Suffolk Maternity Health Needs Assessment

February 2014

Lead Officer: Mashbileg Maidrag, Consultant Public Health, Suffolk Public Health

Report Author: David Edwards, Specialty Registrar Public Health, Suffolk Public Health
i. Executive Summary

Suffolk CCGs requested a refresh of the 2009 Suffolk Maternity Needs Assessment to inform commissioning decisions for 2014/2015. The main objectives of this needs assessment were to identify the health needs of women before, during and after pregnancy and to assess the implementation of the new PbR Tariff maternity pathway to ensure it is working well in Suffolk. The Waveney population was not covered by this health needs assessment. The following key findings were identified with accompanying recommendations:

1. Healthy pregnancy

Reducing health inequalities in Suffolk by giving every child the best start in life begins before conception. A number of important pre-conception modifiable factors such as smoking, obesity, alcohol and diet can affect the risk of stillbirth, low birth weight, preterm delivery, and pregnancy complications, including neural tube defects and neonatal death (foetal growth restriction). Action to improve a woman’s diet, develop a healthier weight and stop smoking not only reduce the risk to the pregnancy but lead to substantial improvements in the long term health and life chances of the mother and child, for example affecting the risk of obesity, heart disease and mental ill-health. During pregnancy women should maintain a healthy diet (including vitamin D supplementation) and remain physically active.

The main issues:

- In Suffolk maternity services report seeing an increasing number of pregnant women who are overweight or obese leading to increased risk of complications.
- Suffolk has significantly higher rates of pregnant women that smoke at time of delivery (14.6%) compared to national and regional rates (13.2%).
- Women who may become pregnant can easily reduce the risk of having a baby with a neural tube defect by taking folic acid supplements before conception, and throughout the first 12 weeks of pregnancy.
- Women of reproductive age living in more deprived areas of Suffolk are more likely to smoke. This results in long term health inequality that starts even before a baby is conceived.
- The number of abortions by Suffolk women aged 18 to 34 years has significantly increased in recent years. This indicates an increasing need for family planning services to help reduce unwanted pregnancy. This also presents a cost pressure for NHS commissioners.
- While difficult to quantify due to underreporting and stigma, foetal alcohol spectrum disorders and other harm caused to babies by mothers drinking alcohol during pregnancy can be prevented by women avoiding drinking more than 1-2 units of alcohol once or twice a week.

Recommendations:

1. CCGs should develop and lead a healthy pregnancy action plan for Suffolk in line with Healthy Child Programme pregnancy to 5 year olds. This should include the following elements:
   - Agreeing consistent and coherent key messages addressing healthy pregnancy and the impact of smoking, excess weight, and alcohol.
   - A review of effective methods for communicating these messages to women of reproductive age in Suffolk, including high risk groups such as young mothers, women living in deprived areas and women with limited education.
Health services (including contraception, fertility and pre-conception advice services, GP practices), pharmacies and Children’s centres should prioritise this health advice to all women of child bearing age in line with the principles of making every contact count (MECC).

Introduction of health improvement key performance indicators targeting women of reproductive age, e.g. the number of women aged 15-44 years referred to weight loss, smoking cessation or alcohol services by providers. Subject to consistent availability of these services.

2. Commissioners (CCGs & SCC) to commission joint training programme for health professionals, pharmacists and children’s centre staff in Suffolk to offer specific dietary advice to women who may become pregnant (including women with small children) regarding of the importance of taking folic acid before they conceive to reduce risk of neural tube defects.

3. CCGs and Public Health Suffolk should commission a health promotion campaign, using evidence based behaviour change techniques in line with NICE PH6, to encourage women of reproductive age who are overweight or obese to achieve a BMI between 18.5 and 24.5 kg/m\(^2\) before they become pregnant. Women with a BMI of 30 more that plan to become pregnant should be supported to lose 5-10% of their weight (a realistic target) which can have significant health benefits for themselves and any subsequent pregnancy.

4. Smoking cessation services and health promotion messaging should target women of reproductive age in more deprived areas of Suffolk to help reduce the high level of smoking in pregnancy.

2. Perinatal Mental Health
Concerns about the identification and management of women in the maternity pathway with mental health conditions have been raised by providers of maternity services and Children’s Centre managers. Poor management of perinatal mental health is also an identified risk factor of maternal mortality (CMAC, 2011).

The main issues:

- Lack of services for midwives to refer women to which leads to inconsistency and uncertainty over the management of pregnant women affected by mental illness or a history of mental illness
- The lack of a perinatal mental health pathway
- The number of pregnant women identified with mental illness is less than half the expected number, indicating possible unrecognized and unmet mental health need.

Recommendations:

5. Review perinatal mental health service provision and develop a clear pathway that is appropriate to improve access, including consideration of introducing a lead midwife on perinatal mental health to coordinate & support work between primary care, specialist care (e.g. psychiatric team) and children’s centres.

6. CCGs conduct a gap analysis between current practice and NICE guidance (CG45) for women referred for psychological therapies during pregnancy and the postnatal period to, with particular regard to the thresholds used for referral and time to referral.

3. PbR Tariff implementation
Implementation of the PbR tariff for the maternity pathway has progressed well through the period of transition in 2013 and has not led to additional cost pressures, although its impact on future clinical outcomes and tackling health inequalities has yet to be established.
The main issue:
- Where national PbR tariff guidance on pathway allocation does not provide clear definitions (e.g. mental health, complex social needs and some long term conditions such as severe asthma), this means there is potential for inconsistency in the allocation of pregnant and postnatal women to the appropriate maternity pathway.
- Hospitals (within Suffolk and neighbouring counties) providing intrapartum care to Suffolk women present challenges that might impact on clinical risk for individuals.
- There is potential financial risk to Suffolk Hospital Trusts from the antenatal tariff and the need for women to receive care from different providers.

Recommendation:
7. CCGs to review with the provider organisations the current local interpretation of the national criteria for pathway allocation to ensure consistency. More detailed guidance for each pathway is required for midwives. To enable providers to appropriately allocate pregnant women to the correct maternity pathway based on their need (for example does a history of depression require allocation to the standard or intermediate pathway?). Allocation according to mental health need should be informed by a clear perinatal mental health pathway (see recommendation 4).
8. CCGs to review progress of the implementation of the PbR tariff after one year (April 2014), specifically antenatal and postnatal maternity pathway allocation and pregnancy outcomes.

4. Partnership Working in support of pregnant women (Midwifery, Health Visiting, Children’s Centres and GPs)
Partnership working around pregnant women is critical to the early recognition of health and social need and timely provision of interventions.

The main issue:
What is working well
- Provision of universal postnatal services by children's centres and health visitors with additional support (via step-up step-down model) for parents or infants identified with additional needs.
- The support of pregnant women through collaborative working between midwives, health visitors and children’s centres has greatly improved in recent years, with processes such as the Antenatal Healthy Child Collaborative (AHCC) and the Common Assessment Framework (CAF).
- Excellent collaborative team working in support of pregnant women was reported between midwives and health visitors/children's centres in some parts of Suffolk. This was more commonly reported in West Suffolk, possibly through chance because of the small number of stakeholders interviewed.
- Examples of joint initiatives by some children's centres and midwifery teams to meet the needs of pregnant women, such as joint provision of evening antenatal parenting classes to improve access for pregnant women and their partners.

What is working less well
- Communication issues (such as timeliness or gaps in communication) were reported between midwives, health visitors, children’s centres and GPS that could affect the care of pregnant women.
- Collaborative working in support of pregnant women between midwives, health visitors and children’s centres was reported to be less well
established in some areas of Suffolk. This has the potential to increase health inequality for pregnant women and their families.

- Handover of some patients from midwives to health visitors is reported to occur via written notes left with the mother without liaison between the midwife and health visitor once the mother and baby are discharged from the maternity service, potentially affecting their continuity of care. In East Suffolk this is reported to only occur when there is no specified concerns/needs and midwife and mother knows when the Health Visitor is visiting.

**Recommendation:**

9. A review of the effectiveness of current antenatal and postnatal provision provided by midwifery, health visiting and children centres to improve service provision, and identify steps to improve partnership working between midwifery services and GP practices. The review should assess the evidence on providing first antenatal booking appointments routinely in the woman’s home and its implications for health and social outcomes.

10. A local maternity partnership group, led by CCGs to oversee county wide strategy and priorities. This will seek to promote positive health outcomes, reduce inequity in maternity services, drive improved standards of maternity care and champion partnership working across Suffolk as a means to improving quality of care, facilitate early intervention and reduce inequalities in maternal and child health outcomes in Suffolk.

### 5. Key Performance Indicators

**The main issue:**

The maternity key performance indicators (KPIs) used by CCGs do not include outcome or risk management indicators recommended by the Royal College of Obstetricians and Gynaecologists (RCOG) Dashboard.

- clinical outcomes
  - maternal morbidity (e.g. Eclampsia, ICU admissions in obstetrics, blood transfusions [4 units of blood], postpartum hysterectomies)
  - neonatal morbidity (e.g. number of cases of meconium aspiration, cases of hypoxic encephalopathy, full term babies admitted to neonatal intensive care unit)
- maternity service risk management (e.g. Number of SI, failed instrument delivery, 3rd-degree tear, admissions after home delivery)
- complaints (e.g. number of complaints, times unit closed for admissions in each month)

**Recommendation:**

11. Review maternity key performance indicators to include clinical outcomes, maternity risk management and service user compliments and complaints in line with the recommendations of the RCOG (2008). This should be informed by National work currently in place to review the Maternity Serious Incident triggers to ensure national consistency and the need to benchmark against national and regional data.

### 6. Maternity Service Provision

Over 2012/2013 IHT and WSH performed well on many maternity KPIs. Some issues with maternity service provision were identified through analysis of routine data.
The main issues:
- Breast feeding initiation and prevalence in Suffolk are improving but there remains a very large decline in the number of mothers breastfeeding at 6-8 weeks compared to those recorded as initiating breastfeeding. Local information indicates that mothers under the age of 25 years are much less likely to initiate breastfeeding.
- Increasing the number of home births is a Department of Health objective and Suffolk does well with high rates of home births than the East of England and England average, although the rate in Suffolk has declined in recent years. The Home Birth Study highlighted the importance of offering women information to enable more choice about the place of birth.
- In 2009/2010 the East and West Suffolk rate of readmissions of babies within 14 days of a hospital birth (including emergency admission to hospital following home birth) were the highest in the East of England. The neonatal admission rate of full term babies in 2010 was also high, amongst the fourth highest quintile nationally.

Recommendations:
12. Implementation of UNICEF Baby Friendly Initiative stage 2 standards by both maternity units in Suffolk to further develop and raise standards of perinatal period breast feeding advice and support. This has been commissioned over 2013/2014 at WSH and IHT by CCGs in Suffolk using CQUIN payments.
13. Maternity services need to ensure that women are offered sufficient information to enable choice about the place of birth. A review of maternity staff training regarding patient choice, the information provided and attitudes of staff regarding home births is recommended. This should consider how to effectively communicate the findings of the birthplace study to offer information and choice, including the increased risk of intervention from hospital births.
14. An investigation of neonatal admission and readmission rates in Suffolk is required, including assessment of more recent local data to determine how current rates compare to those of 2010. This investigation should determine what the contributing factors to neonatal admissions and readmissions are in Suffolk and what measures can be taken to reduce the need for emergency admissions, readmission and neonatal care.

7. Demographic projections and estimated demand on maternity services
The main issues:
- Projected finished delivery episodes (FDE) for patients registered with both CCGs shows that numbers of births will remain relatively stable through to 2015/2016, indicating that a cost pressure from rising numbers of pregnancies is not expected.
- However, projections for Suffolk as a whole (including Waveney) indicate the number of live births is expected to peak in 2014/2015. This has short term resource implications for maternity services, medium term implications for health visiting/preschool and long term implications for school places.

Recommendation:
15. The projections of finished delivery episodes are based on interim 2011-based population projections. These should be reviewed by commissioners in 2014 when 2012-based population projections for CCGs to 2030 become available.
1. Introduction

West Suffolk Clinical Commissioning Group (CCG) and Ipswich and East Suffolk CCG requested a refresh of the 2009 Suffolk Maternity Needs Assessment to inform commissioning decisions in September 2013. This follows the transition of commissioning health services from PCTs to (CCGs) in April 2013 coinciding with the introduction of a new Maternity Pathway payment by results (PbR) tariff structure.

1.1 What is the issue and why is it important for Suffolk?

The health of women, especially their diet, nutrition and lifestyle is important to their own health and the health of their future or current pregnancy and their children. From April 2013 newly formed Clinical Commissioning Groups (CCGs) became responsible for commissioning maternity services. At the same time a new payment by results (PbR) tariff for maternity pathways was implemented from April 1st 2013.

1.2. Which population is this health needs assessment about?

This health needs assessment is concerned with women of reproductive age\(^1\) registered with West Suffolk CCG or Ipswich and East Suffolk CCG; or resident in the populations geographically covered by these CCGs.

1.3. What is the focus of this health needs assessment?

1. To identify the health needs of women before, during and after pregnancy.
2. Assess the implementation of the new PBR tariff to ensure the pathway is working well in Suffolk.
3. This report does not cover the Waveney population, fertility treatment or neonatal services.

1.4. Methodology

This Health Needs Assessment triangulated information using the following three techniques of data collection, analysis and interpretation.

- Epidemiological analysis of available routine and local information.
- Comparative analysis of Suffolk pregnancy risk factors and outcomes against national/regional figures, national policy, guidance and best practice.
- Corporate assessment (17 stakeholders were interviewed face to face/telephone) plus Care Quality Commission (CQC) Maternity Services Report.

\(^1\) The Office for National Statistics definition of reproductive age is 15 to 44 years. While this is the main focus of the maternity health needs assessment, it is recognised that women do become pregnant outside this age range.
1.4.1. Quantitative Data Collection

Routine quantitative data was collated and tabulated or plotted by the Public Health Suffolk Knowledge and Information Team. Information was supplied on request by West Suffolk Hospital and Ipswich Hospital Trust. Information was also obtained from The State of Children in Suffolk Report (2013). A literature review of relevant policy, guidance and best practice was conducted with the literature search conducted by Public Health Suffolk Knowledge and Information Team.

1.4.2. Quantitative data analysis

Descriptive analysis of available quantitative data was conducted using tabulation and graphical displays, with inclusion of 95% confidence intervals for comparisons. This analysis used Microsoft Excel computer software. Where available inferential analysis findings were also incorporated into the needs assessment.

1.4.3. Stakeholder data collection and analysis

The views and wishes of local Stakeholders were sought through telephone and face to face interviews regarding the health needs of pregnant women. The Stakeholders included local CCG Commissioners, maternity services providers, Children's Centre managers and Health Visitors.

A semi-structured interview technique was used in combination with specific closed questions (i.e. requiring a Yes/No answer or with a scale such as rating something excellent down to below average). The semi-structured questions consisted of several key questions that helped to define the areas to be explored, but also allowed the interviewer or interviewee to diverge in order to pursue an idea or response in more detail (Gill et al 2008). Given the tight timeframe it was not possible to speak to women using the service. However the Care Quality Commission (2010) report on maternity services patient satisfaction was summarised, along with the more limited amount of information available from the 2013 Care Quality Commission report.

Between the 16th August 2013 and the 11th September 2013 17 stakeholders were interviewed via telephone and face to face interview, this included commissioners, maternity service staff, GPs, children's centre managers and health visitors. The results of the interviews were collated and a thematic analysis was conducted to capture the main themes and points that came out of the discussion. The thematic analysis consisted of content analyses, counting the frequency of a response to the more structure predefined questions, combined with an inductive approach, noting major issues that arose from responses to the open questions (Gill et al 2008). Because of the small number of respondents the views of this stakeholder sample cannot be considered representative of the views of all provider stakeholders.
2. Maternal Characteristics

2.1 Social Changes facing pregnant women and parents in Suffolk

The State of Children in Suffolk Report (2013) reported that between 2006 and 2011, the number of maternities outside marriage increased in all districts in Suffolk (Table 1). This mirrors the picture across the East of England and England. The highest increase was observed in Mid Suffolk and Suffolk Coastal. The increase in maternities outside marriage reflect long term trends affecting families in the UK, including a rise in the number of children born to unmarried parents, a rise in the number of people cohabiting and a fall in marriage rates. The relevance of marital status is that parents who are cohabiting often differ in substantial ways to parents who are married, for example in terms of education, socio-economic status, ethnicity and history of relationship stability, all of which can impact on the child at a very young age.

Table 1: Maternities to residents of local authority districts in Suffolk County 2006 and 2011 (Taken from State of Children in Suffolk, 2013)

<table>
<thead>
<tr>
<th>Area</th>
<th>All maternities 2006</th>
<th>Outside marriage 2006</th>
<th>All maternities 2011</th>
<th>Outside marriage 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Babergh</td>
<td>831</td>
<td>310</td>
<td>37.3%</td>
<td>787</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>793</td>
<td>227</td>
<td>28.6%</td>
<td>1027</td>
</tr>
<tr>
<td>Ipswich</td>
<td>1683</td>
<td>825</td>
<td>49.0%</td>
<td>1957</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>924</td>
<td>343</td>
<td>37.1%</td>
<td>945</td>
</tr>
<tr>
<td>St Edmunds.</td>
<td>1129</td>
<td>449</td>
<td>39.8%</td>
<td>1251</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>1079</td>
<td>426</td>
<td>39.5%</td>
<td>1106</td>
</tr>
<tr>
<td>Waveney</td>
<td>1159</td>
<td>636</td>
<td>54.9%</td>
<td>1237</td>
</tr>
<tr>
<td>Suffolk County</td>
<td>7598</td>
<td>3216</td>
<td>42.3%</td>
<td>8310</td>
</tr>
<tr>
<td>East of England</td>
<td>66096</td>
<td>26921</td>
<td>40.7%</td>
<td>72302</td>
</tr>
<tr>
<td>England</td>
<td>629339</td>
<td>271459</td>
<td>43.1%</td>
<td>680565</td>
</tr>
</tbody>
</table>

Source: ONS VS2 tables Maternities are defined as one or more live birth or stillbirth to a mother. For example, if a mother gave birth to liveborn twins, this would count as one maternity

A lone parent with adequate resources may provide a stable nurturing home in which children thrive. Unfortunately lone parents are twice as likely to live in poverty and have less resource to support their children compared to two parent households. The impact this has on children is a key issue for local partnerships with responsibility to provide support to optimise positive outcomes for children.

2.2. Age

The female population of Suffolk is approximately 370,567 women. Of this 34% are aged between 15-44 years, commonly referred to as childbearing age, slightly lower than East of England (37%) and England (39%). It should be recognised that women can become pregnant outside this age range, although the numbers are very small.

Between 2006 and 2011 there was an increase in the percentage of live births to mothers in Suffolk aged 20-24 years and 25-29 years, with a decrease in the percentage of live births to younger and older women (Figure 1). A greater proportion of women having children in their 20’s is a positive development because pregnancies in this age range are associated with lower risks of complications than pregnancies in women under 20 years or over 40 years of age. There were 1,552
births to Suffolk women under the age of 20 between April 2009 and October 2012. Births to women aged under 18 years showed a substantial reduction during this period.

**Figure 1: Distribution of live births by mother’s age, residents of Suffolk County, 2006 and 2011 (Taken from State of Children in Suffolk, 2013)**

Projected figures estimate the total number of women aged 15 to 44 years in Suffolk will remain close to 120,000, with a slight increase in the percentage of women aged 25-34 years (Office for National Statistics [ONS] interim 2011-based subnational population projections).

### 2.3 Ethnicity

The ethnicity of women in Suffolk is predominantly categorised as White, 92.5% of women aged 0-24 years and 94.2% of women aged 25-49 years (Office for National Statistics (ONS) [NOMIS], August 2013). The next largest ethnic groups amongst females aged 0-24 years were mixed/multiple ethnic group (3.9%) and Asian/Asian British (2.3%), followed by Black/African/Caribbean /Black British (1.0%) and other ethnic groups (0.4%). For women aged 25 to 49 years Asian/Asian British (2.8%) were the largest ethnic group after White, followed by mixed/multiple ethnic group (1.4%), Black/African/Caribbean/Black British (1.2%) and other ethnic groups (0.4%). This highlights the changing ethnic profile of women of reproductive age. These figures do not provide information on is the proportion of women classified as ‘White’ who are non-British, with differences in culture and language that might affect access and acceptability of maternity services, as well as underlying maternal health needs. This will have an impact on the screening profile of pregnant women and babies with regard to risk of heritable diseases such as Sickle Cell and Thalassemia and preventive measures such as BCG vaccination of a baby if its parents or grandparents are from a country with high risk of TB (Salisbury et al, 2006).

There is research evidence that ethnicity can impact on the parents expectations of maternity services, for example choice regarding type of birth and their intentions to breast feed (Choudhry & Wallace, 2012; Twamley et al 2011; Puthussery, et al 2010). Positively research indicates that UK-born ethnic minority women felt that their ethnic background did not affect the maternity care they received (Puthessery et al
Research also highlights that the attitudes of maternity care professionals with regard to ethnic minority mothers born in the UK are generally equivalent to white English women, but unconscious stereotypical views on ethnic minorities can affect clinical practice (Puthussery, et al 2008).

2.4 Deprivation

People living in areas of high relative deprivation experience poorer physical and mental health outcomes, and are more likely to be exposed to higher risk of individual behavioural factors, including smoking, poor diet, substance misuse; and environmental factors such as higher levels of transport accidents, noise pollution, crime and fear of crime (Marmot Review, 2010). The most deprived wards in Suffolk are predominantly urban (Figure 2). The State of Children in Suffolk report highlighted that less than 5% of all highly deprived areas in Suffolk (11 out of 239) were rural. Recognising that the majority of deprived people do not live in the most deprived areas, particularly in rural areas, with hidden pockets of rural deprivation masked by larger less deprived geographies such as electoral wards or Super Output Areas (SOA) (Oxford Consultants for Social Cohesion, 2008; Fenton et al, 2011).

Figure 2: Relative Deprivation (IMD2010) at ward level in Suffolk County

The State of Children in Suffolk (2013) reported a statistically significant association between under 18 conception rates and ward level deprivation scores (IMD2010) in Suffolk (P<0.05). Nearly half (48.3%) of the variation in teenage conception rates in wards in Suffolk in 2007-09 was explained by deprivation ($r^2=0.4825$) (Figure 9).

2.5 Vulnerability

Some women are vulnerable to higher morbidity and mortality than others living in Suffolk. These women include those who have mental health problems which may worsen with pregnancy, those who are young and unsupported, women who abuse substances such as alcohol and drugs or are themselves abused, and those who live
in relative poverty or are hard to reach including some women from ethnic minority groups, gypsies and travellers, and mothers with learning difficulties.

West Suffolk Hospital Maternity Services provided care for 13 pregnant women with learning difficulties in 2012. The maternity service at WSH are able to draw on the expertise of a specialist nurse when planning care to ensure the service provided takes into account the Mental Capacity Act and avoids discrimination. The care plan for women with learning difficulties is produced through joint agency working with the Suffolk County Council Learning Difficulties Team.

Ipswich Hospital Trust maternity services have close links with the Advocacy service and the Trust Specialist Nurse for Learning disabilities who is able to advise and be involved with clients as needed. For women who have mental health issues there is a specialist psychiatric liaison nurse within IHT who provides support to maternity services particularly with women who are inpatients.
3. Fertility and outcomes

3.1 Fertility Rate

The general fertility rate (GFR) is the number of live births per 1,000 women aged 15-44 years. This is commonly used as a measure of current fertility levels in the population. The most recently available information from the Office of National Statistics (ONS) indicates for the years 2002-2011 indicates that the GFR for Suffolk increased from 54.7 to 65.2 live births per 1,000 women. This increase was similar the East of England and England. Information pooled over the period 1998-2011, indicates that the highest GFR at district council level in Suffolk was in Forest Heath, followed by Ipswich (Figure 3). Possible causes for this rise in fertility across England may include more women in their 20s having children, more women at older ages having children after previously postponing them, increases in the number of foreign born women who tend to have a higher fertility rate than UK-born women (although the increase in mainly driven by UK-born women), government policy and economic factors indirectly influencing individuals decisions around childbearing.

Figure 3: General Fertility Rate (GFR) in Suffolk at District Council level, 1998-2011

![Figure 3: General Fertility Rate (GFR) in Suffolk at District Council level, 1998-2011](image)

Figure 4: Distribution of live births by ward in Suffolk 2007-2011 (Source: ONS Annual District Birth Extracts; population estimates ONS mid-year estimates)

![Figure 4: Distribution of live births by ward in Suffolk 2007-2011](image)
Another way to look at maternity service demand is through the actual number of live births themselves, rather than as a calculated rate as in GFR. The distribution of live births in Suffolk (using most recent data pooled for 2007 to 2011) indicates the areas with higher demand on Maternity services who provide community midwifery services for these areas (Figure 4). For example the electoral ward with the highest number of births between 2007 and 2011 was Eriswell and the Rows ward in Forest Heath with 1,119 births, followed by Westgate ward in Ipswich with 908 births. In contrast there were only 41 births over the same time period in Riverside ward in Suffolk Coastal.

The increasing fertility in Suffolk and across the country has had major implications for demand on maternity services, wider NHS services including GP practices, preschool services, primary and secondary school education and other local authority services. With short term increases in the need to increase midwife and health visitor capacity, increase availability of nursery and preschool places and eventually a large increase the number of school children from primary through to secondary school.

3.2 Multiple pregnancy (carrying more than one baby)

Multiple pregnancy, for example twins or triplets, is associated with higher risks for the mother and her babies, with all women with a multiple pregnancy automatically being allocated to the intensive maternity pathway and PbR tariff (NICE CG129, 2011). The State of Children in Suffolk Report (2013) reported that multiple births occurred at a rate of 32.7 births per 1,000 women in NHS Suffolk in 2010, slightly higher than the England average of 31.3. Between 2002/2006 and 2007/2011 there was a 13% increase in the number of multiple maternities among women in Suffolk, which was a much lower increase than for England (65.7%) and the East of England (54.6%).

3.3 Live birth trend and projections

The number of live births in Suffolk County (based on birth registration statistics) increased from 6,846 in 2002 to 8,403 in 2011. For Suffolk County as a whole the number of live births is projected to increase toward 9,000 peaking in 2014-2015 (Figure 5).

Figure 5: Live births to residents of Suffolk County 2001-11 and Projected numbers of infants resident in Suffolk County 2012-21 (Note the gap between 2011 and 2012 is deliberate to indicate recorded live births vs. estimated live birth projections)

Source: ONS Vital Statistics 1 and ONS interim 2011-based subnational population projections
3.4 Finished delivery episode trend and projections

Finished delivery episode (FDE) statistics report registered births that are NHS delivered births, unlike live birth statistics (above) FDE are available at CCG level, but do not include privately funded births. With a focus on NHS births (and exclusion of Waveney) the projected FDE follow a different pattern to live births at Suffolk County level. The projections estimate a fairly constant number of delivered babies year on year between 2013/2014 to 2021/2022. With FDE in Ipswich and East CCG remaining close to 4000, while in West Suffolk CCG a slight decline from 2,400 per to 2,300 delivered babies per annum is projected (Figure 6). This suggests that maternity service demand from women registered with the two CCGs is not expected to increase. This does not account for any changes in demand on maternity services from women registered with neighbouring CCGs, or account for potential changes in numbers of births at home, which in recent years have decreased in West and East Suffolk.

Figure 6: Observed and projected finished delivery episodes for registered patients (Females aged 15-44 years) in Ipswich and East Suffolk CCG and West Suffolk CCG
Data shown as observed: 2010/11-2012/13; with gap in line followed by projected: 2013/14-2021/22

Note: in 2014 ONS will publish 2012-based subnational population projections with population projections for CCGs to the 2030s. In these projections the assumptions about future trends in births, deaths and migration will be updated to take account of the latest data on these components of population change. The projections of finished delivery episodes based on the interim 2011-based population projections used in this needs assessment should be reviewed when the 2012-based population projections become available.

3.5 Conceptions leading to abortion

Clinical Commissioning Groups (CCGs) became responsible for commissioning Termination of Pregnancy services (TOPS) from April 2013. The rate of legal abortions for women aged 15-44 years in NHS Suffolk (not including Waveney) was
significantly higher in 2010 and 2011 compared to 2007-2009 but remained lower than the rate for the East of England and England (Figure 7).

**Figure 7: Rate of legal abortions per 1,000 women aged 15-44 years resident in NHS Suffolk (Not including Waveney), 2007-2011 (Source: Department of Health)**

The statistically significant increase in abortions in Suffolk has been driven amongst all age groups between 18 to 34 years of age (Figure 8). Approximately a third of all abortions amongst women aged 25 years and over were by women who had a previous abortion in both West Suffolk CCG (32%) and Ipswich & East Suffolk CCG (38%), compared to only 14% and 21% respectively of abortions in women under 25 years of age. It should be noted that statistics on previous abortions are reported voluntarily by women undergoing abortion. It is possible that as abortion has become less stigmatised in the UK women may be more likely to report having a previous abortion when this information is collected (BPAS, 2011).

**Figure 8: Rate of legal abortion amongst women resident in NHS Suffolk by age band, 2007-2011. Source: Department of Health, Legal abortion by age**

- **Note:**
  - All ages = age-standardised abortion rate per 1,000 women aged 15-44 years
  - Under 18 = age-specific abortion rate per 1,000 women aged 15-17 years
  - 35+ = age-specific abortion rate per 1,000 women aged 35-44 years
Termination of pregnancy can be due to medical reasons to protect the health of the mother or due to the detection of very serious abnormalities of the child. Non-medical reasons for the increase in abortions may include unintended pregnancy within a stable relationship, including failures in contraception, use of abortion to manage the size of existing families, changes in a relationship with a partner so a wanted pregnancy becomes unwanted, changes in financial circumstances, and lifestyle changes with more unplanned sexual behaviour amongst women and men of all ages due to a variety of factors, including the influence of excessive alcohol use (Luker, 2010).

An increase in the rate of abortions in Suffolk presents a cost pressure, with acceptability and ease of access to emergency contraception or early abortion important methods of reducing the cost burden of abortion. This also has implications on the provision of termination of pregnancy (TOP) services and future pregnancies. Prevention of unwanted conception in the first instance, through sexual health education, health improvement messaging and acceptability and information and access to all contraception methods, including long acting contraception, are required for both women and men (NICE, CG30). This may require targeted approaches for certain cultural groups.

3.6 Gestation age at birth

Babies born before 37 weeks are more vulnerable and need special care, due to lower birth weight and risks of hypothermia and hypoglycaemia. Between April 2011 and March 2012 88.3% of births in Ipswich Hospital were after 37 weeks gestation, and 85.9% in West Suffolk Hospital. This compares positively with the East of England and England which had a lower percentage of births after 37 weeks (Figure 9). In part the difference between the Suffolk hospitals and regional and England figures is due to better data recording at both WSH and IHT. The percentage of premature births between 35-37 weeks gestation was similar between both Suffolk hospitals and the regional and England figures, but the percentage of very premature births was much lower in Suffolk than the average for the East of England.

Figure 9: Percentage distribution of births by gestations length (weeks) at delivery, by hospital in Suffolk, East of England and England, 1st April 2011 to 31st March 2012
3.7 Maternal Mortality

Despite being very rare, mothers can still die having a baby. In Suffolk the numbers are very small, and every death is subject to a detailed review. Between 2002 and 2011 there were four maternal mortalities in Suffolk, with 49 across the East of England over the same time period.

The eighth report of the Confidential Enquiries into Maternal Deaths in the UK recommended 10 interventions to reduce the risk of maternal mortality (Appendix). These included pre-pregnancy counselling; professional interpretation services, that communications and referrals of pregnant women should be prioritised as urgent; pregnant women with serious medical or mental health conditions (including pre-existing conditions) require immediate appropriate multidisciplinary specialist care; high quality clinical training for all staff regarding the management and treatment of pregnant women; routine use of the national modified early obstetric warning score (MEOWS) for all pregnant and postpartum women that require obstetric or gynaecology services; all pregnant women with systolic hypertension require urgent and effective treatment; all pregnant and recently delivered women need to be informed of the risks, signs and symptoms of genital tract infection and how to prevent its transmission; all maternal deaths must be subject to high quality local review; the standard of maternal autopsy must be improved.
4. Healthy Pregnancy and Lifestyle Risk Factors

4.1 Diet, nutrition and body weight

A woman should ideally have a body mass index (BMI) of between 18.5 and 24.5 kg/m\(^2\) before they become pregnant, in order to reduce the risk of complications in pregnancy (NICE PH27, 2010). Women who plan to become pregnant are advised to take dietary supplementation with folic acid (400 micrograms per day), before conception and up to 12 weeks of gestation (NICE CG62, 2008). This reduces the risk of having a baby with neural tube defects (anencephaly, spina bifida). Pregnant women are also advised to take 10 micrograms of vitamin D supplementation to help maintain their health and the health of their baby, continuing vitamin D supplementation during breastfeeding (NICE CG62, 2008).

Pregnant women should not routinely take iron supplementation and should avoid vitamin A supplementation, including liver and liver products that may contain high levels of vitamin A (NICE CG62, 2008).

Pregnant women who receive benefits or are under 18 years of age qualify for Healthy Start vouchers entitling them to a weekly voucher to spend on fresh milk, fruit and vegetables. Women are identified by their midwife and given a form to complete which is then signed by the midwife. Healthy Vitamin supplements are available from the Children Centres with midwives able to signpost the women to the appropriate centre. Data from March 2013 indicates that the percentage of eligible adults (including pregnant women) who take up health start vitamins in East and West Suffolk (2.4%) was much lower than the percentage uptake in the East of England (6.2%) or England (5.6%). Eligible adult take up of Healthy Start vitamins in Waveney (7.9%) was even lower. In all areas (Suffolk, regionally and nationally) the take up of healthy start vitamins was lower in March 2013 than December 2012. Unfortunately the data that is available on healthy start vitamin uptake is

4.2 Obesity

Maternal obesity, defined as a body mass index (BMI) of 30 kg/m\(^2\) or higher when pregnant, increases the risks to health for both the mother and foetus/baby during and after pregnancy. Obesity in pregnancy is associated with an increased risk of pregnancy complications, including miscarriage, foetal congenital anomaly, thromboembolism, gestational diabetes, pre-eclampsia, induced or longer labour, instrumental delivery, postpartum haemorrhage, wound infections, stillbirth, neonatal death and maternal death (CMACE/RCOG, 2010; NICE PH27, 2010). In addition an obese woman is more likely to have a caesarean section or postpartum haemorrhage and may experience restricted choices with regard to place of delivery and pain relief due to the clinical implications of their bodyweight (NICE PH27, 2010).

Trend data from the Health Survey for England (HSE) shows that the prevalence of obesity amongst women aged 16-44 years increased between 1993 and 2010 from 12.5% to nearly 20%. Women are more likely to be obese if they live in a deprived area, or belong to certain ethnic groups, in particular Black Caribbean, Black African or Pakistan (HSE, 2010).
NICE guidance (NICE PH27) makes a number of recommendations for health professionals to help a pregnant woman who is obese to improve her health and that of her child. It is not advisable for women to be on a reduced calorie diet when they are pregnant, even when obese. NICE guidance (PH27) outlines actions for health professionals including; taking height and weight measurements during first contact, discussing and providing appropriate advice on eating habits and physical activity, and offering practical and tailored information (for example advice on how to use healthy start vouchers). At antenatal booking appointments women who are obese should be offered a referral to a dietician or appropriately trained health professional for assessment and personalised advice on healthy eating and how to be physically active.

### 4.3 Drinking Alcohol before and during pregnancy

When a pregnant woman drinks alcohol, the levels of alcohol in her baby's blood rise as high as her own. Because the baby's liver is immature, it can't break down the alcohol as fast as an adult can. This means the baby is exposed to greater amounts of alcohol for longer than the mother. When an unborn baby is constantly exposed to alcohol, a particular group of problems can develop, known as foetal alcohol syndrome. The government advises pregnant women to avoid alcohol completely, although if they do choose to drink, it says not to have more than one to two units of alcohol once or twice a week. A review did not find consistent evidence on whether drinking low levels of alcohol before conception increases the risk of complications in pregnancy (Gray et al, 2006). The same review did find evidence that binge drinking when pregnant increased the risk of harming a baby's neurodevelopment. Thus binge drinking, even if not done regularly, should be avoided by women planning on getting pregnant or once they are pregnant.

Identifying the true prevalence of babies affected by maternal alcohol consumption during pregnancy, and the impact on infant health, is very challenging. Diagnosis of conditions such as foetal alcohol spectrum disorders requires specialist knowledge and is further underreported due to stigma (Morleo et al 2011). Researchers estimated the rate of foetuses and newborn’s affected by maternal use of alcohol using hospital episode statistics. Their estimated for the East of England was estimated to be 5.2 (95% C.I. 3.1 – 8.0) per 100,000 live births, between 2002/2003 and 2007/2008 (Morleo et al 2011). The reporting authors considered this estimate to be severely limited by underreporting.

There is a Suffolk foetal alcohol spectrum disorder interest group which is run by a Community paediatric consultant. This is a multiagency group with regular midwifery input and representation. This group meets quarterly and the focus of the group is to ensure all professionals are informed and to improve communication across disciplines.

### 4.4 Substance misuse before and during pregnancy

Routine information on the number of pregnant women who misuse substances (alcohol and or drugs) is not available. NICE clinical guideline (CG110) recommends that supportive and coordinated care should be provided to women during pregnancy who are misusing substances. Pregnant women may be anxious about the attitudes of healthcare staff and the potential role of social services if they disclose that they
misuse drugs or alcohol. This can lead to barriers to care such as women feeling overwhelmed by the involvement of multiple agencies, attitudes of staff, women’s fears about removal of their child, and the need to address women’s feeling of guilt about the potential effects on their baby.

NICE (CG110) recommends that healthcare commissioners and providers of local antenatal services should work with social care and third-sector organisations that provide substance misuse services to coordinate antenatal care. For example through jointly developed care plans across agencies and offering women information about the services provided by other agencies. It is recommended that pregnant women with substance misuse issues are offered direct access to a midwife or doctor with specialist knowledge and experience in the care of women who misuse substances.

It is further recommended by NICE (CG110) that healthcare professionals receive training on the social and psychological needs of women who misuse substances. In addition healthcare and non-clinical staff such as receptionists should receive training on how to communicate sensitively with women who misuse substances. The following Information and support for pregnant women who misuse substances should be provided:

- The first time a woman who misuses substances discloses that she is pregnant, offer her referral to an appropriate substance misuse programme.
- Use a variety of methods, for example text messages, to remind women of upcoming and missed appointments.
- The named midwife or doctor should tell the woman about relevant additional services (such as drug and alcohol misuse support services) and encourage her to use them according to her individual needs.
- Offer the woman information about the potential effects of substance misuse on her unborn baby, and what to expect when the baby is born, for example what medical care the baby may need, where he or she will be cared for and any potential involvement of social services.
- Offer information about help with transportation to appointments if needed to support the woman's attendance.

These points are followed by IHT, although transportation may be an issue which social services will sometimes fund. At IHT the named midwife for safeguarding and drug liaison also holds a monthly joint clinic at a local prescribing drug centre and will liaise with hospital and community teams and other statutory and non statutory agencies. IHT maternity services have close links with other appropriate alcohol and substance misuse care providers, including; Iceni, Open road, CRI and Suffolk alcohol treatment services. Training regarding alcohol and substance misuse is provided annually for midwives at IHT as part of the Midwifery mandatory training programme.

West Suffolk Hospital has a midwife who specialises in vulnerable women including women who misuse substances. The midwife works closely with the drug and alcohol service and offers specialist support for a small caseload of women.

### 4.5 Smoking before and during pregnancy

Smoking presents a major risk to the health of the pregnancy, and the future health of the baby. The State of Children in Suffolk Report summarised that smoking in pregnancy causes up to 5,000 miscarriages, 300 perinatal deaths and around 2,200
premature births in the UK each year (Royal College of Physicians, 2010). Additionally, a quarter of stillbirths and a third of deaths within the first four weeks of life are associated with smoking during pregnancy. Women who smoke more than ten cigarettes a day double their risk of stillbirth. Cigarettes restrict the essential oxygen supply so the baby’s heart has to beat harder every time the mother smokes.

In 2011-2012 Suffolk had significantly higher numbers of women recorded as smoking at time of delivery than the national or regional average (Table 2). Although the State of Children in Suffolk Report (2013) highlights the downward trend in the rate of mothers smoking during pregnancy among NHS Suffolk registered women from 14.4% in 2010/11 to 13.0% in the second quarter of 2012/13. This mirrors the East of England trend. In the most deprived areas a much higher proportion of the population smoke tobacco. For example, in Woodbridge/Kesgrave and High Suffolk 8% of people reported smoking compared to 30% in Felixstowe. Because these figures rely on self-reporting, there is likely to be a degree of inaccuracy.

Table 2: Percentage of women recorded as smoking at time of delivery in Suffolk compared to England and East of England, 2011-2012.

<table>
<thead>
<tr>
<th></th>
<th>Percentage of women recorded as smoking at time of delivery</th>
<th>95% confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suffolk</td>
<td>14.6</td>
<td>13.8 - 15.4</td>
</tr>
<tr>
<td>East of England</td>
<td>13.2</td>
<td>12.9 – 13.4</td>
</tr>
<tr>
<td>England</td>
<td>13.2</td>
<td>13.1 – 13.3</td>
</tr>
</tbody>
</table>

Source: PHE Knowledge and Intelligence Team Eastern, calculated from the Health and Social Care Information Centre’s return on Smoking Status at Time of delivery (SSATOD)

In terms of service provision and access, only a small number of women take up the NHS Stop Smoking service offer during pregnancy or after childbirth. The success rate of pregnant women who set the quit date for Suffolk was 38% in the second quarter of 2012/13. This was much lower than the average rate of 46% in the East of England.

NICE guidance (PH26) recommends that those responsible for health and support services to pregnant women should use any appointment or meeting as an opportunity to ask women if they smoke. If they do then it should be explained how NHS stop smoking services can help people to quit and advise them to stop smoking. Specific guidance is provided for midwives, who at first antenatal booking appointment should:

- Assess a woman’s exposure to tobacco smoke using discussion and a CO test.
- Provide information about the risks to the unborn child of smoking when pregnant and hazards of second hand smoke for both mother and baby.
- Explain the health benefits of stopping for mother and baby, advising the woman to stop smoking - not just cut down.
- Explain that it is normal practice to refer all women who smoke for help to quit and that a specialist midwife or advisor will phone and offer support.
- Refer all women who smoke, have stopped smoking within last 2 weeks or with a CO reading of 7ppm or above, to NHS stop smoking services.
- Give the NHS pregnancy smoking helpline number.
- If a partner or person in household smokes recommend that they contact NHS stop smoking services.
• At next appointment check if an offered referral was taken up. If not ask if woman is interested in stopping smoking and offer another referral to the stop smoking service.
• If a referral is declined, accept the answer in an impartial manner and leave the offer open.

4.6 Stillbirths and perinatal/neonatal mortality

Stillbirths and infant deaths in Suffolk remain rare but do occur and are an indicator of health inequality. For stillbirths, smoking in pregnancy and maternal obesity are major modifiable risk factors. Other major risk factors include maternal age over 35 years or teenage mothers, twin or multiple births, mothers with pre-existing conditions such as diabetes, women from ethnic minority groups and women living in areas of social deprivation. Smoking is also a major risk factor for infant mortality, along with low birth weight, multiple births and socio-economic deprivation. A baby born into a deprived household is more likely to have multiple high risk exposures for infant mortality.

The four main conventional measures for stillbirths and infant deaths in Suffolk were lower than the East of England and England averages (Table 3). Trend data from 1998 to 2011 indicate that Suffolk has remained lower than the East of England and England throughout this period, although the slope of decline for England has been steeper over this time period for infant mortality and neonatal mortality.


<table>
<thead>
<tr>
<th></th>
<th>Suffolk County</th>
<th>East of England</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Still birth rate</td>
<td>4.4</td>
<td>4.6</td>
<td>5.1</td>
</tr>
<tr>
<td>Stillbirths per 1000 total live births and stillbirths</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perinatal mortality rate</td>
<td>6.3</td>
<td>6.8</td>
<td>7.5</td>
</tr>
<tr>
<td>Stillbirths and deaths at under 1 week per 1000 total live births and stillbirths</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neonatal mortality rate</td>
<td>2.5</td>
<td>2.8</td>
<td>3.1</td>
</tr>
<tr>
<td>Deaths at age under 28 days per 1000 total live births</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>4.0</td>
<td>4.0</td>
<td>4.5</td>
</tr>
<tr>
<td>Deaths at age under 1 year per 1000 total live births</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The State of Children in Suffolk Report (2013) highlighted that in addition to biological and medical factors that increase the chances of a stillbirth, including infections, umbilical cord problems and congenital abnormalities, evidence suggests that carrying excessive weight, smoking, drinking alcohol during pregnancy or not getting vaccinated against seasonal flu increase the risk for stillbirth. In addition, regular midwife, and or consultant, appointments allow effective monitoring of the development of the baby, which can allow early detection and effective treatment. National guidance is for women with increased clinical or social risks to have increased surveillance (NICE CG110). The Suffolk Child Death Overview Panel
(CDOP) in 2011/2012 identified common themes regarding a very small number of preventable deaths due to Sudden Unexpected Infant Deaths (SIDS), which were parental smoking, overheating (co-sleeping), and family environment/pressure (co-sleeping).

4.7 Low birth weight

Low birth weight (less than 2500 grams) is strongly associated with increased risk of infant death and is associated with poorer outcomes for the health and development of the child. This is commonly measured by use of the low birth weight rate (LBWR), the number of births <2500 grams per 1000 live births. The prevalence of low birth weight is known to be influenced by a range of factors including the mother's age (teenage pregnancy) and general well-being, multiplicity of birth, ethnicity and/or country of birth, smoking, nutrition, socio-economic position and related deprivation issues.

The State of Children in Suffolk Report (2013) indicated that the LBWR in Suffolk decreased from 7.2 per 1,000 live births in 2006 to 6.7 in 2011, similar to the East of England figures, with a marginal decrease in the England average LBWR also. Analysis of local data (simple linear regression analysis) indicated a statistically significant association between LBWR and deprivation in Suffolk in 2007-11 (p=0.0021). However, at ward level only about 5% of the variation in low birth weight rates was explained by deprivation ($r^2=0.0535$).

4.8 Perinatal Mental Health

Women can develop mental issues and disorders before conception, when pregnant and during the postnatal period. Mental health issues can include mild, moderate and severe depression, a range of anxiety disorders, post-traumatic stress following child birth and severe mental illnesses such as puerperal psychosis, bipolar disorder and schizophrenia. This can have serious short and long term consequences for the health and wellbeing of the woman, her baby and wider family. For example depression during pregnancy is an independent risk factor for low birth weight and preterm delivery while postnatal depression can impair attachment between the mother and baby, impacting on emotional and cognitive development of the child (Gold and Marcus 2008, Children, 2011). Early detection of women at risk of developing, or with, mental health disorders followed by prompt and appropriate healthcare provision can reduce the harm to mothers, their baby and other family members (Children, 2011). Current policy emphasises the importance of early intervention in preventing mental ill-health and improving outcomes and life chances (No Health without Mental Health, 2011; Early Intervention: The next steps, 2011, NICE CG 110 Pregnancy and Social Factors, 2010; The Healthy Child Programme 2008, Maternity Matters 2007).

Based on estimates from NICE Guidance CG45, approximately 320 pregnant women per year in Ipswich and East Suffolk CCG would be expected to require referral for psychological therapies (expected 80 per 1,000 deliveries), with a further 192 per year in West Suffolk. West Suffolk Hospital Maternity services identified 67 pregnant women with mental illness in 2012 and 24 women between January 1st and August 31st 2013. Comparable information from IHT was not supplied as this data was not collected in this reportable format at that time. In addition to mental ill health during
pregnancy prevalence rates suggest that postnatal depression affects 1 in 10 pregnancies (100 affected per 1,000 live births) while Puerperal Psychosis affects 1-2 women per 1,000 live births (Postnatal depression and Puerperal Psychosis, SIGN 60, 2002). This would lead to an expected figure of 400 women with postnatal depression per year in Ipswich and East Suffolk CCG and 240 women in West Suffolk CCG.

The National Institute for Health and Clinical Excellence (NICE) Clinical Guideline 45 Antenatal and Postnatal Mental Health (2007) provides clinical management and service guidance on the most appropriate organisation of services for the delivery of effective treatment within a stepped care framework. NICE CG45 identified establishment of clinical networks for perinatal mental health services as a key priority for implementation. NICE guidance recommends that during pregnancy and the postnatal period women who need psychological treatment should be seen within one month of initial assessment because of a lower threshold for psychological therapies.

The provider for mental health services in Suffolk is Norfolk and Suffolk Foundation Trust (NSFT). Pregnant women with mental health difficulties can access counselling and cognitive behaviour therapy (CBT) supplied by NSFT, with the main routes of referral via their GP or self-referral. The GP may decide to treat a diagnosed mental health condition with medication, with or without referral for psychological therapies such as CBT. For more serious mental ill health GP referral to NSFT for secondary care is required. Health professionals such as midwives, obstetric or gynaecology consultants or health visitors are not able to refer pregnant women directly to NSFT, but can refer patients to their GP or advise self referral.

At West Suffolk Hospital the pathway for women identified with mental health difficulties depends on their diagnosis and whether they have an existing care plan within NSFT. The pregnancy is managed through collaboration with NSFT mental health services and an agreed plan is normally put in place by 34 weeks gestation. The women without a diagnosis and support from the NSFT mental health team were identified as a particularly challenging group as WSH have no access to a Perinatal Mental Health Service.

At IHT women who have an identified mental health issue are referred for consultant led care and the consultant will refer for psychiatric opinion as required. This will depend on the woman’s diagnosed illness and whether she is currently under the care of a mental health team. Each GP surgery has a linked Community Psychiatric Nurse (CPN) and the community midwife is able to directly refer/ consult to these link CPN’s for opinion. The CPN may be able assist with the development of a care package for some woman alongside maternity services and the GP although this is not a bespoke Perinatal Mental Health service. This pathway is informal in nature and there is a need to develop a perinatal mental health service and pathway as there are a group of women who will not meet current thresholds for referral.

In interviews midwives stated that:

“*There is a big gap in meeting perinatal mental health needs of women. To get psychiatric input currently is ad-hoc*.”

Some staff interviewed seem to suggest that they hope the new NSFT safeguarding team may enable access to support in the future for women without a diagnosis.
The Department of Health circulated draft best practice guidance for a Maternal Mental Health Pathway in August 2012 (DH, 2012). This document highlighted the importance of close working between midwifery teams and health visitors with 2-way communication between midwives and health visitors from the initial booking appointment that the pregnant woman make through to 10-14 days after the baby is born. This reflected key messages from the Healthy Child Programme for services to promote positive mental health and wellbeing of the mother, promoting a healthy start for all women and preparing families for childhood. These require partnership working with Children’s Centres to facilitate support for mothers and families and referral to specialist services provided by Suffolk County Council.

Improving Outcomes and Ensuring Quality: a guide for commissioners and providers of perinatal and infant mental health services, NHS North West (2011) identified the following challenges to the development and delivery of integrated perinatal mental health services many of which exist in Suffolk (Table 4):

<table>
<thead>
<tr>
<th>Identified in NHS North West</th>
<th>Suffolk situation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Leadership</strong></td>
<td>In Suffolk there is no service area with overall responsibility for the commissioning delivery and evaluation of perinatal mental health care across universal, targeted and specialist settings. This leadership gap is a regional as well as local issue.</td>
</tr>
<tr>
<td><strong>Access to Specialist Mental Health Services in Line with NICE CG45</strong></td>
<td>There is no perinatal mental health network in Suffolk.</td>
</tr>
<tr>
<td>Key aspects identified from CG45 were the needs to establish a locally managed clinical network.</td>
<td>A consultant psychiatrist with a special interest in perinatal mental health has not been identified for Suffolk.</td>
</tr>
<tr>
<td>Local areas should identify a consultant psychiatrist with a special interest in perinatal mental health. To provide leadership and develop the knowledge, skills and resources necessary for the identification and timely intervention of perinatal mental ill health across all levels of health care provision.</td>
<td>Such a lead could assist the training and guidance of midwives in Suffolk on identification of mental health need during the antenatal assessment for the PbR Tariff.</td>
</tr>
<tr>
<td><strong>Access to in-patient care</strong></td>
<td>Currently the nearest in-patient care is in London. The development of specialist perinatal mental health inpatient services for the East of England by specialist commissioners should be promoted.</td>
</tr>
<tr>
<td>This is highly specialised care that is not cost effective to provide locally. Many women do not wish to be treated and cared for a long way from home and families.</td>
<td>This is where joint working between midwives and children’s centres in Suffolk can, and in some areas already is, making a difference to families.</td>
</tr>
<tr>
<td><strong>The availability of practical support to aid recovery</strong> – mothers suffering from mental or emotional ill health often require practical support with issues such as child care and transportation to services.</td>
<td>Stakeholder feedback reports local variation within Suffolk in the quality of partnership working between midwives, children’s centres and Health visitors in identifying pregnant women with mental health or social needs. This suggests inequity in the ability of</td>
</tr>
<tr>
<td><strong>Equality of Access to Specialist Perinatal (and Infant) Mental Health Services</strong></td>
<td></td>
</tr>
</tbody>
</table>

Table 4: Comparison of the key challenges identified in a review of NHS perinatal mental health and infant mental health services North West England (2011) with the current situation in Suffolk
<table>
<thead>
<tr>
<th>Identified in NHS North West</th>
<th>Suffolk situation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Equality of Access to Services for Minority Groups</strong> – Many mothers are single parents. Lesbian, gay, bisexual and transgender families are significant minorities which are more likely to abstain from perinatal mental health services.</td>
<td>Services to respond with early interventions to meet mental health and social needs of pregnant women. Information is not available on minority group access to perinatal mental health services in Suffolk.</td>
</tr>
<tr>
<td><strong>Disabled Parents</strong> – the challenges and health inequalities that disabled parents face can impact their risk of developing perinatal mental health issues.</td>
<td>Information is not available on access to perinatal mental health services in Suffolk by disabled parents.</td>
</tr>
<tr>
<td><strong>Stigma</strong> - The NHS North West Guidance indicated that women have reported that the stigma of perinatal illness has stopped them from seeking help. These women experience huge pressures to parent their infants effectively and this is sometimes compounded by the attitudes of health professionals as well as the rest of society. The result is that women are afraid to share their thoughts and feelings because of what might happen to them and if this is not picked up by adequate screening processes, serious deterioration in maternal mental health can occur before an intervention is made. <strong>Information</strong></td>
<td>The concerns raised by stakeholders in Suffolk about the lack of clear guidance to for assessment of women’s mental health during the initial antenatal appointment highlights the need for professionals making such as assessment to be aware of the impact stigma can have on women’s willingness to share their thoughts and feelings.</td>
</tr>
<tr>
<td>Families should be routinely provided with information about mental health problems in pregnancy, how to find appropriate help and from whom.</td>
<td>All women at WSH are routinely asked at booking and throughout their pregnancy about their mental health status. They are asked a series of questions (the Whooley questions) and any woman with a positive response to the assessments is signposted to her GP.</td>
</tr>
<tr>
<td>The Equality Act 2010 requires all services to promote equality across their communities and to publish information in a way that the public can judge how it has been used to eliminate discrimination, and advance equality of opportunity.</td>
<td>The publication of information on how perinatal mental health provision in Suffolk advances equality of opportunity should be one of the roles of a Suffolk perinatal mental health network.</td>
</tr>
</tbody>
</table>
5: Current Service Provision

5.1 Introduction

The Department of Health strategy for maternity services was outlined in Maternity Matters (2007) which identified the following objectives:

- To improve performance against quality and safety indicators.
- For mothers to report a good experience.
- To encourage normality in births by reducing unnecessary interventions, reflecting that usually this involves healthy women being supported through a natural life event.
- To promote public health with a focus on reducing inequalities.
- To improve diagnosis of pregnancy-related mental health problems and improve services for these women.

The strategy stated that these objectives would be achieved through offering choices, providing continuity of care and ensuring an integrated service through networks and agreed care pathways. Maternity Matters (2007) states that women have a guaranteed choice on: how to access maternity care, their type of antenatal care, place of birth, and place of postnatal care. Professionals will make a recommendation to choice depending on social and medical risk assessment of that woman.

Maternity services in Suffolk are commissioned by West Suffolk CCG and Ipswich & East Suffolk CCG. The two main providers of maternity services in Suffolk are West Suffolk Hospital (WSH) and Ipswich Hospital Trust (IHT). In addition a number of hospitals in neighbouring counties, including Addenbrookes Hospital, Colchester Hospital and Norfork and Norwich University Hospital, are intrapartum providers of care for some pregnant women in Suffolk, with associated risks when antenatal care and investigation results take place in another hospital.

West Suffolk Hospital is the main provider covering the population in Babergh, Forest Heath and St Edmundsbury and Ipswich Hospital Trust the main provider for Ipswich, Mid Suffolk and Suffolk Coastal. The maternity service providers are commissioned to meet the requirements of Maternity Matters (2007):

- Women are allowed to book their initial antenatal appointment (booking appointment) through a GP or direct referral to a midwifery team.
- Antenatal care is provided by midwifery teams or maternity team (consultant led) care, dependent on the needs and choice of the pregnant woman.
- Provision of home birth, midwife led birth, maternity team (consultant led) care, dependent on the needs and choice of the pregnant woman.
- Postnatal care by the midwifery team until discharge of mother and baby from maternity service care (on average 10 days) depending on clinical need.

In addition to Maternity Matters the routine antenatal care and screening of pregnant women provides the initial stages of the Healthy Child Programme (HCP) including the midwife undertaking a full health and social care assessment of the needs, risks and choices of pregnant women by 12 completed weeks of pregnancy. Under the HCP midwives provide routine health and lifestyle advice which include diet, weight control, physical activity, stress in pregnancy, substance misuse, breastfeeding, baby feeding and weaning.
In Suffolk community midwifery teams work jointly with children’s centres, health visitors and GP practices to support the holistic care of pregnant women. Facilitating contact of pregnant women with children’s centres before the birth of the child helps to ensure that women become aware of what services and support is available, including developing social links with women who face similar challenges, at a time when some women can become increasingly isolated. While the aim for most pregnancies is to normalise pregnancy with minimal medical involvement, the GP continues to have a role working with maternity services in managing ongoing health conditions, including long term and mental health conditions. For example through medication management that is appropriate during pregnancy. Both midwifery services have a midwife who looks after vulnerable women and work closely with children’s centres through antenatal and postnatal classes.

The important role of children’s centres in meeting the needs of pregnant women was highlighted in a 2013 All Party Parliamentary Group (APPG) report on Sure Start (Children’s Centres) recommendation that all perinatal services should be available from children’s centres.

When asked, nearly all stakeholders responded positively to this recommendation from a maternity service, children’s centre and commissioning point of view, including the potential to better meet the needs of pregnant women and families.

“A good idea because at the moment local midwives have a lot of different venues, so an area which parents could recognize as a hub, it will be a good spin off for all the services”.

“I would like to see more antenatal clinics at all the children’s centres, because it introduces the families to a children’s centre environment from a very early stage, which is not quite so daunting when the baby is born. The earlier that parents are identified and worked with the better the outcome for their children in the long run”.

“It could help with applications of tariff, with care closer to home and home births, but depends where [children’s centre is] based with considerations such as overheads and access by patients”.

“There would be real opportunities for shared care and a more holistic approach. May reduce duplication of visits and interventions. Ideally record keeping would be more straightforward with single system, more mutual learning”.

It seems that there are some challenges of having all perinatal services available in children’s centres, in terms of the amount of space available in different centres and in some cases centre locations that are sub-optimal. The potential impact on midwife working relationships with GPs was also mentioned:

“There is a danger of losing integration with GP practices…….. there does need to be some co-management with the midwife, GP and consultant and that can become dysfunctional without effective communication”.

“The antenatal record is carried by the patient but is often not available to the GP [e.g. when forgotten by patient]. This is where the informal conversations with midwives help”.

Page 31 of 70
In Ipswich young mothers (under 20 years of age) with their first child will benefit from the newly commissioned Family Nurse Partnership (FNP). The FNP is a maternal and early years public health programme that uses a psycho-educational approach. On-going, intensive support is provided through structured home visits delivered by highly trained nurse starting in early pregnancy and continuing until the child’s second birthday.

5.2 Antenatal care

5.2.1 Booking first antenatal midwife appointment

Both WSH and IHT facilitate women to book their first antenatal appointment with a midwife through their GP or by contacting a community midwife directly. The WSH website has a webpage providing details of how to book an appointment through the different community midwife teams, GP surgery or via the direct access midwife telephone line answer phone enabling a midwife to call back within 48 hours. Nationally there is a target for 90% of pregnant women to receive an antenatal appointment by 12 weeks and six days. Between April and June 2013 both maternity service providers in Suffolk were above this target with 97.6% of women having at IHT and 96.1% of women at WSH having their antenatal ‘booking’ appointment by 12 weeks and six days. The IHT community midwives provide the first antenatal booking appointment in a variety of venues, including GP practices, health centres and children’s centres, plus at the woman’s home if required depending on clinical and social risk assessment, In contrast all WSH community midwives conduct the first booking appointment in the woman’s own home, in order to make a more holistic assessment of the woman’s social as well as clinical needs.

5.2.2 Organisation of Community Midwifery teams

There are six community midwifery teams in the West of the county covering a different geographical area, with each team based in midwifery group practices that covers a number of GP practices. Community based midwife clinics are provided in all of the midwifery group practices and in some GP practices, and in the community within designated health centres or at the woman’s home. This is an integrated service with midwives taking responsibility for case load irrespective of high or low risk cases. Midwives can arrange ultrasound appointments and pathology investigations and have direct referral to consultant obstetrician for advice. Specialist midwifery roles identified by WSH include, Lead Midwife Risk whole time equivalent (WTE) 0.80, Midwife Safeguarding Children and Vulnerable Adults (WTE 1.0), Practice Development Midwife (WTE 1.0), Senior Midwife, Projects (WTE 1.0). This is consistent with NICE guidance (CG62) that there should be continuity of antenatal care provided throughout the antenatal period by a small group of healthcare professionals with whom the woman feels comfortable.

There are also six teams of community midwives covering the geographical catchment area for IHT. Each team has a senior midwife team leader, a number of midwives and a maternity care assistant. Every woman will have an identified named midwife and the named midwife will coordinate the care for the woman including those who have medical or social risk factors. The IHT community midwifery teams are attached to GP surgeries. Antenatal clinics are conducted in a range of venues.
including GP practices, health centres, children’s centres (subject to availability) and a bespoke venue for midwifery clinics in the Gilchrist Birth Centre in Eye. All midwives have access to the consultant and obstetric ultrasound services and are able to make direct referrals.

The specialised midwifery roles identified by IHT are specialist midwife in diabetes 0.5wte, Infant feeding midwife 1.0 WTE and Named Midwife for safeguarding 1.0 wte, Practice development midwife 0.8 wte, Antenatal screening coordinator 1.0 wte. There is a clinical governance manager 1.00wte and a Clinical effectiveness midwife 1.00 wte. There is currently 0.2 wte midwife assigned to ‘Birth debriefing’ although it is envisaged that the hours for this post will increase in the next financial year.

The named midwife for safeguarding and drug liaison at IHT is able to make direct referrals to the Gynaecologists at the Trust for termination of pregnancy for women who are vulnerable and have chaotic lifestyles who may be less likely to access GP services either due to lifestyle or because they are not GP registered.

At both trusts the midwife with the safeguarding lead role is responsible for pregnant women with mental ill health or disability, including learning needs.

5.2.3 Antenatal support for pregnant women

In Suffolk community midwives work with health visitors and children’s centres in the county to holistically assess the health and social needs of pregnant women. This is facilitated by the Antenatal Healthy Child Collaborative (AHCC) process, with joint meetings between a midwife, health visitor and children’s centre manager to share information and plan actions to support pregnant women. Through the AHCC pregnant women with additional need are referred through midwifery for universal plus services to see what can be done quickly to get woman back down to universal services. This can include additional support provided through children’s centres and antenatal involvement of health visitors. Also if more specialised social support needs are identified then midwives have a role in contributing to Common Assessment Framework (CAF) meetings to identify and agree the support required, in addition to universal services.

IHT have direct links to the Positive Choices Team in Ipswich who will work intensively to support women who have had a previous child removed from their care. This support is to help address issues that currently impact on their ability to parent and also to prevent repeat pregnancies while undressed issues exist.

Different models of antenatal parenting classes, formal and informal, are available to pregnant women in Suffolk dependent on their community midwifery teams and or local children’s centre. In some cases midwives deliver their own classes in different settings, including children’s centres, in other cases the antenatal parenting classes are delivered jointly with children’s centres, health visitors, or other groups. Increasingly these antenatal classes include information about the health, emotional and behavioural needs of the baby, rather than focusing on delivery. This includes specific support for ‘young mums’ under 20 years of age;

“Baby and Me Program runs for 10 weeks provided jointly by Health Visitor, Midwife, Children’s Centre professional, mental health worker and youth worker. Young mum goes every week for lots of practical skills learning, bath baby, breast
feed, bottle feed, baby early needs, parenting strategies, how to engage with baby, attachment and other areas raised by teenage mums. Starts pre-birth continues after baby is born”.

Some stakeholder reported that access to parenting classes might be an issue;

“Pregnancy and beyond is a good group but pregnant women are at work so [the weekday classes] do not fit with parents being able to come out of hours”

In some areas of Suffolk measures have been taken to improve parent access to antenatal parenting classes including an example reported by a children’s centre manager;

“[We] moved the antenatal programme to evening delivery because ladies want partners to come. Since midwives and children’s centre staff have had Solihull ‘Journey to Parenthood’ training, the antenatal programme includes issues such as bonding and attachment, with a new approach of what it is like for both baby and parents. Promoting engagement with baby throughout the antenatal period”.

Some stakeholders shared their concern over the potential for inequality in accessing antenatal parenting classes;

“The midwives parent-craft classes are via an invitation letter sent to all pregnant women who have to book themselves. But this means that vulnerable women are unlikely to book on and midwives will not allow the children’s centre to contact and invite vulnerable women. Midwives attitude is that parents should be able to read and understand what parent-craft is”.

Stakeholder feedback included concerns over variation in partnership working between midwives and children’s centres and health visitors in different parts of Suffolk. For example;

“Need to improve the offer to vulnerable women during the antenatal period. Need to improve collaborative working. While variation between localities is going to exist in Suffolk the inconsistency in services is high”.

The stakeholder feedback in West Suffolk indicated strong working links between WSH community midwives and children’s centres in identifying the needs and supporting pregnant women. For example;

“All going very well, the midwifery links are brilliant, they are willing to give ideas a go, really pleased with midwifery team”.

“Joint working with midwives is excellent they are easy to contact and work with in general”.

In contrast stakeholders in East Suffolk expressed concern over the quality of partnership working between midwives and children’s centres and health visitors in supporting pregnant women (Appendix 3). Although it seems there are different expectations:
“Midwives do identify the right women for Healthy Child Collaborative, which is really good, but midwives are not interested in support work for such women”.

“They [midwives] will not complete CAF [common assessment framework] they are only interested in their ‘core service’ not offering holistic care”. [IHT response is - that at times if the threshold for safeguarding is not met but the women are in need of additional support a referral to the Healthy child collaborative is appropriate and will provide access to services required].

Another theme raised by different stakeholders in East Suffolk was challenges in communication and information flows both to and from midwives. Including the following comments;

“Some children’s centre’s are much better at providing timely information to midwives than others”.

“More information needs to travel from the GP to midwives to enable them to assess the mothers health needs”.

“We [midwives and children’s centre’s] need better collaborative working with better communication, [there’s an] obsession with using data protection as a barrier to information exchange”.

[IHT commented – all of the teams hold a clinic and antenatal education in a children’s centre. Each children’s centre has a link midwife. Some children’s centre’s do not have the facilities for midwifery care to be delivered]

5.2.4 Perinatal Mental Health Services

The maternity services at Ipswich hospital and West Suffolk Hospital have reported that the absence of a perinatal mental health pathway and training for maternity staff proves a challenge to their management of women with poor mental health. Ipswich Hospital does have a psychiatric liaison available for the whole hospital, which maternity services can refer pregnant women to. West Suffolk Hospital are developing the delivery of a psychiatric liaison service from Norfolk and Suffolk Foundation Trust.

5.3. Intrapartum Care

5.3.1 Choice of place of delivery

In line with Maternity Matters (2007) pregnant women who register with either the WSH or IHT maternity service are able to choose where to deliver their baby including which hospital.

West Suffolk Hospital provides the options of home birth, obstetric unit or a co-located Midwifery Led Birthing Unit. Patients from outside Suffolk boundaries are seen at West Suffolk Hospital, for example from Thetford in Norfolk, along with patients from East Suffolk. A number of women living in Forest Heath or Haverhill areas tend to receive antenatal care from West Suffolk Midwives but deliver at the Rosie Maternity Unit, Addenbrookes Hospital. In the financial year 2012/2013 nearly
three quarters of births at WSH were provided by a maternity team rather than midwifery led birthing or home births (Table 5).

Table 5: Actual place of birth of babies delivered by West Suffolk Hospital Maternity Services (2012/2013). Source West Suffolk Hospital

<table>
<thead>
<tr>
<th>Actual Place of Birth</th>
<th>Count</th>
<th>Percentage of total (2694)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour Suite</td>
<td>1995</td>
<td>74.1%</td>
</tr>
<tr>
<td>Birthing Unit (Midwifery Led)</td>
<td>602</td>
<td>22.3%</td>
</tr>
<tr>
<td>Home Birth</td>
<td>97</td>
<td>3.6%</td>
</tr>
<tr>
<td>Total women delivered</td>
<td>2694</td>
<td>100%</td>
</tr>
</tbody>
</table>

Ipswich Hospital also provides a wide range of options for place of delivery including home birth, a midwife led co-located unit (Brook Birth Centre), a standalone midwife led birthing unit (Gilchrist, located in Eye) and consultant led care (Deben Ward). Nearly 75% of births delivered by IHT maternity services were in consultant led units or in theatre (Table 6).

Table 6: Actual place of birth of babies delivered by Ipswich Hospital Maternity Services (2012/2013). Source Ipswich Hospital Trust

<table>
<thead>
<tr>
<th>Actual place of birth</th>
<th>Count</th>
<th>Percentage of total (3790)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant led care – all</td>
<td>2925</td>
<td>77.2%</td>
</tr>
<tr>
<td>Midwife led care (co-located Birthing unit)</td>
<td>729</td>
<td>19.2%</td>
</tr>
<tr>
<td>Home Birth</td>
<td>133</td>
<td>3.5%</td>
</tr>
<tr>
<td>BBA – no health care present for birth of baby or placenta</td>
<td>3</td>
<td>0.1%</td>
</tr>
<tr>
<td>Total</td>
<td>3790</td>
<td>100%</td>
</tr>
</tbody>
</table>

There is evidence that for pregnancies identified as low risk, having a consultant led birth actually increases the likelihood of an intervention and adverse outcome compared to a home birth or midwifery led birth (Birthplace in England Collaborative Group, 2011). The new maternity PBR tariff allocation for 2013 indicates the majority of pregnancies are assessed to be on a standard pathway, indicating a large number of low risk pregnancies. However, not all pregnancies on the standard pathway are low risk, for example women who have gestational diabetes or history of GD may be allocated to the standard pathway. Thus it cannot be assumed that all standard pathway pregnancies are low risk or remain low risk at the time of delivery.

Despite the choice available to pregnant women at both WSH and IHT only 3.6% of deliveries were home births in 2012/2013, just over a fifth were midwifery led births and approximately three quarters of births were maternity team/consultant led. This suggests that pregnant women in Suffolk may need clearer information about the benefits and reduced risks from home births and midwife led births for uncomplicated pregnancies. This is to ensure pregnant women are able to make an informed choice regarding birth location. However women may choose to transfer from midwife led care to consultant led care for access to wider pain relief options, for example epidural.
At both WSH and IHT obstetric consultant led care is provided if risk factors are identified during the antenatal booking appointment or subsequently during pregnancy or labour.

Ipswich hospital has a consultant led delivery suite (Deben Ward) with 24 hour access to obstetric, paediatric and anaesthetic medical teams in addition to midwife care during labour. The ward has 6 delivery rooms, 3 assessment rooms and a 4 bed antenatal room, plus an en-suite quite room. If a woman has a planned caesarean section then they are admitted to Orwell Ward a 22 bed consultant led antenatal and postnatal ward at Ipswich Hospital, staffed by midwives. As of Feb 2014 IHT will have a total of 10 consultants in post, 2 dedicated obstetricians, 6 obstetricians and Gynaecologist and 2 Gynaecology/oncologists in post. This is in line with the proposed obstetric targets set out in Safer Childbirth (2007).

West Suffolk Hospital has a consultant led labour suite for high risk women. It has 6 labour rooms including a pool room, a bereavement room and a high dependency room. The labour suite has consultant presence 60 hours per week as per RCOG guidelines from a team of 8 consultant obstetricians with a consultant available on call outside of the 60 hour cover (Safer Childbirth 2007). The maternity service has 24 hour availability of anaesthetists and paediatricians to support deliveries. Labour suite has a dedicated recovery area for women who undergo caesarean sections or instrumental deliveries where babies remain with their mothers facilitating the bonding process.

The antenatal/postnatal ward has 32 beds of which 4 are single rooms. Care is provided by midwives, supported by the obstetric team

5.4. Postnatal care
Depending on the needs of the mother and baby the community midwifery team continue to provide postnatal support in the first weeks after birth. In the second week a midwife hands over care to a Health Visitor local to the mother and babies place of residence. Ahead of the face-to-face New Baby review by the Health Visitor with mother and father/partner (Healthy Child Programme, 2009). West Suffolk Hospital report that the handover by maternity services to health visitors occurs on day 11. Ipswich Hospital Trust report that handover occurs between days 10 to 14.

A few stakeholders expressed their concern about the handover of patients from maternity services to health visitors in both West and East Suffolk;

“The main way the midwife communicates with the health visitor [at handover] is by leaving information at the mother’s house. Historically [health visitors] used to get handover information from midwives before health visitor visited family, but timescale are now tighter. [There is] no liaison between midwives and health visitors on when the midwife has discharged a mother and baby so there can be an overlap in service or a gap of several days between discharge and the health visitor visit, which is not wanted’.

After the handover, a mother and baby will receive differing levels of input from their health visitor depending on whether this is the woman’s first child and any identified needs. A few stakeholders interviewed commented that for some mothers this meant
a gap of several weeks, between midwife handover to the health visitor and the six week check,

“…within which recognition of postnatal depression is delayed”.

This highlights the importance of the postnatal assessment by the midwife and potential benefit of encouraging pregnant women/new mothers to make links with their local children’s centre for support.

Children’s centres in Suffolk provide a range of practical support to mothers/parents during the postnatal period. The children’s centres differ in service provision, but can include parenting classes, breastfeeding support, drop-in sessions and infant feeding workshops. In addition some children’s centres provide interventions to support mothers when there are concerns about attachment with their baby. For example Video Interactive Guidance (VIG) helps a mothers identify positive aspects of their interactions with their baby, supporting them to build a stronger relationship.

5.5 Antenatal/Newborn Screening Programme in Suffolk

Within Suffolk, both WSH and IHT maternity units are performing very well with respect to antenatal and newborn screening KPIs (these are set at a national level and monitored regionally). IHT maternity unit has appointed an antenatal failsafe officer to follow up and ensure all women who have booked for antenatal provision get all screening tests available and that there is an outcome to each test. IHT will also be appointing 1.wte deputy antenatal and newborn screening coordinator in 2014/15.

WSH have appointed a full time administrative clerk who is currently training with the antenatal and newborn screening midwife. He will take on the role of the Failsafe Officer in due course.

5.6 Support for Breastfeeding

As part of promoting good infant health, the Department of Health recommends exclusive breastfeeding for the first 6 months of life and states that breastfeeding can continue to benefit your babies along with solid foods for one year after. Breastfeeding can help to reduce the risks of infection, obesity and diabetes in later life (NHS Choices, 2012). Compared to breastfed babies, babies who are not fed their mother’s milk are twice as likely to be admitted to hospital with a chest infection within their first seven years.

Breast feeding initiation ideally takes place as soon after birth as is practical. Between 2008/09 and 2011/12, the percentage of mothers initiating breastfeeding at birth in Suffolk has increased by 5% to 78%, higher than for the East of England and England (Table 7). Almost 40% of mothers are reported to be exclusively breastfeeding when the baby is six weeks old (Suffolk County Council, 2013). Further definition for breast feeding initiation is required for such comparisons, for example IHT record initiation as the babies first feed.
Table 7: Breastfeeding among Suffolk mothers, 2008/09 - 2011/12

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of births</th>
<th>% mothers breastfeeding at birth</th>
<th>% of mothers breastfeeding at 6-8 weeks</th>
<th>East of England</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Exclusive</td>
<td>Partial</td>
<td></td>
</tr>
<tr>
<td>2008/09</td>
<td>6747</td>
<td>N/A</td>
<td>30%</td>
<td>7%</td>
<td>N/A</td>
</tr>
<tr>
<td>2009/10</td>
<td>6566</td>
<td>73%</td>
<td>35%</td>
<td>9%</td>
<td>71.3 %</td>
</tr>
<tr>
<td>2010/11</td>
<td>6778</td>
<td>71%</td>
<td>36%</td>
<td>10%</td>
<td>73.1%</td>
</tr>
<tr>
<td>2011/12</td>
<td>6809</td>
<td>78%</td>
<td>38%</td>
<td>11%</td>
<td>73.5%</td>
</tr>
</tbody>
</table>

Source: Suffolk Breastfeeding Performance Report, Public Health Suffolk, 2013

Currently in Suffolk there is a 25-30% drop off between initiation of breastfeeding to breastfeeding prevalence at 6-8 weeks. The UNICEF UK Baby Friendly Initiative provides recognised standards for maternity services, along with neonatal, health visiting and children’s centre services. Stage 1 of the UNICEF standard is for services to have an infant feeding policy, staff training plan and protocols and guidelines on how staff will implement the standards. Both IHT and WSH have attained stage 1 Baby friendly accreditation and the next step is for them to attain UNICEF stage 2, which includes an educated workforce supported by commissioning for quality and innovation (CQUIN) payments from the commissioning CCGs. As part of this process an infant feeding coordinator has recently been appointed at and WSH with an aim to reduce the reduction in breastfeeding drop off and support each hospital reach UNICEF stage 2 accreditation by March 2015. Funding for the equivalent post at IHT post March 2014 not yet confirmed.

Recent interim data for April to December 2013 indicate that Breast feeding initiation at WSH was 77.9% and at IHT was 79.8%. Suffolk County Council breastfeeding performance reports (initial quarter 1 2013/2014) at CCG level highlight how the percentage of women recorded as breastfeeding at the new birth check (NBC) declined to around 62%, then down to 50% (I&ES) or 48% (WS) at 6-8 weeks. While the initial quarter 2013/2014 breastfeeding data is very similar between the CCG populations there is only a slight improvement over the 2012/2013 breastfeeding rate in I&ES CCG (Figure 10) compared to WS CCG (Figure 11).

Figure 10: Interim quarter 1 breastfeeding initiation and prevalence figures for Ipswich and East Suffolk CCG for 2013/2014 compared to 2012/2013. Note: These percentages are interim figures and may change with the annual figure in quarter 4

Source: Public Health Suffolk, Suffolk County Council
Note the initial quarter one of 2013/2014 breastfeeding performance report figures are interim and may vary by around 2% with the final initiation rate calculated at the end of the year (Figure 10 & Figure 11). Also the quarter 1 figures at CCG level recorded lower breast feeding initiation at birth than hospital level figures for the same period which were 76.6% for IHT and 75.9 for WSH.

Figure 11: Interim quarter 1 breastfeeding initiation and prevalence figures for West Suffolk CCG for 2013/2014 compared to 2012/2013. Note: These percentages are interim figures and may change by quarter 4 when the annual figure will be calculated

Source: Public Health Suffolk, Suffolk County Council

Both CCGs have agreed CQUIN payments with the IHT (I&ESCCG) and WSH (WSCCG) to improve breast feeding initiation and retention. This is being achieved through two different approaches.

1. Ipswich Hospital trust is further developing a breastfeeding friendly environment for mothers, training midwifery staff in the importance of breastfeeding, ensuring all positive social materials for breastfeeding are offered and that mothers are signposted to voluntary and charitable organisations such as breastfeeding network. Mothers are to be supported from birth to discharge, by working with voluntary and charitable organisations, ensure social marketing materials are available. An audit of why mothers stop breastfeeding is going to be developed in partnership with Public Health Suffolk This will inform coordination of services for mothers to support them to breastfeed.

2. The breastfeeding initiative for WSH is aimed at increasing initiation within acute services and ensuring a higher prevalence of mothers sustaining breastfeeding up to and including 6-8 week check within the community. This will involve redefining breastfeeding initiation to ensure mothers are successfully breastfeeding within 48 hours or at least 2 hours before discharge. The infant feeding coordinator for WSH will develop a UNICEF level 2 accreditation antenatal model and coordinate staff training within Paediatrics / Neonatal staff. WSH are to work with community clusters in reducing the breastfeeding prevalence drop off between breastfeeding initiation and the 6-8 week check. A home visiting model to support breastfeeding is to be implemented in partnership with the acute antenatal
model. This will involve coordinating visits to new mothers after discharge and ensuring they continue to breastfeed within the community up to 6 - 8 weeks.

Stakeholders identified that the needs of fathers/partners in supporting pregnant women to breastfeed were often overlooked.

“The Breastfeeding support group is run antenatal but dads are excluded from this session. It would be good for dads not to be excluded, as dads should be engaged”.

“A dad was saying if partner had concerns or difficulties she would be speaking to him, but because he is excluded from support session, he is not informed”.
6. Maternity service use

6.1 Choice of maternity provider for delivery

Pregnant women are able to choose their provider and place of delivery. This means women from West Suffolk CCG or Ipswich and East Suffolk CCG can have their baby delivered at a maternity unit outside of Suffolk.

Under the new PbR maternity tariff the main maternity provider paid by the CCG is the maternity service provider. The ‘provider’ is the maternity service which the pregnant woman initially registers with and which provides an initial midwife antenatal booking appointment. During the antenatal booking appointment the main provider assesses the maternity pathway PbR tariff. When a woman delivers her baby using the services of a different maternity provider then the main provider has to pay the second provider from maternity pathway tariff funds. This is commonly known as a split tariff. For example, where a pregnant woman has only her initial booking appointment provided by WSH, yet her pregnancy, including delivery, is managed by Addenbrookes Hospital, the main maternity provider remains WSH. The commissioner pays the maternity pathway payment to WSH which then pays Addenbrookes Hospital.

One source of information which provides an indication of deliveries by provider is the Finished Delivery Episode (FDE) statistic. A FDE is recorded when a delivery has resulted in a registrable birth either in an NHS hospital or non-NHS organisation funded by the NHS. Over a three year period (April 2010 to March 2013) the majority of deliveries to mothers registered within the Ipswich and East Suffolk CCG were delivered through IHT (10,799, 89%) and 8.5% (1,034) of deliveries with WSH (Figure 12).

Figure 12: Distribution of Finished Delivery Episodes by Provider for births registered to patients in Ipswich and Suffolk Clinical Commissioning Group (CCG), Pooled data for Financial Years 2010/2011 to 2012/2013
Between April 2010 to March 2013 75% of FDE from the West Suffolk CCG population were delivered by WSH maternity services (Figure 13). Over a fifth of women from West Suffolk CCG population had their baby delivered at the Rosie Maternity Unit, at Addenbrookes Hospital, Cambridge which is close to and easily accessible to women resident in the Western part of Suffolk, for example Newmarket.

Stakeholder feedback indicates that such split tariff situations can make it challenging to obtain necessary clinical and management information in a timely manner through the paper based systems that some maternity services use. This presents a risk with implications for the transfer of information between providers and continuity of care, and the need for transparent information for payment transfer. IHT reported that information transfer from alternative providers of maternity services has been delayed in some instances due to provider concerns over the information governance of patient identifiable information. WSH reported that split tariff governance and safety issues with Addenbrookes Hospital have been resolved with a system that uses the hospital number as a unique identifier for the transfer of patient specific information without disclosure of patient identifiable information. Reportedly other split tariff providers that WSH patients sometimes deliver at, are in the process of adopting a system of information transfer similar to Addenbrookes Hospital.

Figure 13: Distribution of Finished Delivery Episodes by Provider for births registered to patients in West Suffolk Clinical Commissioning Group (CCG), Pooled data for Financial Years 2010/2011 to 2012/2013

6.2 Choice of birth location

Maternity Matters (Department of Health 2007) outlined a commitment to offer all women and their partners a wider choice of type and place of maternity care and birth. Evidence from the Birthplace Cohort study shows that for women having a second or subsequent low risk pregnancy, home births and midwifery unit births are safe for the baby and offer benefits to the mother, with significant and substantially increased likelihood of having a more ‘normal birth’ rather than caesarean section, instrumental delivery or episiotomy (Birthplace in England Collaborative Group, BMJ 2011).
The number of home births by IHT maternity services during 2012/13 was 133 (3.5% of 3,790 deliveries), of which 100 (75%) were planned home births and 33 (25%) were unplanned but a professional was in attendance for the completion of the birth. In addition to the home births there were also 3 BBA’s these are babies that were born when there was not a health care professional present for any stage of labour.

For WSH the number of home births for 2012-2013 was 97 (3.6% of 2694 deliveries) of which 43 (44.3%) were planned and there were 53 (55.6%) unplanned home births.

In Suffolk the proportion of live births at home and non-NHS hospitals between 2002 and 2011 was higher than across the East of England (Figure 14). This indicates provision a wider choice for delivery in Suffolk than the regional and national average. The majority of live births were in hospitals, with 95.1% of live births in Suffolk in either an NHS or non-NHS hospital, compared to 96.4% in the East of England and 97.4% across England. The high proportion of births in non-NHS hospitals in Suffolk includes the use of military facilities in Forest Heath.

Figure 14: Percentage distribution of live births by place of confinement, Suffolk, East of England and England (Data pooled 2002-2011)

Between 2002 and 2011 there was a regional and national increase in home births followed by a decline between 2008 and 2011. In Suffolk this trend in the annual percentage of home births was mirrored with 5 to 6% of births at home in 2005 and 2007 falling closer to 3% in 2011, just above the regional average (Figure 15).

The decline in home births in Suffolk (mirrored nationally) between 2006 and 2011 was mirrored by an increase in births in NHS hospitals. This fall in home births is undesirable if it corresponds with an increase in low risk obstetric unit births, with a corresponding increase in the chance of a non-normal delivery. It should be recognised that IHT has a local neonatal unit, and the information does not indicate the full clinical history of these births. In addition this information does not indicate what proportion of ‘hospital’ births were in a midwife led units, although information for IHT indicates over half of births are consultant led (Table 6).
In Suffolk the provision of more relaxed ‘home from home’ birthing facilities at the midwife led birth centres co-located with the main hospital or separate birthing units like the Gilchrist in Eye provide a choice for women expecting a low risk birth, including delivery of a first child, that increases the likelihood of a ‘normal’ delivery compared to traditional hospital births, but without the resource implications of a home birth which requires 2 midwives.

6.3 Maternity Staff Mix

Key performance indicators for the maternity services are a 1:30 ratio for midwife to pregnant women and 1 to 1 care during established labour. At IHT the midwifery ratio, whole time equivalent (WTE), for 2012/2013 was 1:32 with 1 to 1 care during labour for 98.7% of births indicating some women’s perception as that they did not receive the required level of midwife support during labour. In WSH the midwifery ratio was 1:29, which is a concern, while 100% of established births had 1 to 1 midwife care during labour.

Ipswich Hospital Trust

Ipswich Hospital Trust have the following specialist midwife roles; antenatal screening coordinator, specialist midwife for diabetes, midwife with responsibility for governance, Practice development midwife, Infant Feeding Midwife (fixed term contract to 2014), Clinical effectiveness midwife and a Named midwife for safeguarding and drug liaison 1.00wte. Plus Head of Midwifery, Nursing and Clinical Services, and two midwifery managers.

As of Feb 2014 IHT will have a total of 10 consultants in post, 2 dedicated obstetricians, 6 obstetricians and Gynaecologist and 2 Gynaecology/ oncologists in post. The consultants are supported by 8 registrars providing middle grade cover. The deanery allocation is for 9 middle grade trainees but IHT currently have 1 vacancy to which they are actively recruiting
Specialist consultant roles include, Endocrine, Fetal Health (amniocentesis & screening) and a Gynae and early pregnancy unit. Junior posts are 7-14 Specialty Registrars and 7 SHO’s with current advertising for 4 Registrar Posts, which were reportedly difficult to fill. This is in line with what is required given the number of deliveries managed by IHT (Safer Childbirth 2007).

West Suffolk Hospital
At West Suffolk Hospital the midwifery team includes 1 WTE Risk Manager, a Lead Midwife for Risk (WTE 0.8), a Midwife Lead for Safeguarding Children and Vulnerable Adults (WTE 1), Practice Facilitator (WTE 0.33), Practice Development Midwife (WTE 1) and Senior Midwife for Projects (WTE 1). A total eight consultant posts were reported for WSH maternity services, but a breakdown of the consultant roles was not identified. Specialist consultant roles include, Diabetes (medieval and obstetrics), Colposcopy, Urology/gynaecology. This is in line with what is required for the number of deliveries managed by WSH (Safer Childbirth 2007).

6.4 Implementation of the Maternity Pathway Payment by Results (PbR) Tariff
From April 2013 a new system of payments to providers for maternity services was introduced. With the new PbR Tariff system the commissioner pays a provider for all the pregnancy related care a woman may need for the duration of her pregnancy, broken down into the three stages of Maternity care, Antenatal, delivery and postnatal care. The previous payment system was based on individual elements of care (Ante Natal appointment, Inpatient antenatal episode, etc) meant that hospitals proving more proactive, community-based maternity care would be financially worse off. The new PbR tariff pathway payment system is based on the principle of money following the patient which no longer provides a financial disincentive against prevention and care closer to home, i.e. the hospital does not gain financially from higher levels of pregnancy or birth interventions (Maternity Services Pathway Payment Systems a Simple Guide, 2012).

Each lead provider retains full responsibility for how they deliver care to women, while commissioners will judge providers solely on how well they deliver their overall service. The aim of the pathway PbR payment system is to encourage proactive care and prevention, rather than reaction. If a woman chooses a different provider for certain elements of her maternity care for example a woman registered with West Suffolk Hospital (WSH) chooses to have part of her Antenatal care delivered at the Rosie Maternity unit, Addenbrookes Hospital, the lead provider (WSH) receives the pathway payment for the Antenatal care and is required to pay the second provider (Addenbrookes) for any care given as part of the Antenatal pathway.

During a woman's first booking appointment midwives assess her needs based on the medical and social risk assessment. They collect comprehensive information on her health and social care characteristic using a proforma developed for this purpose by the maternity unit based on national guidance. Based on this assessment women are allocated to one of three different pathways. Standard (£1,124 pathway payment including market forces factor), Intermediate (£1,799) or Intensive (£2994). The delivery stage payment is dependent upon the level of intervention required and is
based on the Healthcare Resource Group for the Spell of Care. The postnatal phase is also split into the same three pathway categories, using antenatal assessment booking information plus information from later stages of pregnancy and delivery. The postnatal pathway payments (including MFF) are lower than the antenatal payments; standard (£252), intermediate (£318) and Intensive (£854). The factors informing the decision on whether to allocate a woman to the intermediate or intensive PbR tariff, rather than standard, during the antenatal assessment and postnatal assessment are shown in appendix 1.

In the Department of Health publication ‘Maternity Services Pathway Payment Systems a Simple Guide’ the Average case mix across England is provided as a percentage of patients classified as standard, intermediate or intensive. This was used as a comparator with the antenatal and postnatal pathway categorisations by West Suffolk Hospital and Ipswich Hospital (Tables 8 & 9).

In the first three months of the new PbR maternity pathway tariff the proportion of women classified in the three different antenatal assessment categories was similar to the percentage calculated for the England average case mix. With a higher proportion of women in Suffolk assessed as standard, and markedly fewer assessed as Intensive. These figures are roughly in line with expectations but both WSH and IHT indicated concern over the ambiguity of national guidance on assessing the allocation of pregnant women to different pathways. Stakeholders reported that the lack of clear guidance for mental health assessment during the booking appointment represents a challenge for midwives. For example;

“The mental health aspects are a challenge [when assessing the PbR tariff maternity pathway], deciding on the degree of mental health need, there is no clear definition. For example a history of mental health problems but not currently on treatment or patient receiving treatment are they standard or intermediate or intensive”?

Stakeholders indicated that the assessment criteria are unclear for different sub categories of long term conditions. It is also difficult due to dependence on paper based systems and also risks factors that may place a woman in a higher category may not be available at the time of the midwife booking e.g. twins, or medical conditions requiring specialist input

<table>
<thead>
<tr>
<th>Antenatal Assessment Categories</th>
<th>West Suffolk Hospital April - June 2013</th>
<th>Ipswich Hospital</th>
<th>England Average Case Mix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard</td>
<td>426 Number</td>
<td>718 Number</td>
<td>628 Number</td>
</tr>
<tr>
<td></td>
<td>67.8% Percent</td>
<td>69.1% Percent</td>
<td>65.5% Percent</td>
</tr>
<tr>
<td>Intermediate</td>
<td>165 Number</td>
<td>270 Number</td>
<td>51 Number</td>
</tr>
<tr>
<td></td>
<td>26.3% Percent</td>
<td>26.0% Percent</td>
<td>4.9% Percent</td>
</tr>
<tr>
<td>Intensive</td>
<td>37 Number</td>
<td>51 Number</td>
<td>8 Number</td>
</tr>
<tr>
<td></td>
<td>5.9% Percent</td>
<td>4.9% Percent</td>
<td>7.1% Percent</td>
</tr>
<tr>
<td>Total Activity</td>
<td>628 Total Activity Number</td>
<td>1039 Total Activity Number</td>
<td>100.0% Percent</td>
</tr>
</tbody>
</table>

Following assessment in the postnatal phase a much higher proportion of women in April to June 2013 were assessed as standard rather than intermediate, with a very
small number of women assessed as intensive. This is encouraging from a resource use perspective,

<table>
<thead>
<tr>
<th>Postnatal Assessment Categories</th>
<th>West Suffolk Hospital</th>
<th>Ipswich Hospital</th>
<th>England Average Case Mix</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>April - June 2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td>Standard</td>
<td>351</td>
<td>81.3%</td>
<td>697</td>
</tr>
<tr>
<td>Intermediate</td>
<td>81</td>
<td>18.8%</td>
<td>146</td>
</tr>
<tr>
<td>Intensive</td>
<td>0</td>
<td>0.0%</td>
<td>(&lt;5)</td>
</tr>
<tr>
<td>Total Activity</td>
<td>432</td>
<td>100.0%</td>
<td>845</td>
</tr>
</tbody>
</table>

**6.5 Neonate admissions to hospital**

Data from 2009/2010 (South Eastern Public Health Observatory, SEPHO) indicated East and West Suffolk had a high rate (51 per 1,000 live births) of emergency admissions of home births and re-admissions to hospital of babies within 14 days of being born (NHS Atlas of Variation in Healthcare for Children and Young People 2012). Data produced by the Neonatal Data Analysis Unit (NDAU) in August 2011 indicated that Suffolk had a high rate (58%) of admissions to neonatal care of full term babies (37 weeks gestational age at birth) (NHS Atlas of Variation in Healthcare for Children and Young People 2012). With both of these measures East and West Suffolk were amongst the 4th highest quintile nationally (Evans, 2012). An investigation neonatal admission and readmission rates in Suffolk is required, including assessment of more recent local data to determine how current rates compare to those of 2010. This investigation should determine what the contributing factors to neonatal admissions and readmissions are in Suffolk and what measures can be taken to reduce the need for emergency admissions, readmission and neonatal care.
7. Stakeholder experience

7.1 Experience of women using maternity services in Suffolk

The Care Quality Commission (CQC) conducted a Maternity Services Survey in 2010 (Appendix 2). This included survey results for women using the Ipswich Hospital Trust and West Suffolk Hospital Trust maternity services. The survey indicated with both Suffolk maternity services, user responses were about the same as the England average, indicating no particular concerns but room for improvement in all areas. The area with the poorest score was feeding the baby during the first few days. Respondents indicated a low score on providing consistent advice on feeding their baby and a low score for the provision of active support for feeding the baby. The CQC are conducting a further maternity services survey in 2013.

7.2 Stakeholder Responses to Interviews

7.2.1 Summary of Key themes
The key themes are listed below and these have been incorporated in to the report (Appendix 3).

- Suffolk does not have a clear strategy for helping women of reproductive age to prepare for a healthy pregnancy, e.g. obesity, smoking, alcohol, advice on diet.
- For women of reproductive age with a long term condition the pre-pregnancy advice regarding implications for medication and condition management varies between clinicians. Diabetes was been given as an example where women receive effective advice preconception and long term mental health conditions have been given as an example where women appear poorly prepared by advice from clinicians.
- Partnership working between midwives and children’s centres/health visitors proved a key theme during interviews (Table 9). Partnership working between midwives and health visitors was reported as excellent or above average in West Suffolk (n3) compared to mainly average or below average in East Suffolk (4). The role of chance cannot be ruled out with this difference because of small numbers.
- Mental health was identified by all stakeholders (commissioner, maternity service provider and children’s centres/health visitors) as an issue or challenge
- Breastfeeding was identified as a priority by commissioners and children’s centres/health visitors
- Commissioners and maternity service providers consider the implementation of the PbR tariff to have progressed well.
- Maternity service staff and some commissioners identified the mental health assessment part of the booking appointment as a challenge, due the absence of clear definition of how different mental health conditions or histories should be allocated to maternity care pathways. Provider also indicated that the assessment criteria are also unclear for different sub categories of long term conditions.
- When asked about the APPG report on Sure Start recommendation that all perinatal services should be delivered in children’s centres, all groups of people identified opportunities including improved partnership working (with
particular benefits for vulnerable pregnant women/families), better access and outcomes for pregnant women and their families, pooled budgets, reduced duplication of work between midwives, health visitors and children’s centres.

- The main challenges identified regarding APPG were many children’s centres are not big enough, many lack required facilities and some are not well located, along with staff who are resistant to change.
- One children’s center manager described how they had engaged with a national volunteer peer support group PANDAS (pre and postnatal depression advice and support), with the centre providing facilities and practical help to the charity (such as a mobile phone), to facilitate support of women at the CC.
- Children centre managers in both East and West Suffolk highlighted the isolation of pregnant women and mothers in rural villages as a problem.
- The role of fathers/partner in supporting pregnant women/mothers should not be overlooked or hindered for the convenience of providers.

7.2.2: Reponses from all stakeholder groups when asked about the All-party Parliamentary Group (APPG) report on Sure Start (Children’s Centres) recommendation that all perinatal services should be available from children’s centres.

Nearly everyone asked about the APPG report recommendations regarded the recommendation for the provision of all perinatal services at Childrens centre in a positive light.

- “Fantastic recommended CC should target 0-2 year olds & everything under one roof will make better sense to families”
- “I would like to see more antenatal clinics at all the children’s centres, because it introduces the families to a children’s centre environment from a very early stage, which is not quite so daunting when the baby is born. The earlier that parents are identified and worked with the better the outcome for their children in the long run”.
- “Would be the best situation for the clients in which they know where to go and where everything would be”
- “Great! Initially when Sure Start was set up this one stop shop approach was followed. Really helpful for vulnerable families”
- “Vast [opportunities], to have a health day with midwives, health visitors and seamless for parents to access all services, parents then know where to come”.
- “Good for continuity of care with same teams involved from start to finish”
- “Could help avoid cross charging”
- “Help with applications of tariff and help with care closer to home and home births, but depends where based with considerations such as overheads and access by patients”
- “Good idea because at the moment local midwives have a lot of different venues, so an area which parents could recognize as a hub, it will be a good spin off for all the services”
- “Taking pregnancy away from being medicalised”
- “Real opportunities for shared care and a more holistic approach. May reduce duplication of visits and interventions. Ideally record keeping would be more straightforward with single system, more mutual learning”.
8. Information gaps

At the time of writing this report the following information was not easily available.

1. Information on incidence and treatment of perinatal and postnatal mental health conditions, including clinical depression.
   Possible data sources:
   - Maternity units – data collected by safeguarding midwives
   - Health Visitors
   - GP practice databases – how consistent is coding for depression?
   - Mental Health Trust data – do they have an indicator for if a woman is pregnant or has an infant (child <12 months of age)?

2. Information on vulnerable women using maternity services, including maternity service use and access by women with special needs, women with disability.

3. There is limited information available on the experience of women using maternity services in Suffolk, who belong to defined groups with protected characteristics, defined under the Equality Act 2010. Specifically; age, disability, gender reassignment, marriage and civil partnership, race, religion (or belief), sexual orientation, or gender (the treatment of men/partners of women using maternity services). Information on race might be obtainable from the risk assessment made for screening (e.g. for Thalassemia) or to determine need for tuberculosis immunisation (BCG) of infants. For some protected characteristics use of qualitative survey methods may be considered.

4. Information on the number of mother and/or neonate transfers from home births or midwifery led units to consultant led care

5. Information on the demographics of women having abortions, including repeat abortions, and the reasons for the decision to have an abortion.
9. Conclusions

The maternity services in Suffolk provided by WSH and IHT have received positive feedback from professional stakeholders and patients participating in the CQC survey. Suffolk compares favourably with the East of England and England in terms of mortality and morbidity statistics related to maternity services. In both West Suffolk and East Suffolk the maternity services are working closely with primary care providers and Children’s Centres, where facilities allow, as well as with Health Visitors.

Maternity services in Suffolk provide an individualised service for pregnant women to enable a safe pregnancy without managing it as a medical problem. Consultant led care is available for women with identified risks or who develop complications in pregnancy, during labour and in the postnatal period. The PbR maternity tariff pathway provides a payment mechanism to commissioned maternity units that are dependent on assessment of women during their first antenatal appointment. The implementation of the PbR tariff appears to have been successful at both the WSH and IHT. Implementation of the PbR tariff has progressed well in the first quarter of 2013/2014. There is no indication of financial pressure from the antenatal assessment of women to the three different maternity treatment pathways, at either WSH or IHT. This is something that needs to be monitored over the next twelve months and assessed against pregnancy outcomes.

Part of the rational for the PbR tariff maternity pathway approach is to help incentivise providers to prevent adverse health outcomes in pregnancy, which can result in increased use of maternity health services funded by the pathway payments. In order to optimise appropriate pathway assignment of pregnant women in the antenatal phase midwives require clear guidance to assist decision making during the initial antenatal booking appointment. At present national guidance on maternity pathway allocation does not provide clear definitions (e.g. mental health, complex social needs and some long term conditions such as severe asthma) for midwives. This is a challenge for maternity services when allocating pregnant women to the appropriate maternity pathway. For example where a woman is currently well but has a history of recurrent depression is a standard or intermediate maternity pathway appropriate?

The fertility rate in Suffolk and resulting number of pregnancies has increased substantially in Suffolk over the last decade (especially in Forest Heath and Ipswich), in line with the regional and national increase. These will put pressure in the short and medium term on maternity services as well as subsequent preschool and school services. However, long term birth projections are expected to remain stable over the coming decade. This means that maternity cost pressures for commissioners are not expected to come from increased numbers of birth. The proportion of pregnant women aged 20-29 years has also increased in recent years this is also a positive development, with women of this age range more likely to have a healthy uncomplicated pregnancy.

Maternity services describe a pattern of increasing numbers of pregnant women who are obese with resulting higher risk of complications during pregnancy. This represents a likely future cost pressure, with obesity among women of reproductive age increasing nationally. In addition Suffolk has higher levels of pregnant women reported to be smoking in pregnancy. These are both important lifestyle factors that increase the risk of stillbirths, pregnancy complications, premature births, low birth
weight births and perinatal mortality. In addition risk factors such as smoking and obesity are more prevalent in deprived populations contributing to health inequalities before a baby is even conceived. The Marmot review (2010) recommended a life course approach to tackling such health inequalities with action in the early years including support and messaging to prospective parents prior to conception to improve the prospects for the child and the child’s family. To achieve this consistent and coherent evidence based health promotion messages to women and their families to prepare for pregnancy are required in Suffolk. These messages will need to be targeted at women in more deprived areas of Suffolk using effective techniques for the identified target groups in line with NICE PH6. For example, invest in interventions and programmes that identify and build on the strengths of individual and communities and the relationship within communities. Such a preventive approach is in line with the goals of the PbR maternity pathway tariff, Maternity Matters (2007) and The Healthy Child Programme.

Perinatal mental health was a common theme of concern raised by all stakeholders, in particular the absence of a clear pathway to guide professionals in the management and referral of women with mental ill health while pregnant or after birth of the baby. Including informing professionals undertaking a risk assessment based on a woman’s history of mental ill health. The lower than expected number of pregnant women identified as having mental ill health also indicates potential unmet need, although this might reflect the absence of readily available local data. Perinatal mental health service provision in Suffolk needs to be reviewed leading to development of a clear pathway that is appropriate to improve access to identified services. This should include consideration of introducing a lead midwife on perinatal mental health to coordinate and support work between primary care, specialist care and children's centres. The development of a perinatal mental health pathway should be used as an opportunity to improve information capture to better establish perinatal mental health need, inform commissioners and target prevention.

Breastfeeding rates in Suffolk are improving with sustained effort required by midwives, children’s centres and health visitors to ensure this continues. Respondents to the CQC 2010 Maternity Survey indicated that feeding support for mothers in the early days after birth and consistent information on infant feeding were two areas where further training of midwives and provision of feeding support (for example by lay breastfeeding support workers) may be required. Unfortunately the 2013 CQC survey did not release comparable information on breast feeding support.

In Suffolk two distinct models of community midwifery are followed. The WSH service provides the initial booking appointment in the pregnant woman’s home to enable more effective assessment of the woman’s social needs as well as clinical needs. In comparison IHT community midwifery service is based in GP practices and does not routinely provide antenatal booking appointments in the pregnant woman’s home, so midwives do not have an opportunity to assess the home environment. Although IHT aim to offer a home visit at around 36 weeks to discuss birth plan and an earlier assessment of the home environment may be indicated if the woman chooses home birth or has identified social needs and this can be planned and conducted during the pregnancy as indicated. Nationally there has been a move away from home booking as not only is this resource heavy but is felt to be paternalistic and intrusive.

WSH community midwives provide clinics at children’s centres and stakeholders reported close working with children’s centre staff and health visitors to identify pregnant women’s needs and actions required. IHT community midwives provide
antenatal clinics in a wider range of community locations, including GP practices and children's centres, potentially improving patient choice, but losing opportunities to introduce a pregnant women to her local children’s centre and the support that is available.

A disappointing finding was how stakeholders in some parts of Suffolk reported excellent working relationships and communication between midwives and children’s centre staff/health visitors, while in other parts of Suffolk the working relationship and communication between midwives and children’s centres or health visitors was not described in such positive terms. This difference should be interpreted with caution, because the small number of stakeholders interviewed cannot be considered representative. This does indicate potential variation in the quality of interdisciplinary team working and communication between midwives, children’s centres and health visitors in Suffolk that might introduce inequity and health inequalities for pregnant women and their babies. This is an area for further investigation by commissioners and providers to facilitate effective partnership working to meet the needs of pregnant women, their babies and families.
10. Recommendations

1. Healthy pregnancy

Reducing health inequalities in Suffolk by giving every child the best start in life begins before conception. A number of important pre-conception modifiable factors such as smoking, obesity, alcohol and diet can affect the risk of stillbirth, low birth weight, preterm delivery, and pregnancy complications, including neural tube defects and neonatal death (foetal growth restriction). Action to improve a woman’s diet, develop a healthier weight and stop smoking not only reduce the risk to the pregnancy but lead to substantial improvements in the long term health and life chances of the mother and child, for example affecting the risk of obesity, heart disease and mental ill-health. During pregnancy women should maintain a healthy diet (including vitamin D supplementation) and remain physically active.

The main issues:
- In Suffolk maternity services report seeing an increasing number of pregnant women who are overweight or obese leading to increased risk of complications.
- Suffolk has significantly higher rates of pregnant women that smoke at time of delivery (14.6%) compared to national and regional rates (13.2%).
- Women who may become pregnant can easily reduce the risk of having a baby with a neural tube defect by taking folic acid supplements before conception, and throughout the first 12 weeks of pregnancy.
- Women of reproductive age living in more deprived areas of Suffolk are more likely to smoke. This results in long term health inequality that starts even before a baby is conceived.
- The number of abortions by Suffolk women aged 18 to 34 years has significantly increased in recent years. This indicates an increasing need for family planning services to help reduce unwanted pregnancy. This also presents a cost pressure for NHS commissioners.
- While difficult to quantify due to underreporting and stigma, foetal alcohol spectrum disorders and other harm caused to babies by mothers drinking alcohol during pregnancy can be prevented by women avoiding drinking more than 1-2 units of alcohol once or twice a week.

Recommendations:
1. CCGs should develop and lead a healthy pregnancy action plan for Suffolk in line with Healthy Child Programme pregnancy to 5 year olds. This should include the following elements:
   - Agreeing consistent and coherent key messages addressing healthy pregnancy and the impact of smoking, excess weight, and alcohol.
   - A review of effective methods for communicating these messages to women of reproductive age in Suffolk, including high risk groups such as young mothers, women living in deprived areas and women with limited education.
   - Health services (including contraception, fertility and pre-conception advice services, GP practices), pharmacies and children’s centres should prioritise this health advice to all women of child bearing age in line with the principles of making every contact count (MECC).
   - Introduction of health improvement key performance indicators targeting women of reproductive age, e.g. the number of women aged 15-44 years
referred to weight loss, smoking cessation or alcohol services by providers.

2. Commissioners (CCGs & SCC) to commission joint training programme for health professionals, pharmacists and children’s centre staff in Suffolk to offer specific dietary advice to women who may become pregnant (including women with small children) regarding of the importance of taking folic acid before they conceive to reduce risk of neural tube defects.

3. CCGs and Public Health Suffolk should commission a health promotion campaign, using evidence based behaviour change techniques in line with NICE PH6, to encourage women of reproductive age who are overweight or obese to achieve a BMI between 18.5 and 24.5 kg/m² before they become pregnant. Women with a BMI of 30 more that plan to become pregnant should be supported to lose 5-10% of their weight (a realistic target) which can have significant health benefits for themselves and any subsequent pregnancy.

4. Smoking cessation services and health promotion messaging should target women of reproductive age in more deprived areas of Suffolk to help reduce the high level of smoking in pregnancy.

2. Perinatal Mental Health

Concerns about the identification and management of women in the antenatal or postnatal period with mental health conditions have been raised by providers of maternity services and Children’s Centre managers. Poor management of perinatal mental health is also an identified risk factor of maternal mortality (CMAC, 2011).

The main issues:
- Uncertainty amongst health professionals over the management of pregnant women affected by mental illness or a history of mental illness and access to services
- Wide spectrum of mental health illness ranging from mild reactive depression to enduring mental illnesses and these will need a different pathway of care and level of service
- The lack of a perinatal mental health pathway
- The number of pregnant women identified with mental illness is less than half the expected number, indicating possible unrecognized and unmet mental health need.

Recommendations:

5. Review perinatal mental health service provision and develop a clear pathway that is appropriate to improve access, including consideration of introducing a lead midwife on perinatal mental health to coordinate & support work between primary care, specialist care and children’s centres. This assessment should consider other core service professionals required and scope for referral to support services.

6. CCGs conduct a gap analysis between current practice and NICE guidance (CG45) for women referred for psychological therapies during pregnancy and the postnatal period to, with particular regard to the thresholds used for referral and time to referral.
3. PbR Tariff implementation

Implementation of the PbR tariff for the maternity pathway has progressed well through the period of transition in 2013 and has not lead to additional cost pressures, although its impact on future clinical outcomes and tackling health inequalities has yet to be established.

The main issue:
- Where national PbR tariff guidance on pathway allocation does not provide clear definitions (e.g. mental health, complex social needs and some long term conditions such as severe asthma), maternity services find it a challenge to appropriately allocate pregnant women to the appropriate maternity pathway and there is a possible inconsistency in interpretation both within organisations and between providers.
- Hospitals (within Suffolk and neighbouring counties) providing intrapartum care to Suffolk women through split tariff contracts present challenges that present a financial risk for hospital trusts and might impact on clinical risk for individuals.

Recommendation:
7. CCGs to review with the service providers the current guidance of allocating women to maternity pathways, in light of available guidance. To enable providers to consistently allocate pregnant women to the correct maternity pathway based on their need (for example does a history of depression require allocation to the standard or intermediate pathway?). Allocation according to mental health need should be informed by access to a clear perinatal mental health pathway (see recommendation 4).
8. CCGs to review progress of the implementation of the PbR tariff after one year (April 2014), specifically antenatal and postnatal maternity pathway allocation and pregnancy outcomes. Including service provider view of risks and benefits.

4. Partnership Working in support of pregnant women (Midwifery, Health Visiting, Children’s Centres and GPs)

Partnership working around pregnant women is critical to the early recognition of health and social need and timely provision of interventions.

The main issue:
What is working well
- Provision of universal postnatal services by children’s centres and health visitors with additional support (via step-up step-down model) for parents or infants identified with additional needs.
- The support of pregnant women through collaborative working between midwives, health visitors and children’s centres has greatly improved in recent years, with processes such as the Antenatal Healthy Child Collaborative (AHCC) and the Common Assessment Framework (CAF).
- Excellent collaborative team working in support of pregnant women was reported between midwives and health visitors/children’s centres in some parts of Suffolk. This was more commonly reported in West Suffolk possibly due to chance because of the small number of stakeholders interviewed.
Examples of joint initiatives by some children’s centres and midwifery teams to meet the needs of pregnant women, such as joint provision of evening antenatal parenting classes to improve access for pregnant women and their partners.

What is working less well

- Communication issues (such as timeliness or gaps in communication) were reported between midwives, health visitors, children’s centres and GPS that could affect the care of pregnant women.
- Collaborative working in support of pregnant women between midwives, health visitors and children’s centres was reported to be less well established in some areas of Suffolk. This has the potential to increase health inequality for pregnant women and their families.
- Handover of some patients from midwives to health visitors is reported to occur via written notes left with the mother without liaison between the midwife and health visitor once the mother and baby are discharged from the maternity service, potentially affecting their continuity of care.

Recommendation:

9. A review of the effectiveness of current antenatal and postnatal provision provided by midwifery, health visiting and children centres to improve service provision, and identify steps to improve partnership working between midwifery services and GP practices. The review should assess the evidence on providing first antenatal booking appointments routinely in the woman’s home and its implications for health and social outcomes.

10. A local maternity partnership group, led by CCGs to oversee county wide strategy and priorities. This will seek to promote positive health outcomes, reduce inequity in maternity services, drive improved standards of maternity care and champion partnership working across Suffolk as a means to improving quality of care, facilitate early intervention and reduce inequalities in maternal and child health outcomes in Suffolk.

5. Key Performance Indicators

The main issue:

The maternity key performance indicators (KPIs) used by CCGs do not include outcome or risk management indicators recommended by the Royal College of Obstetricians and Gynaecologists (RCOG).

- clinical outcomes
  - maternal morbidity (e.g. Eclampsia, ICU admissions in obstetrics, blood transfusions [4 units of blood], postpartum hysterectomies)
  - neonatal morbidity (e.g. number of cases of myconium aspiration, cases of hypoxic encephalopathy, full term babies admitted to neonatal intensive care unit)
- maternity service risk management (e.g. Number of SI, failed instrument delivery, 3rd-degree tear, admissions after home delivery)
- complaints (e.g. number of complaints, times unit closed for admissions in each month)

Recommendation:

11. Review maternity key performance indicators to include clinical outcomes, maternity risk management and service user complaints in line with the recommendations of the RCOG dashboard (2008).
6. Maternity Service Provision

Over 2012/2013 IHT and WSH performed well on many maternity KPIs. Some issues with maternity service provision were identified through analysis of routine data.

The main issues:

- Breast feeding initiation and prevalence in Suffolk are improving but there remains a very large decline in the number of mothers breastfeeding at 6-8 weeks compared to those recorded as initiating breastfeeding. Local information indicates that mothers under the age of 25 years are much less likely to initiate breastfeeding.
- Increasing the number of home births is a Department of health objective and Suffolk does well with high rates of home births than the East of England and England average, although the rate in Suffolk has declined in recent years. The Home Birth Study highlighted the importance of offering women information to enable more choice about the place of birth.
- In 2009/2010 the East and West Suffolk rate of readmissions of babies within 14 days of a hospital birth (including emergency admission to hospital following home birth) were the highest in the East of England. The neonatal admission rate of full term babies in 2010 was also high, amongst the fourth highest quintile nationally.

Recommendations:

12. Implementation of UNICEF Baby Friendly Initiative stage 2 standards by both maternity units in Suffolk to further develop and raise standards of perinatal period breast feeding advice and support. This has been commissioned over 2013/2014 at WSH and IHT by CCGs in Suffolk using CQUIN payments.
13. Maternity services need to ensure that women are offered sufficient information to enable choice about the place of birth. A review of maternity staff training regarding patient choice, the information provided and attitudes of staff regarding home births is recommended. This should consider how to effectively communicate the findings of the birthplace study to offer information and choice, including the increased risk of intervention from hospital births.
14. An investigation of neonatal admission and readmission rates in Suffolk is required, including assessment of more recent local data to determine how current rates compare to those of 2010. This investigation should determine what the contributing factors to neonatal admissions and readmissions are in Suffolk and what measures can be taken to reduce the need for emergency admissions, readmission and neonatal care.

7. Demographic projections and estimated demand on maternity services

The main issues:

- Projected finished delivery episodes (FDE) for patients registered with both CCGs shows that numbers of births will remain relatively stable through to 2015/2016, indicating that a cost pressure from rising numbers of pregnancies is not expected.
- However, projections for Suffolk as a whole (including Waveney) indicate the number of live births is expected to peak in 2014/2015. This has short term
resource implications for maternity services, medium term implications for health visiting/preschool and long term implications for school places.

Recommendation:
15. The projections of finished delivery episodes are based on interim 2011-based population projections. These should be reviewed in 2014 when 2012-based population projections for CCGs to 2030 become available.
### 11. Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHCC</td>
<td>Antenatal Healthy Child Collaborative</td>
</tr>
<tr>
<td>APPG</td>
<td>All Parliamentary Party Group [on Sure Start], a report</td>
</tr>
<tr>
<td>BPAS</td>
<td>British Pregnancy Advisory Service</td>
</tr>
<tr>
<td>CAF</td>
<td>Common Assessment Framework</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CDOP</td>
<td>Child Death Overview Panel</td>
</tr>
<tr>
<td>CMAC</td>
<td>Centre for Maternal and Child Enquiries</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation</td>
</tr>
<tr>
<td>CYP</td>
<td>Children and Young Peoples services, Suffolk County Council</td>
</tr>
<tr>
<td>FDE</td>
<td>Finished Delivery Episode</td>
</tr>
<tr>
<td>HCP</td>
<td>Healthy Child Programme</td>
</tr>
<tr>
<td>GFR</td>
<td>General Fertility Rate</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>IHT</td>
<td>Ipswich Hospital Trust</td>
</tr>
<tr>
<td>IMD</td>
<td>Indices of Multiple Deprivation</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Healthcare and Clinical Excellence</td>
</tr>
<tr>
<td>NOMIS</td>
<td>National Online Manpower Information System</td>
</tr>
<tr>
<td>ONS</td>
<td>Office for National Statistics</td>
</tr>
<tr>
<td>PbR</td>
<td>Payment by results</td>
</tr>
<tr>
<td>RCOG</td>
<td>Royal College of Obstetricians and Gynaecologists</td>
</tr>
<tr>
<td>SCC</td>
<td>Suffolk County Council</td>
</tr>
<tr>
<td>SIGN</td>
<td>Scottish Intercollegiate Guidelines Network</td>
</tr>
<tr>
<td>WSH</td>
<td>West Suffolk Hospital</td>
</tr>
</tbody>
</table>
12. References


4Children. Suffering in Silence 70,000 reasons why help with postnatal depression has to be better. 4Children, September 2011.


Healthy Child Programme; Pregnancy and the first five years of life 2008

Hogg, S. Prevention in Mind All Babies Count: Spotlight on Perinatal Mental Health. NSPCC, June 2013.

Improving Outcomes and Ensuring Quality: a guide for commissioners and providers of perinatal and infant mental health services. NHS North West (2011)

Infant Feeding Survey 2010. The NHS Information Centre, IFF Research, June 2011


NICE Public Health Guidance 27. Guidance on weight management before, during and after pregnancy (NICE PH27).


No Health without Mental Health, a cross-government mental health outcomes strategy for people of all ages. HM Government, February 2011.


Appendix 1: Factors informing the decision to allocate a woman to the intermediate or intensive PbR tariff on the maternal pathway


Antenatal factors informing the decision to allocate a woman to the intermediate or intensive PbR tariff instead of standard

<table>
<thead>
<tr>
<th>Intensive</th>
<th>Intermediate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current factors</td>
<td>Current factors</td>
</tr>
<tr>
<td>Expecting twins or more</td>
<td>Complex social factors</td>
</tr>
<tr>
<td>Medical factors</td>
<td>BMI greater than 35</td>
</tr>
<tr>
<td>HIV</td>
<td>BMI less than 18</td>
</tr>
<tr>
<td>Renal disease</td>
<td>Physical disabilities</td>
</tr>
<tr>
<td>Diabetes and other endocrine disorders</td>
<td>Substance / Alcohol Misuse</td>
</tr>
<tr>
<td>Rhesus isoimmunisation/ other significant blood group antibodies</td>
<td>Medical factors</td>
</tr>
<tr>
<td>Cardiovascular/cardiac disease</td>
<td>Hepatitis B or C</td>
</tr>
<tr>
<td>Sickle cell disease/thalassaemia</td>
<td>Genetic/Inherited disorder</td>
</tr>
<tr>
<td>Malignant disease</td>
<td>Epilepsy requiring anti-convulsants</td>
</tr>
<tr>
<td>Severe (brittle) asthma</td>
<td>Previous uterine surgery (excluding previous caesarean section)</td>
</tr>
<tr>
<td>Venous thromboembolic disease</td>
<td>Hypertension</td>
</tr>
<tr>
<td>Autoimmune disease</td>
<td>Previous Obstetric History</td>
</tr>
<tr>
<td>Thrombophilia/clotting disorder</td>
<td>Eclampsia, Pre-eclampsia, HELLP</td>
</tr>
<tr>
<td>Previous Obstetric History</td>
<td>Puerperal psychosis</td>
</tr>
<tr>
<td>Previous fetal congenital anomaly that required specialist fetal medicine</td>
<td>Early pre-term birth (&lt;34 weeks)</td>
</tr>
<tr>
<td></td>
<td>3 or more consecutive miscarriages</td>
</tr>
<tr>
<td></td>
<td>Fetal loss (2nd or 3rd trimester)</td>
</tr>
<tr>
<td></td>
<td>Neonatal death or stillbirth</td>
</tr>
<tr>
<td></td>
<td>Intrauterine growth restriction</td>
</tr>
<tr>
<td></td>
<td>Placenta accreta</td>
</tr>
<tr>
<td></td>
<td>Low weight term baby – less than 2½ kg</td>
</tr>
<tr>
<td></td>
<td>High weight term baby – more than 4½ kg</td>
</tr>
<tr>
<td></td>
<td>Fetal congenital anomaly</td>
</tr>
</tbody>
</table>
Postnatal factors informing the decision to allocate a woman to the intermediate or intensive PbR tariff instead of standard

<table>
<thead>
<tr>
<th>Intensive Medical factors</th>
<th>Intermediate Current Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>Complex Social factors</td>
</tr>
<tr>
<td>Renal disease</td>
<td>Substance / Alcohol Misuse</td>
</tr>
</tbody>
</table>

Medical factors
- Mental health
- Diabetes or other endocrine disorder
- Genetic/Inherited disorder
- Rhesus isoimmunisation/ other significant blood group antibodies
- Cardiovascular/cardiac disease

During this pregnancy
- Multiple pregnancy
- Gestational hypertension
- Gestational Diabetes
- Neonatal death or still birth
- Pre-eclampsia, eclampsia or HELLP
- Deep vein thrombosis or Pulmonary Embolism
## Appendix 2a: Suffolk Hospital Results Care Quality Commission Maternity Services Survey 2010
(25,488 responders, response rate 52%)

How this score compared with other trusts in England (144 Trusts in total)

<table>
<thead>
<tr>
<th></th>
<th>Ipswich Hospital Trust score out of 10 (response 167 women using IHT)</th>
<th>In comparison with the patient response score for England (144 Trusts in total)</th>
<th>West Suffolk Hospital score out of 10 (response 152 women using WSH)</th>
<th>In comparison with the patient response score for England (144 Trusts in total)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care during pregnancy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being given the choice to have their baby at home</td>
<td>8.7  about the same</td>
<td>8.8  about the same</td>
<td>8.8  about the same</td>
<td></td>
</tr>
<tr>
<td>Having reasons for a dating scan clearly explained</td>
<td>8.9  about the same</td>
<td>8.7  about the same</td>
<td>8.7  about the same</td>
<td></td>
</tr>
<tr>
<td>Having the reasons for Down’s syndrome screening clearly explained</td>
<td>8.9  about the same</td>
<td>8.7  about the same</td>
<td>8.7  about the same</td>
<td></td>
</tr>
<tr>
<td>For having reasons for a 20 wk scan clearly explained</td>
<td>8.8  about the same</td>
<td>8.8  about the same</td>
<td>8.8  about the same</td>
<td></td>
</tr>
<tr>
<td><strong>Labour and Birth</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For being able to move around and choose the most comfortable position during labour</td>
<td>7.8  about the same</td>
<td>7.9  about the same</td>
<td>7.9  about the same</td>
<td></td>
</tr>
<tr>
<td>For receiving pain relief they wanted during labour and birth</td>
<td>8.0  about the same</td>
<td>8.1  about the same</td>
<td>8.1  about the same</td>
<td></td>
</tr>
<tr>
<td>For having stitches at an appropriate length of time after a cut (episiotomy) or tear</td>
<td>6.1  about the same</td>
<td>5.5  about the same</td>
<td>5.5  about the same</td>
<td></td>
</tr>
<tr>
<td>For having skin to skin contact with baby shortly after the birth</td>
<td>8.4  about the same</td>
<td>7.9  about the same</td>
<td>7.9  about the same</td>
<td></td>
</tr>
<tr>
<td><strong>Staff during labour and birth</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For having confidence and trust in staff caring for them during labour and birth</td>
<td>8.4  about the same</td>
<td>8.4  about the same</td>
<td>8.4  about the same</td>
<td></td>
</tr>
<tr>
<td>For partners or companions being made welcome by staff during labour and birth</td>
<td>9.4  about the same</td>
<td>9.3  about the same</td>
<td>9.3  about the same</td>
<td></td>
</tr>
<tr>
<td>For not being left alone by midwives or doctors at a time when it worried them</td>
<td>8.3  about the same</td>
<td>8.3  about the same</td>
<td>8.3  about the same</td>
<td></td>
</tr>
<tr>
<td>For feeling they were spoken to in a way they could understand during labour and birth</td>
<td>9.1  about the same</td>
<td>9.1  about the same</td>
<td>9.1  about the same</td>
<td></td>
</tr>
<tr>
<td>For being involved enough in decisions</td>
<td>8.4  about the same</td>
<td>8.3  about the same</td>
<td>8.3  about the same</td>
<td></td>
</tr>
</tbody>
</table>
How this score compared with other trusts in England (144 Trusts in total)

<table>
<thead>
<tr>
<th></th>
<th>Ipswich Hospital Trust score out of 10 (response 167 women using IHT)</th>
<th>In comparison with the patient response score for England (144 Trusts in total)</th>
<th>West Suffolk Hospital score out of 10 (response 152 women using WSH)</th>
<th>In comparison with the patient response score for England (144 Trusts in total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>about their care during labour and birth</td>
<td>8.4</td>
<td>about the same</td>
<td>8.5</td>
<td>about the same</td>
</tr>
<tr>
<td>How good the overall care was that they received during labour and birth</td>
<td>8.4</td>
<td>about the same</td>
<td>8.5</td>
<td>about the same</td>
</tr>
<tr>
<td>Postnatal Care</td>
<td>7.4</td>
<td>about the same</td>
<td>7.8</td>
<td>about the same</td>
</tr>
<tr>
<td>For feeling their stay in hospital after the birth was the right amount of time</td>
<td>7.3</td>
<td>about the same</td>
<td>8.0</td>
<td>about the same</td>
</tr>
<tr>
<td>For feeling they were given the information and explanations they needed after birth</td>
<td>6.9</td>
<td>about the same</td>
<td>7.4</td>
<td>about the same</td>
</tr>
<tr>
<td>For feeling they were treated with kindness and understanding by staff after birth</td>
<td>8.0</td>
<td>about the same</td>
<td>8.1</td>
<td>about the same</td>
</tr>
<tr>
<td>Feeding the baby during the first few days</td>
<td>6.1</td>
<td>about the same</td>
<td>6.5</td>
<td>about the same</td>
</tr>
<tr>
<td>For feeling midwives and other carers provided consistent advice about feeding their baby in the first few days</td>
<td>5.8</td>
<td>about the same</td>
<td>6.1</td>
<td>about the same</td>
</tr>
<tr>
<td>For feeling midwives and other carers provided active support for feeding the baby in the first few days</td>
<td>6.4</td>
<td>about the same</td>
<td>6.9</td>
<td>about the same</td>
</tr>
</tbody>
</table>

Source: http://www.cqc.org.uk/survey/maternity/RGQ
Appendix 2b: Suffolk Hospital Results Care Quality Commission Maternity Services Survey 2013  
(Over 23,000 responders, response rate 46%)

<table>
<thead>
<tr>
<th>How this score compared with other trusts in England (137 Trusts in total)</th>
<th>Ipswich Hospital Trust score out of 10 (response 172 women using IHT)</th>
<th>In comparison with the patient response score for England (137 Trusts in total)</th>
<th>West Suffolk Hospital score out of 10 (response 164 women using WSH)</th>
<th>In comparison with the patient response score for England (137 Trusts in total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care during pregnancy</td>
<td>?</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>Labour and Birth</td>
<td>8.7</td>
<td>about the same</td>
<td>9.1</td>
<td>about the same</td>
</tr>
<tr>
<td>Staff</td>
<td>8.8</td>
<td>Better</td>
<td>8.7</td>
<td>about the same</td>
</tr>
<tr>
<td>Care in hospital after birth</td>
<td>8.3</td>
<td>Better</td>
<td>8.3</td>
<td>Better</td>
</tr>
<tr>
<td>Feeding the baby during the first few days</td>
<td>?</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
</tbody>
</table>

Source: http://www.cqc.org.uk/survey/maternity/RGR
### Appendix 3: Partnership working between Midwives and Children’s Centres (CC)/Health Visitors (HV). Common themes and answers to questions in interview

<table>
<thead>
<tr>
<th></th>
<th>West Suffolk CC/HV</th>
<th>East Suffolk CC/HV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working relationship with midwifery regarded as excellent or above average</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Working relationship with midwifery regarded as average or below average</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Working relationship between HV and CC regarded as excellent or above average</td>
<td>Not mentioned by CC/HV</td>
<td>2</td>
</tr>
<tr>
<td>Working relationship between HV and CC regarded as average or below average</td>
<td>Not mentioned by CC/HV</td>
<td>2</td>
</tr>
<tr>
<td>Midwives use CC as a base for parent craft</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Midwives provide breastfeeding workshops at CC</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Midwife antenatal clinics at CC</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Midwives involved with Common Assessment Framework (CAF)</td>
<td>Not mentioned by CC/HV</td>
<td>No</td>
</tr>
<tr>
<td>Midwives are “resistant to change”</td>
<td>Not mentioned by CC/HV</td>
<td>3</td>
</tr>
<tr>
<td>Baby and me for parents under age of 20 years (with MW covering birth)</td>
<td>Not mentioned by CC/HV</td>
<td>Yes (2)</td>
</tr>
<tr>
<td>Pregnancy and beyond for any parent that want to come along and prepare for baby</td>
<td>Not mentioned by CC/HV</td>
<td>Yes</td>
</tr>
<tr>
<td>Antenatal healthy child collaborative (AHCC)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Midwife antenatal clinics at CC</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Antenatal programme ‘Bump Birth and Beyond’ (BB&amp;B) jointly facilitated by CC and midwives</td>
<td>Yes</td>
<td>Not mentioned by CC/HV</td>
</tr>
<tr>
<td>Stepping stones: Midwife led Antenatal programme for teenage parents (similar to BB&amp;B but approaches thing from different angle)</td>
<td>Yes</td>
<td>Not mentioned by CC/HV</td>
</tr>
</tbody>
</table>