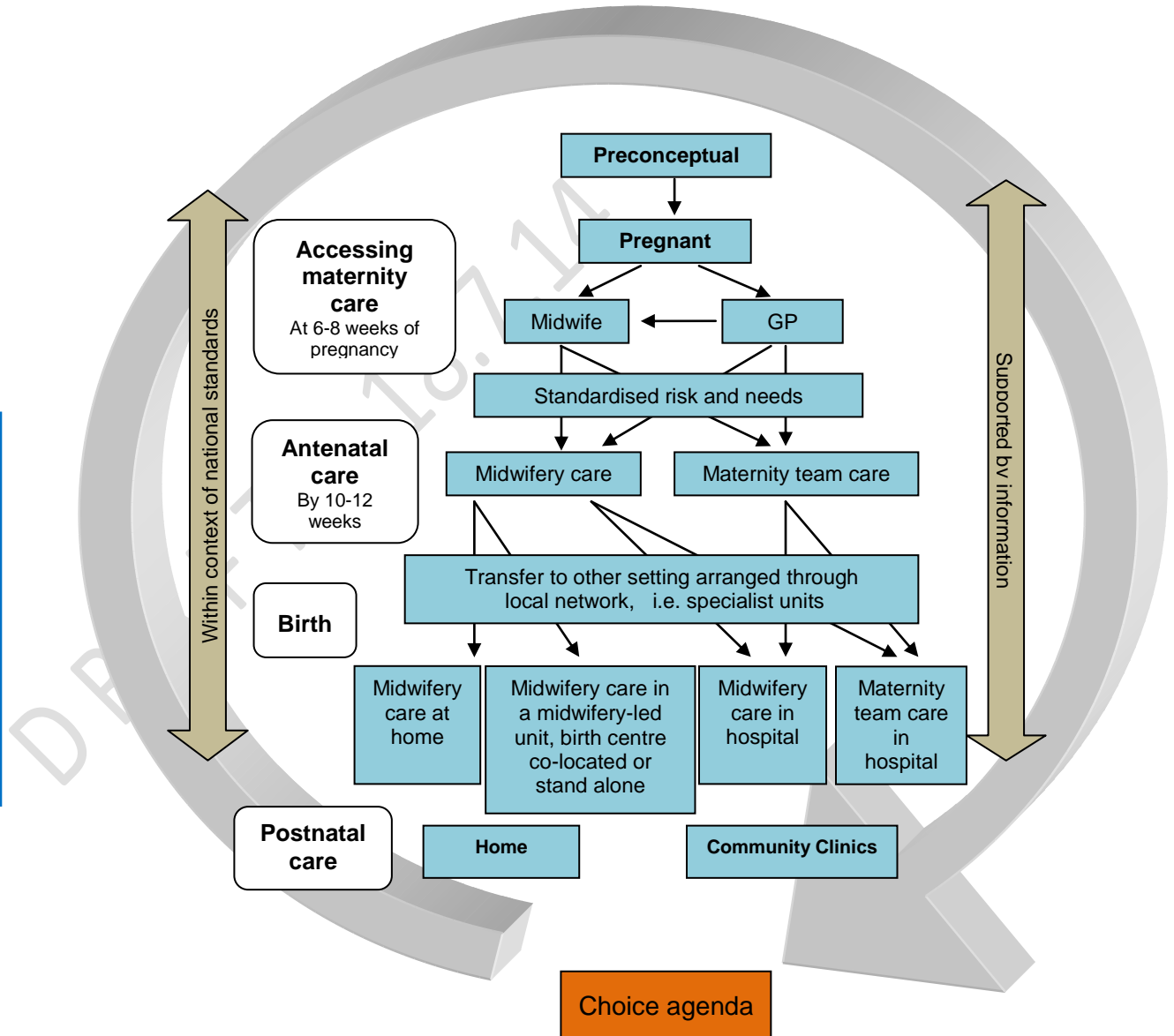
The model of care for women in the Peninsula will place the mother and her family at the centre of her care, ensuring that service provision is timely and women-focused, based on the National Institute of Clinical Excellence (NICE) guidance, including the NICE Pathways of Care.

We know from listening to a number of parents that being ‘listened to’ and involved in planning their care is very important.

We will work with local providers:

- to develop the choice guarantee for women and their partners
- to facilitate and empower women and their partners to make an informed choice with their multidisciplinary team
- to provide comprehensive information in a variety of formats to assist that choice.

Maternity Care Pathway (*Maternity Matter 2007*)



14.0 Pre-conceptual care

Pre-conceptual care provides support and advice for families to ensure women have the best chance of having a healthy pregnancy and a healthy baby.

*Preconception Health (Womenshealth.gov. 2010)*³⁷. We recognise it is important in ensuring their optimum health outcomes.

It may provide the opportunity to:

- optimize the management of chronic maternal health problems
- provide lifestyle advice to avoid behaviours hazardous to a pregnancy, such as smoking, drinking excessive alcohol, or taking drugs
- provide advice to optimize the health of the mother and baby, such as guidance on taking folic acid supplements

- identify couples who are at increased risk of having a baby with a genetic or chromosomal malformation, and providing them with sufficient knowledge to make informed decisions.

Nationally only 50 per cent of the population plan a pregnancy (*UCL 2013*)³⁸

We will work with the relevant providers to scope the current provision.



15.0 Antenatal care

Antenatal services cover all the care for a woman when she discovers she is pregnant until she goes into labour. Having a healthy pregnancy is one of the best ways to promote a healthy birth.

Access

Early access to maternity services is essential in order that mothers and their unborn child will be able to receive assessment and screening services. This enables all women to receive the most appropriate care pathway for their individual needs.

Women needing additional care will be referred to the consultant obstetrician, which may subsequently enable shared care between the consultant and the midwifery team, including specialist midwives.

The national target for completion of the initial booking assessment is 90 per cent by 12 weeks and six days of pregnancy. Generally most women do receive this important early assessment.

Reducing the percentage of women who access maternity services late through targeted outreach work for vulnerable

and socially excluded groups will provide a focus on reducing the health inequalities these groups face whilst also guaranteeing choice to all pregnant women.

We will work with our providers to reduce the number of women who access services later than 12 weeks and six days through targeted outreach work to those most vulnerable women with the outcome of reducing the health inequalities some families face.

Continuity

All women and their partners, however complex the pregnancy, will want to know and trust the midwife and doctor who are responsible for providing information, support and on-going care.

We know that continuity of care throughout pregnancy by the same midwifery team is important for the confidence and safety of women and their families. A guiding principal for this commissioning strategy is that all women will experience continuity of care from their midwifery team during their pregnancy.

Midwives are the experts in normal pregnancy and birth and have the skills to

refer to and coordinate between any specialist services that may be required. Medical consultants will ensure those women who require additional help and support receive the care they need.

On-going needs assessment should be undertaken throughout the antenatal period.

Care will be provided in line with *NICE Guidelines for Antenatal Care (2013)*³⁹.

We will work with our service providers to ensure that women receive individualised care, according to their needs, in a safe and accessible environment by appropriate professionals. This care should be evidence based reflecting NICE guidance and the Healthy Child Programme.

Evidence tells us that women with pre-existing medical conditions are at a higher risk of serious complications and morbidity.

We will ensure pathways are updated in line with national evidence and best practice to ensure women with complex medical problems receive the appropriate medical assessment and on-going obstetric care.

Fetal medicine

Some maternity units will have specialists in fetal medicine, delivering care in specialist centres.

We will work with providers to ensure access to appropriate fetal medicine services.



Loss in pregnancy

The loss of a baby at any stage is an emotional and stressful time and affects the whole family. There are particular challenges for women who miscarry early in pregnancy.

Nationally seventeen babies are stillborn or die shortly after birth every day and 20 per cent of all pregnancies end in miscarriage. *A review of support available for loss in early and late pregnancy (2010⁴⁰)*, (See Figures 15 & 16 Appendix 15).

Maternal death

The death of a mother from pregnancy related causes is very rare in the UK.

This is also the case in the Peninsula where there were fewer than five maternal deaths between 2008 and 2012 (HSCIC based on ONS mortality data).

We would wish to ensure that women and their families experiencing loss in early or late pregnancy receive sensitive support through their contact with maternity services.

Education for parenthood

Emerging evidence identified in *Maternal Emotional Wellbeing and Infant Development*, RCM 2011 – “the transition to parenthood”⁴¹ suggests that if done well, preparation for parenthood can impact significantly on bonding, attachment and parenting, and reducing social and health inequalities.

In line with national findings a number of parents told us they felt unprepared for either the birth of their baby or how to provide care for their baby following birth.

We will work with our service providers to ensure there is a parent centred approach to the provision of parent education that is:

- provided equitably
- accessible i.e. times and venue
- content relevant and evidence based
- inclusive
- considers a range of approaches.

We will work with parents, Local Authorities / County Council colleagues, providers and third sector providers to review and plan more equitable services for those parents embarking on parenthood.

Good Practice in Plymouth

The Great Expectations is a free six week parenting programme and represents a partnership approach between Plymouth Community Healthcare, Plymouth City Council, local children's centres and Plymouth Hospitals NHS team. This is also now in place in Cornwall and Isles of Scilly.

The programme has been redesigned in line with Department of Health quality standards and ensures that parents are offered first class parenting education wherever they live across the city (See [Appendix 16](#)).

Add Cornwall info



16.0 Intrapartum care

Intrapartum care is the care and support provided for a woman and her partner during labour.

The National Choice Guarantees ensures all women will have an informed choice of place of birth.

Depending upon their circumstances, women and their partners will be able to choose between three different options:

- a home birth
- birth in a local facility under the care of a midwife
- birth in a consultant-led unit.

We are aware that these choices are available but not to all women in all areas.

Commissioners and service providers are all committed to the principle that pregnancy is for most women a normal process. Therefore all women and their partners will be offered the opportunity to choose their place of birth, including having their baby at home if safe and appropriate. *(NICE guidance 62 Routine Antenatal care for healthy pregnant women 2008)*⁴²

To help families make this important decision, every effort must be made to ensure information is provided to enable them to make an informed choice.

Women will be informed about what emergency care can be provided in and out of the hospital setting by midwives and paramedics.

Where a woman chooses to give birth at home or outside of an obstetric-led unit, there will be plans in place to ensure that if there are complications, the woman and baby can be transported safely and quickly to a consultant led unit.

Where women choose to give birth in hospital, NICE guidance recommends one-to-one care in labour, ideally from a midwife they know.

Many women cite one-to-one care in labour as the most important factor for them in having a positive birth experience. *(NICE guidance and Maternal Emotional Wellbeing and Infant Development (RCOG 2012)*⁴¹

The Department of Health have advised that applying evidence-based good practice of care leads to lower caesarean section rates and most importantly a better experience for women.

Between 1998/99 and 2005/06, the caesarean section rate in England rose from 12 per cent of all births to 24 per cent without measurable improvement in outcomes for babies and decreased morbidity for mothers.

We are aware that where clinicians in maternity units actively apply Best Practice in their management of labour and birth, caesarean section rates can be reduced.

We recognise that for some women a caesarean birth can be the safest and most appropriate way for their baby to be delivered, which can still be a positive birth experience for mothers and their partners *(See Appendix 17)*.

We will work with our service providers to address the challenge of meeting the full choice agenda providing equitable access to choice of place of birth.

We will work with our providers to ensure all women receive one-to-one care where possible and to experience a positive birth.

17.0 Postnatal care, new born and neonatal care

Postnatal care begins with the birth of a baby and continues in hospital and home and then through transfer to the health visiting service.

We know that supportive skilled care postnatally can promote bonding between mother and baby, enhance parenting skills, and support breast feeding. This is a vital time for both the mother and her partner to share and get to know their baby. It is a time when sensitive support can both recognise early perinatal mental health issues and ensure early intervention.

Yet we also know that postnatal wards can be very busy with maternity staff increasingly facing the challenges of providing care, advice and support to women with more complex needs.

Positive experience for the mother at this time can impact considerably upon her and her baby's health outcomes, relationships with family and friends, and her parenting capabilities.

New born and neonatal care

All babies receive care from midwives following birth, continuing after transfer home from midwives and maternity support workers assessing both mother and baby. This care includes all babies receiving the New born and Infant Physical Examination (NIPE).

The NIPE examination is undertaken to ensure diagnosis of any medical conditions the baby may have. The optimum time for this is within 72 hours of birth and may be in the hospital or in the baby's home.

It is vitally important that all front line staff are trained to undertake this examination and able to recognise and care for an unwell new born baby. This especially applies to those babies with early onset neonatal bacterial infection within 72 hours of birth, which can be a cause of morbidity and mortality.

Babies with a low birth rate are more likely to die or have special medical or education needs than those with a normal birth rate. Low birth rate is affected by risk factors such as smoking, alcohol and drug use which are more prevalent in areas of deprivation (Figure 17 Appendix 18).

It is important therefore that maternity service staff are appropriately skilled to ensure that care is targeted to those living in the most deprived areas in order to improve the life chances of the baby within the whole context of the family.

Transition to the health visiting service

Transfer of care from the midwife to the health visiting service will occur between 10 and 28 days following the birth of a baby in line with the *Healthy Child Programme (DoH 2009)*⁴³.

A full and comprehensive handover and discharge process focussed upon the individual needs of the mother, baby and the family ensures a seamless and safe transfer of care.

We are committed to ensuring that the care delivered by our providers postnatally gives a positive experience for women, their partners and baby.

We will also:

- work with our partners and providers to ensure services identify and provide for the most vulnerable families
- work with our partners and providers to ensure protocols are in place to enable safe individualised discharge/ transition processes

18.0 Workforce

In order to implement this commissioning strategy and to be able to provide a high quality, safe, personalised service, we recognise there needs to be a strong workforce that is caring, compassionate, experienced, skilled focussed, flexible and responsive to need. This workforce needs to have access to appropriate training and supervision and be focussed upon service delivery and feel supported and safe.

In common with the rest of the NHS, maternity services face some significant challenges over the next few years.

These include:

- changing demographic rising birth rates
- high levels of retirement
- the need for a more technically educated skilled workforce
- an increase in part-time working
- the development of specialist midwives
- high levels of public expectations
- the development of midwifery leaders
- the majority of the workforce is female.

In order to maintain high quality, safe and personalised care, in line with *The Right People in the Right Place*⁴⁴ and *Towards Safer Childbirth (RCOG 2007)*⁴⁵ providers will require a robust workforce development plan.

The recommended midwife to birth ratio, appropriate levels of consultant presence on labour wards, and appropriate skill mix should also be reflected in workforce plans.

The plan should also reflect local model of care, case mix, the needs of women and their families, and service redesign.

Provision of supervision and access to supervisory support in line with *Modern Supervision in Action – a practical guide for midwives NMC 2009*⁴⁶ should be in place.

We will work with our service providers to ensure long term sustainability of maternity services that are flexible to meet changing demands



19.0 Public sector equality duty

All maternity services must meet the requirements of the Government *Public Sector Equality Duty 2011* by ensuring services are appropriate and individualised to observe the nine protected characteristics of age, marriage and civil partnerships, religion and belief, gender, gender reassignment, race, sexual orientation, disability, pregnancy and maternity. They should also make particular consideration about people including those with:

- disabilities including mental health and sensory disabilities
- learning disabilities
- younger and older mothers
- sexual orientation such a same sex parents
- religious restrictions
- ethnicity and those for whom English is not their first language.

Services must also ensure the specific needs of disadvantaged groups within our communities are met and that they are treated compassionately and with respect.

The Women's Health and Equality Consortium recently undertook a piece of research examining the barriers that

women in various groups face when accessing pregnancy care (*Briefing: Women's voices on health : Addressing barriers to accessing primary care, May 2014, WHEC⁴⁷*).

The report identifies a number of issues that are relevant for black and many ethnic women, refugees and women seeking asylum, women living with HIV, lesbian, gay and women with learning disabilities. It will be key in enabling commissioners to identify issues for attention and inclusion in the maternity service implementation plan.

We will seek assurance that providers:

- make reasonable adjustments to meet needs that may arise from a person's protected characteristic
- are following national guidance in relation to vulnerable groups
- are striving to continually improve their communications and pathways to support prospective parents.

20.0 Financial framework

In 2013/14 the introduction of a Payment by Result (PbR) pathway tariff for maternity makes CCGs pay for pathways of care. This gives the CCGs the opportunity to develop performance management indicators with maternity service providers that are outcome focussed.

The aim is to develop contracts that free up the CCGs to focus on monitoring what matters to the local population (their outcome and experience of maternity care) and it frees up the provider to focus on the detail of how best to provide maternity services in order to deliver those outcomes.

Further work will be required to assess the financial implications of implementing the changes required to achieve this strategy once the detailed commissioning intentions and changes to contracts have been established.

It is well recognised that the cost of litigation to the Health Service regarding maternity cases is large and places the burden on the whole health economy.

A safe evidence based service therefore not only benefits the family, but also the wider health economy.

21.0 Data collection

It is the responsibility of maternity services to provide up-to-date/ robust information and data in order for commissioners, alongside Public Health colleagues, to monitor that service and identify areas for development and future commissioning priority.

Much of the data on risk factors is not available from national datasets and needs to be collected from local maternity services. This is being negotiated with providers so that the data presented is comparable across the area.

We will continue to work with the South West Maternity and Children's Strategic Clinical Network, County Council, Public Health colleagues and provider units to ensure there is a consistent methodology for collecting, monitoring, utilising and sharing maternity data.

There is an expectation that a regional-wide dashboard will be implemented.

22.0 Governance arrangements

This commissioning strategy and its associated work programme will be led and monitored by the CCGs.

Progress on the delivery of the strategy will be monitored on an on-going basis with an annual review and progress reported to the NHS NEW Devon CCG Board as part of the partnerships programme update arrangements.

23.0 Way forward / implementation plan

Following the final round of stakeholder engagement comments will be collected to include in an implementation plan to ensure implementation of the commissioning intentions included within this commissioning strategy.

We will work with commissioners from across the maternity pathway to develop a collective/ collaborative approach to commissioning maternity services.



25.0 Acknowledgements

The commissioners from NHS NEW Devon, South Devon & Torbay, and Kernow CCGs would like to thank all of the members of the maternity strategy programme group and the support of the task and finish groups that have worked so hard to help develop this commissioning strategy (see list opposite).

We would also like to thank stakeholders, including GPs, maternity clinicians, children's centres, Healthwatch, NHS England, communications department and providers who have contributed to the document.

Special thanks must also go to all the women and their partners who so generously shared their experiences, thoughts and ideas with us. These have greatly enhanced the development of this strategy.

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