Commissioning strategy for maternity services
2014 - 2019

Northern, Eastern and Western Devon
Clinical Commissioning Group

South Devon and Torbay
Clinical Commissioning Group

Kernow Clinical Commissioning Group
Delivering “Excellence in Maternity Care”

(NHS Institute Maternity Improvement Programme, 2011-12)

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

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

<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword and Executive Summary</td>
<td>3-5</td>
</tr>
<tr>
<td>1.0 Introduction</td>
<td>6</td>
</tr>
<tr>
<td>2.0 Glossary / abbreviations</td>
<td>8</td>
</tr>
<tr>
<td>3.0 Summary Guide underpinning the Commissioning Intentions (Full details contained within the appropriate section)</td>
<td>10</td>
</tr>
<tr>
<td>4.0 Current service provision</td>
<td>13</td>
</tr>
<tr>
<td>5.0 Commissioning principles</td>
<td>14</td>
</tr>
<tr>
<td>6.0 Scope / definition of commissioning strategy</td>
<td>14</td>
</tr>
<tr>
<td>7.0 Service user / stakeholder / clinical engagement</td>
<td>15</td>
</tr>
<tr>
<td>8.0 Commissioning context</td>
<td>16</td>
</tr>
<tr>
<td>9.0 Partnership working</td>
<td>17</td>
</tr>
<tr>
<td>Public Health Nursing (health visiting)</td>
<td>17</td>
</tr>
<tr>
<td>General practice</td>
<td>17</td>
</tr>
<tr>
<td>Children’s centres</td>
<td>18</td>
</tr>
<tr>
<td>Maternity Networks</td>
<td>19</td>
</tr>
<tr>
<td>Public Health</td>
<td>19</td>
</tr>
<tr>
<td>10.0 Strategic National Framework</td>
<td>20</td>
</tr>
<tr>
<td>11.0 Changes in demand for maternity services</td>
<td>21</td>
</tr>
<tr>
<td>12.0 Reducing health inequalities and promoting health</td>
<td>22</td>
</tr>
<tr>
<td>Health inequalities</td>
<td>22</td>
</tr>
<tr>
<td>Substance misuse in pregnancy</td>
<td>23</td>
</tr>
<tr>
<td>Maternal obesity</td>
<td>23</td>
</tr>
<tr>
<td>Smoking in pregnancy</td>
<td>24</td>
</tr>
<tr>
<td>Perinatal maternal / infant mental health</td>
<td>24</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>25</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>25</td>
</tr>
<tr>
<td>Female Genital Mutilation (FGM)</td>
<td>25</td>
</tr>
<tr>
<td>Infant feeding</td>
<td>26</td>
</tr>
<tr>
<td>13.0 Enabling choice</td>
<td>27</td>
</tr>
<tr>
<td>14.0 Pre-conceptual care</td>
<td>28</td>
</tr>
<tr>
<td>15.0 Antenatal care</td>
<td>29</td>
</tr>
<tr>
<td>Access</td>
<td>29</td>
</tr>
<tr>
<td>Continuity</td>
<td>29</td>
</tr>
<tr>
<td>Fetal medicine</td>
<td>30</td>
</tr>
<tr>
<td>Loss in pregnancy</td>
<td>30</td>
</tr>
<tr>
<td>Maternal death</td>
<td>30</td>
</tr>
<tr>
<td>Education for parenthood</td>
<td>30</td>
</tr>
<tr>
<td>Good Practice in Plymouth</td>
<td>31</td>
</tr>
<tr>
<td>Best Practice in Cornwall &amp; IOS</td>
<td>31</td>
</tr>
<tr>
<td>16.0 Intrapartum care</td>
<td>32</td>
</tr>
<tr>
<td>17.0 Postnatal care, new born and neonatal care</td>
<td>33</td>
</tr>
<tr>
<td>New born and neonatal care</td>
<td>33</td>
</tr>
<tr>
<td>Transition to the Health Visiting service</td>
<td>33</td>
</tr>
<tr>
<td>18.0 Workforce</td>
<td>34</td>
</tr>
<tr>
<td>19.0 Public sector equality duty</td>
<td>35</td>
</tr>
<tr>
<td>20.0 Financial framework</td>
<td>35</td>
</tr>
<tr>
<td>21.0 Data collection</td>
<td>36</td>
</tr>
<tr>
<td>22.0 Governance arrangements</td>
<td>36</td>
</tr>
<tr>
<td>23.0 Way forward / Implementation Plan</td>
<td>36</td>
</tr>
<tr>
<td>24.0 Acknowledgements</td>
<td>37</td>
</tr>
<tr>
<td>25.0 References</td>
<td>38</td>
</tr>
</tbody>
</table>
Foreword

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

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

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

Signatures

NHS Northern, Eastern & Western Clinical Commissioning Group

South Devon & Torbay Clinical Commissioning Group

Kernow Clinical Commissioning Group
Executive summary

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

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

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

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

This aim is supported by the following five main principles:

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

   The majority of healthy women can give birth with a minimum of medical procedures and most women prefer this provided they and their baby are safe. To this end midwives will take a key role in maternity care by encouraging early and direct access, and performing risk assessments throughout pregnancy and the postnatal period. This will ensure that women who are at a higher risk are identified as early as possible to ensure that specialist care appropriate to their needs is provided.

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

3. **Local context**: This commissioning strategy will be delivered within the local context of a financially challenged community. It will be considered alongside each organisation’s development plan.

4. **The National Choice Guarantee**: We will aim through this commissioning strategy to support the delivery of the National Choice Guarantee. This aims to give women choice of how to access maternity care, the type of antenatal care they receive, choice of place of birth whenever possible, practical and safe, and choice of postnatal care.

5. **Continuity of care**: All women and their partners, however complex the pregnancy, need to know and trust the midwives who are caring for them. We will work towards every woman being supported by a midwife she knows and trusts throughout her pregnancy and after birth, and to strive to achieve one-to-one midwifery care in established labour.

The strategy will provide a clear direction to examine best practice and develop families’ choices and commission the best arrangement of services.
This commissioning strategy will aim to ensure that all services commissioned will deliver the most equitable outcomes in areas of deprivation. It will be responsive to, and targeted at the specific needs of mothers, partners and babies known to be at risk of poor outcomes.

This strategy has five key measurable outcomes linking to the NHS outcomes framework indicators and national public health outcomes framework:

- An improvement in maternal health – this includes improvements in rates of early access to midwifery care leading to a reduction in maternal obesity and rates of smoking
- A reduction in infant mortality
- A reduction in infant morbidity
- An improvement in the experience that women and their families’ have of maternity services
- Enhancing life for people with long term conditions.

The key outcomes will be delivered through the maternity services implementation plan, an example of which can be found in Appendix 1.

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

This strategy has been written with the aim that the voice of women and their families is vital to improving future service provision.
1.0 Introduction

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

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

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

This commissioning strategy recognises the wider determinants of health and the links between maternity and the broader social and public health agenda. It also recognises the need to achieve true parity of esteem between mental and physical health. Achieving parity of esteem between mental and physical health (Gov.uk 2013)^2

There is strong evidence that good maternal and paternal health contributes to positive health outcomes in babies and onwards throughout their childhood into later life (Kuh Dt, Ben-Schlomo, Y1997)^3. The promotion of healthy lifestyle behaviours around the time of a pregnancy is therefore particularly important.

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

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

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

We are committed to promoting the ‘Normalisation Agenda’ (Promoting Normal Childbirth, NCT 2010)^4. However, some women, particularly those with more complex needs, will require specialised care from a consultant or a specialist midwife.

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

This maternity services commissioning strategy aims to ensure maternity services meet both local and national guidance and requirements. The strategy links needs assessment work with national policy, statutory obligations, evidence based commissioning intentions and importantly, reflect the views of service users and stakeholders. The NHS England Mandate for Maternity^2 and its focus on personalised maternity care is embedded in this strategy.

It should be noted that the context for future commissioning is set by the significantly challenging financial environment being faced by the NHS. In 2013/14 the National Payment by Results (PbR) guidance changed the funding for maternity services.
It will therefore be vital for maternity services to ensure the funding available is used effectively by highly skilled clinicians making the most appropriate use of their skills.

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

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

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BME</td>
<td>Black, Minority and Ethnic</td>
</tr>
<tr>
<td>BMI</td>
<td>Body Mass Index</td>
</tr>
<tr>
<td>CC</td>
<td>County Councils</td>
</tr>
<tr>
<td>CC</td>
<td>Complications and Co-morbidity</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>CMACE</td>
<td>Centre for Maternal and Child Enquiries</td>
</tr>
<tr>
<td>CNST</td>
<td>Clinical negligence scheme for trusts</td>
</tr>
<tr>
<td>CO</td>
<td>Carbon monoxide</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
</tr>
<tr>
<td>CYP</td>
<td>Children and young people</td>
</tr>
<tr>
<td>DCC</td>
<td>Devon County Council</td>
</tr>
<tr>
<td>DERRIFORD</td>
<td>Derriford Hospital, Plymouth</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>FGM</td>
<td>Female Genital Mutilation</td>
</tr>
<tr>
<td>GOV</td>
<td>Government</td>
</tr>
<tr>
<td>GP</td>
<td>General practitioners</td>
</tr>
<tr>
<td>HCP</td>
<td>Healthy child programme</td>
</tr>
<tr>
<td>HRG</td>
<td>Healthcare resource groups</td>
</tr>
<tr>
<td>HSCIC</td>
<td>Health and social care information centre</td>
</tr>
<tr>
<td>HV</td>
<td>Health Visitors</td>
</tr>
<tr>
<td>IMD</td>
<td>Index of multiple deprivation</td>
</tr>
<tr>
<td>IQ</td>
<td>Intelligence quotient</td>
</tr>
<tr>
<td>LA</td>
<td>Local Authorities</td>
</tr>
<tr>
<td>MLU</td>
<td>Midwifery led units</td>
</tr>
<tr>
<td>MSLC</td>
<td>Maternity Services Liaison Committee</td>
</tr>
<tr>
<td>NCT</td>
<td>National Childbirth Trust</td>
</tr>
<tr>
<td>NEW Devon</td>
<td>Northern, Eastern and Western Devon</td>
</tr>
<tr>
<td>NDDH</td>
<td>North Devon District Hospital</td>
</tr>
<tr>
<td>NDHCT</td>
<td>Northern Devon Healthcare NHS Trust</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
</tr>
<tr>
<td>NMC</td>
<td>Nursing and midwifery council</td>
</tr>
<tr>
<td>NRT</td>
<td>Nicotine Replacement Therapy</td>
</tr>
<tr>
<td>NSF</td>
<td>National Service framework</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>PHAST</td>
<td>Public Health Action Support Team</td>
</tr>
<tr>
<td>PHE</td>
<td>Public Health England</td>
</tr>
<tr>
<td>PHN</td>
<td>Public Health Nurses</td>
</tr>
<tr>
<td>PHNT</td>
<td>Plymouth Hospitals NHS Trust</td>
</tr>
<tr>
<td>PMIMH</td>
<td>Perinatal Maternal and Infant Mental Health</td>
</tr>
<tr>
<td>RCHT</td>
<td>Royal Cornwall Hospital Trust</td>
</tr>
<tr>
<td>RCM</td>
<td>Royal College of Midwives</td>
</tr>
<tr>
<td>RCP</td>
<td>Royal College of Physicians</td>
</tr>
<tr>
<td>RD&amp;E</td>
<td>Royal Devon &amp; Exeter Hospital</td>
</tr>
<tr>
<td>RGOC</td>
<td>Royal College of Obstetricians &amp; Gynaecologists</td>
</tr>
<tr>
<td>SD&amp;T</td>
<td>South Devon &amp; Torbay</td>
</tr>
<tr>
<td>UCL</td>
<td>University College of London</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations International Children’s Emergency Fund</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>YTD</td>
<td>Year to Date</td>
</tr>
<tr>
<td>&lt;</td>
<td>Less than</td>
</tr>
<tr>
<td>&gt;</td>
<td>More than</td>
</tr>
</tbody>
</table>
What you told us about maternity services

"The Breast Feeding support worker was amazing and without her I probably would have given up".  
**Cornwall**

"All the maternity staff I came into contact with were, without exception helpful, professional and supportive"  
**Cornwall**

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

"Good being able to contact midwives by 'phone".  
**Devon**

"Baby groups at Children’s Centres are brilliant"  
**Devon**

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

"I had a fantastic home birth with two lovely community midwives attending. They were wonderful, respectful of my birth plan, encouraging, friendly, and enabled me to have an incredible birth".  
**Cornwall**

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

"Specialist perinatal team really helped me when I started to get depressed".  
**Devon**
3.0 Summary guide underpinning the commissioning intentions
(Full details contained within the appropriate section)

The pronoun “We” used throughout this document describes the three commissioning organisations.

7.0 Service user engagement (p.15)
Women and their families will be at the heart of developing maternity services.
We will develop and support local MSLCs.

8.0 Commissioning context (p.16)
We will aim to work with our commissioning colleagues across the pathway to develop seamless co-ordinated maternity care.

9.0 Partnership working (p.17-19)
The maternity pathway will involve all relevant disciplines in order that the best outcomes are achieved for parents and babies.
We will:
• work with GPs to identify, clarify and discuss the role of primary care
• ensure that GPs are involved in line with local and national guidance
• work with all our partners to develop a strategic approach to children’s centres, and ensure commitment to each area’s Early Years Offer.

We will also work with:
• the South West Maternity and Children’s Strategic Clinical Network to develop best practice
• Public Health to promote a whole systems approach, ensuring relevant Public Health initiatives including the midwifery contribution
• Public Health England to increase the uptake of flu vaccination among pregnant women from 30% to 75% by March 2016.

10.0 Strategic national framework (p.20)
We will work collaboratively to ensure services are delivered in line with national directives and regulatory standards and local requirements.

11.0 Changes in demand for maternity services (p.21)
We will ensure services are non-stigmatising, equitable, fair and accessible and targeted to the needs of parents and their families.
12.0 Reducing health inequalities and promoting health (p.22-26)

We will work with:
- all relevant providers to reduce health inequalities and promote health and wellbeing
- audit the provision of advice about alcohol and substance misuse during pregnancy
- ensure better recording of data on BMI
- colleagues to ensure the ‘Quit Smoking’ programme is a high priority for maternity services
- providers to ensure there is an equitable and seamless pathway of care for all women who require perinatal infant health services
- all appropriate organisations to ensure the safeguarding needs of children and young adults are met, including girls and women at risk of FGM
- providers to ensure all midwives are trained to recognise and act on domestic abuse
- service providers to develop, support and implement the principles of the UNICEF Baby Friendly initiative and seek to establish an infant feeding alliance to monitor progress to achieving their principles
- our providers to ensure a regional wide dashboard will be implemented.

13.0 Enabling choice (p.27)

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

14.0 Pre-conceptual care (p.28)

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

15.0 Antenatal care (p.29-31)

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

16.0 Intrapartum care (p.32)

We will work:
- with our service providers to address the challenge of meeting the Choice Agenda regarding place of birth
- to ensure all women receive one-to-one care where possible, enabling a positive birth experience.
17.0 Postnatal care, new born and neonatal care (p.33)
We are committed to ensure that postnatal care gives a positive experience for women, their partners and babies, including vulnerable families, and that there is a robust and safe transfer process to public health nursing services.

18.0 Workforce (p.34)
We will work with our service providers to ensure the long-term sustainability of maternity services which are flexible to meet changing demands.

19.0 Public Sector Duty (p.35)
We will seek assurance that providers follow Public Sector Quality duty (EHRC 2011)

21.0 Data collection (p.36)
We will continue to work with the South West Maternity and Children's Strategic Clinical Network, County Council, Public Health colleagues and Provider Units to ensure there is a consistent methodology for collecting, monitoring, utilising and sharing maternity data.

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

23.0 Way forward / implementation plan (p.36)
We will work with commissioners from across the maternity pathway to develop a collective/ collaborative approach implementing these commissioning intentions.

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

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

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

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

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

The following key values and principles, on which this strategy rests, have been drawn up with the view of putting women, their partners and babies at the heart of maternity services. Commissioners and service providers will work together to ensure that services:

- Are of a high quality, providing safe, accessible, equitable and sustainable service outcomes for women and their babies
- Place the woman and their family at the centre of care and support the principle of normalisation (*Promoting Normal Birth* DHS 2011)⁶
- Are based upon best practice and national guidance
- Are commissioned and delivered, reflecting and listening to service users throughout the process
- Are responsive to change, recognising the need to be open and transparent and reflecting the lessons learnt from incidents and events (*Introducing the Duty of Candour* Gov.uk, 2014)⁷
- Uphold the six fundamental values identified in *Compassion in Practice* (DoH 2012)⁸ recognising the unique midwifery and nursing contribution to these values
- Promote Progressive Universalism.

6.0 Scope / definition of commissioning strategy

For the purposes of this document, ‘maternity services’ refers to professional care delivered to women and their babies, and the support provided to their partners in the pre-conceptual, antenatal, labour and birth (intrapartum), and the postnatal period (up to 28 days).

The maternity services delivered throughout this process are provided by midwives, obstetricians, anaesthetists and neonatologists / paediatricians, all working collaboratively with other specialties as required.

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

This commissioning strategy defines the strategic commissioning direction for maternity services whilst recognising the need for the wider maternity care agenda to be considered.
7.0 Service user / stakeholder / clinical engagement

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

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

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

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

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

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

- I had access to an interpreter and signage
- I felt my birthing partner was fully included and listened to
- I felt supported when I became a new parent
- I felt visiting times were flexible enough to allow my partner to support me
- I was offered choice of where I had my baby
- I was treated with respect, dignity and empathy
- I felt supported when my baby died

For detailed analysis of stakeholder involvement (see appendix 3)
8.0 Commissioning context

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

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

We will aim to work with our commissioning colleagues across the pathway to develop seamless coordinated maternity care.
9.0 Partnership working

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

We will work collaboratively to:

- Ensure the maternity pathway involves all relevant disciplines and provides clarity regarding their individual contribution, in order that the best outcomes are achieved for parents and babies
- Develop a strategic approach to information sharing between South Devon and Torbay, and Kernow CCGs in order to provide a seamless pathway of support to all prospective parents.

Public Health Nursing (health visiting)

Health visitors link with midwifery services in the antenatal and postnatal periods to provide additional and on-going support to families contributing to early help.

This includes intervention support and referral ensuring readiness for parenthood through working with mothers and their babies and families (as recommended in the Healthy Child Programme).”

General practice

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

GPs are also in a key position to identify those women who may be socially isolated or vulnerable.

GPs may also be involved in:

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

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

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

We will ensure that where GP’s are involved in the provision of maternity care, they are supported to provide care according to local and national guidelines.
**Children’s centres**

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

The All Party Partnership Survey Strategy Groups *‘Best Practice for a Sure Start: The Way Forward for Children’s Centres’*\(^{12}\) makes a number of recommendations that reflect on maternity services (*see Appendix 4*).

Currently children’s centres are subject to national and local review, the outcomes of which may affect their model of delivery with a reduction in the number of buildings.

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

- develop a strategic approach to services through children’s centres where it is possible and appropriate
- ensure commitment to each area’s early years offer
- effective data sharing.
Maternity networks

The Way Forward: Strategic Clinical Networks (NHS England, 2012)\(^{12}\) states that:

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

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

Public Health

The Department of Health Mandate (April 2013-2015)\(^{5}\) has identified that improving public health is one of their key priorities and that it is the business of every nurse and midwife. There are two clear directives with relevance to midwives. These are:

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

Public Health England is currently leading work that will increase the uptake of flu vaccination among pregnant women from 30% to 75% by March 2016.

It is important that women and babies who are at particular risk of infection or medical conditions are identified early and appropriate care organised.

Maternity services will continue to work closely with Public Health England to ensure women are offered a range of tests, including blood tests and ultrasound baby scans which are designed to help make pregnancy safer, check and assess the development and wellbeing of mothers and their babies, and screen for particular conditions.

Public Health as a whole system approach

We will work with:

- partners in Public Health to promote a whole systems approach to ensure the midwifery contribution is included within relevant public health outcomes
- Public Health England to increase the uptake of flu vaccination among pregnant women.
10.0 Strategic National Framework


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

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

The National Choice Guarantee is to offer all women:

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

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

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

*Promoting normal Childbirth* showed that a focus on promoting normality and birth is associated with a lower rate of medical intervention such as instrumental deliveries and caesarean sections. This results in better quality and care for mother and baby allowing midwives to spend more time caring for them.

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

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

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

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

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

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

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

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

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

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

Nationally the number of babies born to women aged 40 or over rose by 85 per cent between 2001 and 2012. This pattern is mirrored locally (see Figure 1, Appendix 7).

Teenage pregnancy rates are declining across the South West Peninsula although rates in Plymouth and Torbay are still above the South West and England average (see Figures 2, Appendix 7).

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

Young and older parents told us access to services that recognise their specific needs can be difficult.

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

Maternity services should be responsive to the needs of:
- ethnic minorities
- recently arrived families
- travelling families
- substance abusing women and their families
- children in need of protection, and targeted according to need
- disabled parents.

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

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

The percentage of deliveries by the ethnicity of the mother is outlined in Table 1, Appendix 8. This information does not however capture diversity within ethnic categories. For example the ethnic category ‘White’ would include mothers from Eastern Europe some of whom may not speak English and therefore need support with translation services.

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

“It is clear that a good start makes a crucial difference in securing good outcomes for children / adults.” (Best Practice for a Sure Start 2013)\textsuperscript{12}

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

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

The Marmot Review reflects the above in six key statements referring to children and young people (see Appendix 9). (Fair Society, Healthy Lives 2010 – the Marmot review of health inequalities in England)\textsuperscript{27}

**Health inequalities**

Socio-economic status is strongly associated with health outcomes for mothers and their babies. Babies born to mothers living in the most deprived areas have around twice the rate of still birth and neonatal death than those born to mothers living in the least deprived areas. (Unexplained deaths in infancy, ONS 2012)\textsuperscript{28}

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

“Each midwife has the opportunity to influence the woman and the subsequent life chances for her child from pre-conception to the postnatal period”. (Midwifery 2020)\textsuperscript{14}

Deprivation varies across the CCGs. Cornwall & IOS, Torbay and Plymouth have above the national average levels of urban deprivation. All rural areas of the peninsula, with the exception of East Devon and Teignbridge, have above the national average score. Deprivation is associated with issues of social isolation, a low wage economy, high housing and living costs and greater distance to travel to services (see Figure 1 & 2, Appendix 10).

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

We will take a collaborative approach with all relevant providers to reduce health inequalities and promote health and wellbeing.
**Substance misuse in pregnancy**

There is little reliable information available locally or nationally on the proportion of women consuming drugs or alcohol during their pregnancy or pre-pregnancy. We do know that women misusing substances do not access or maintain contact with maternity services and are likely to experience other social disadvantages. *(Pregnancy and Complex Social Factors – a model for service provision for pregnant women with complex social factors (NICE 2010))^{29}*

Pregnancy can act as a catalyst for change and presents a ‘window of opportunity’ for engagement with treatment. Women who enter methadone treatment programmes during pregnancy have better outcomes as do their babies *(Drug Misuse and Dependence: UK Guidelines on clinical management, (DoH 2007))^{30}*. Engagement of substance-misusing partners in treatment is also important in enabling pregnant women to achieve progress at the earliest possible stage.

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

**Maternal obesity**

There is substantial evidence that obesity in pregnancy contributes to increased morbidity and mortality for both mother and baby. *(CMACE/ RCOG 2010)\(^{31}\).*

Women who are obese are more likely to have a longer or induced labour and an instrumental delivery or caesarean section *(Yu et al, 2006)\(^{32}\).*

Obese women are likely to spend longer in hospital than those with a healthy weight because of morbidity during pregnancy and labour related to their weight *(Chu et al, 2008)\(^{33}\).*

Babies born to obese women also face increased health risks, including fetal death, still birth, congenital abnormality and subsequent obesity *(Ramachenderan et al, 2008)\(^{33}\).*

Women with a high BMI need to be supported to achieve and maintain a healthy weight before, during and after pregnancy. *(NICE guidance PH27)\(^{34}\).* Better recording of BMI status is important to support the development and provision of appropriate services. *(See Table 1, Appendix 11)*

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

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

Smoking in pregnancy is probably the main cause of adverse outcomes for babies:

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

There are significant variations in smoking rates across the Peninsula (see Figure 1, Appendix 12). Plymouth, Torbay and Cornwall & Isles of Scilly have higher rates of smoking at delivery when compared with the South West and England averages.

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

The proportion of mothers smoking at delivery varies dramatically according to socio-economic status from nearly 26 per cent in the most deprived group to five per cent in the least deprived group (see Figure 2, Appendix 12).

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

Perinatal maternal / infant mental health

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

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

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

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

Safeguarding is everyone’s responsibility. For services to be effective each professional and organisation should play their full part and adopt a children-centred approach where provision of service is based on a clear understanding of the needs of children. Providing early help is vital in promoting the wellbeing of children. This strategy supports the national guidance of *(Working Together to Safeguard Children 2013)*.37

**Domestic violence**

Domestic violence is any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 years and over who are or have been intimate partners or family members. Domestic violence is more likely to begin or escalate during pregnancy. In Devon 10 per cent of pregnant women were identified by their health visitor as being victims of domestic abuse.

Domestic violence has been identified as a significant cause of miscarriage or still birth and of maternal death during childbirth. More than 14 per cent of maternal deaths occur in women who have told their health professional they are in an abusive relationship. *(Public Health Devon, Devon Family Needs Survey (2012 and 2011) and NICE, 2001)*38

The ability to recognise potential indicators and signs of abuse to both the pregnant woman and her child is imperative, and early intervention in securing additional support is vital. All services will work to NICE guidance and appropriate evidence based Assessment Framework for their area. *(PH50 Domestic Violence & Abuse)*39 *(See Appendix 14)*

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

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

**Female Genital Mutilation (FGM)**

Female genital mutilation is estimated to have affected 66,000 women nationally (this is a conservative estimate in Britain). FGM is a violation of the human rights of girls and women and must be treated as abuse. *(WHO Fact Sheet 241)*40

FGM causes physical, psychological and sexual harm which lasts a life time and is performed on a child who is unable to resist or give informed consent.

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

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

- a reduction in infection, including gastroenteritis, respiratory and ear infections leading to hospitalisation (Ip S.et al, 2007)\textsuperscript{41}
- a reduction in childhood obesity increasing the risk of developing type-2 diabetes
- reduction of blood pressure and cholesterol in adulthood. (Horta, B. et al, 2007)\textsuperscript{42}

For mothers breastfeeding is associated with a reduction in the risk of breast and ovarian cancers. (Beral, V. 2002)\textsuperscript{43}

Rates of breastfeeding vary widely between different socio-economic groups, (see Figure 1 and 2, Appendix 15), with mothers from professional and managerial groups much more likely to initiate breast feeding than mothers from the most deprived groups.

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

On the other hand South Hams and West Devon (relatively affluent areas), and Cornwall & Isles of Scilly have higher rates of breastfeeding initiation than the peninsula’s average as well as the England and South West average.

The United Nations International Children's Emergency Fund (UNICEF) UK Baby Friendly Initiative (2012), supported by the World Health Organisation (2001) and the Royal College of Midwives, provides a framework for the implementation of best practice by NHS trusts and other healthcare facilities. The aim is of ensuring that all parents are helped to make informed decisions about feeding their babies and that they are supported in their chosen feeding method.

Implementing the Baby Friendly best practice standards is a proven way of increasing breastfeeding rates (NICE, 2006; Broadfoot, M., 2005; Tappin, D.M. et al, 2001; UNICEF, 2012; Kramer M.S. et al, 2001)\textsuperscript{44}.

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

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

We will seek to establish an infant feeding alliance to monitor progress towards achieving the principles of the UNICEF UK Baby Friendly initiative.
13.0 Enabling choice  
(as defined in Maternity Matters 2007)

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

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

We will work with local providers:

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

Maternity Care Pathway (Maternity Matter 2007)
14.0 Pre-conceptual care

Pre-conceptual care provides support and advice for families to ensure women have the best chance of having a healthy pregnancy and a healthy baby. *Preconception Health (Womenshealth.gov. 2010)* We recognise it is important in ensuring their optimum health outcomes.

It may provide the opportunity to:

- optimize the management of chronic maternal health problems
- provide lifestyle advice to avoid behaviours hazardous to a pregnancy, such as drinking / excessive alcohol consumption, drug-taking or smoking
- provide advice to optimize the health of the mother and baby, such as guidance on taking folic acid supplements
- identify couples who are at an increased risk of having a baby with a genetic or chromosomal malformation, and providing them with sufficient knowledge to make informed decisions.

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

We will work with the relevant providers to address any gaps in the current provision.
15.0 Antenatal care

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

Access

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

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

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

Reducing the percentage of women who access maternity services late through targeted outreach work for vulnerable and socially excluded groups, will provide a focus on reducing the health inequalities these groups face whilst also guaranteeing choice to all pregnant women.

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

Continuity

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

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

Midwives are the experts in normal pregnancy and birth and have the skills to refer to and coordinate between any specialist services that may be required. Medical consultants will ensure those women who require additional help and support receive the care they need.

On-going needs assessment should be undertaken throughout the antenatal period. Care will be provided in line with NICE Guidelines for Antenatal Care (2013)\(^7\).

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

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

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

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

---

**Loss in pregnancy**

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

Nationally seventeen babies are stillborn or die shortly after birth every day and 20 per cent of all pregnancies end in miscarriage. A review of support available for loss in early and late pregnancy (2010) suggests that if done well, preparation for parenthood can impact significantly on bonding, attachment and parenting, and reducing social and health inequalities.

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

---

**Maternal death**

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

This is also the case in the Peninsula where there were fewer than five maternal deaths between 2008 and 2012 (Health & Social Care Information Centre based on Office of National Statistics mortality data).

---

**Education for parenthood**

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

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

---

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

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

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

- provided equitably
- accessible i.e. times and venue
- content relevant and evidence based
- inclusive
- inclusive of a range of approaches
- aware of the needs of the most vulnerable families.

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

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

The programme has been redesigned in line with Department of Health quality standards and ensures that parents are offered first class parenting education wherever they live across the city (See Appendix 17).

Best practice in Cornwall & IOS

In Cornwall and Isles of Scilly every first time father now receives a Dad’s pack. The pack which covers the following topics includes:

- Breastfeeding and bottle feeding
- Holding and handling a baby
- Caring for a crying baby
- Safe sleeping and surviving without sleep
- How to change a nappy
- Washing and bathing a baby
- Communicating with a baby
- Baby massage and bonding
- Child development and baby milestones
- Positive mental health
- Legal information - including Parental Responsibility (PR).

The Dads’ Pack also includes fun and practical parenting gifts dads told us they would find useful in caring for their new baby:

- Sports bag – for carrying baby care essentials on the go
- Baby bib & feeding spoon – for daddy feeding time
- Foldable changing mat - for nappy changing at home or out and about.
- Blind-cord safety ties – to keep blind cords tied-up out of reach of little fingers
- Family Information Service (FIS) pen – you never know when you’ll need a pen!
16.0 **Intrapartum care**

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

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

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

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

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

Commissioners and service providers are all committed to the principle that pregnancy is for most women a normal process. Therefore all women and their partners will be offered the opportunity to choose their place of birth, including having their baby at home if safe and appropriate. (*NICE guidance CG62 Routine Antenatal care for healthy pregnant women 2008*) ²⁴⁷

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

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

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

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

Many women cite one-to-one care in labour as the most important factor for them in having a positive birth experience. (*NICE guidelines 2007*) ⁵⁰ and *Maternal Emotional Wellbeing and Infant Development (RCOG 2012)* ⁴⁹

The Department of Health have advised that applying evidence-based good practice of care leads to lower caesarean section rates and most importantly a better experience for women. Between 1998/99 and 2005/06, the caesarean section rate in England rose from 12 per cent of all births to 24 per cent without measurable improvement in outcomes for babies and decreased morbidity for mothers.

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

However we recognise that for some women a caesarean birth can be the safest and most appropriate way for their baby to be delivered, and this can still be a positive birth experience for mothers and their partners (for breakdown see Appendix 18).

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

We will work with our providers to ensure all women receive one-to-one care where possible and experience a positive birth.
17.0 Postnatal care, new born and neonatal care

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

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

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

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

New born and neonatal care

All babies, wherever they are born, receive care from midwives following birth. This care continues until transfer to the health visiting service and involves assessment of the health of both mother and baby, including performance of the New born and Infant Physical Examination (NIPE).

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

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

Babies with a low birth weight are more likely to die or have special medical or education needs than those with a normal birth weight. Low birth weight is affected by risk factors such as smoking, alcohol and drug use which are more prevalent in areas of deprivation (see Figure 1, Appendix 19).

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

Transition to the Health Visiting service

Transfer of care from the midwife to the health visiting service will occur between 10 and 28 days following the birth of a baby. Healthy Child Programme (DoH 2009)\textsuperscript{10}. This is in line with Health Visiting and Midwifery Partnerships\textsuperscript{51}.

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

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

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

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

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

These include for example:

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

In order to maintain high quality, safe and personalised care, in line with *The Right People in the Right Place*\(^2\), providers will require a robust workforce development plan.

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

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

Provision of supervision and access to supervisory support in line with *Modern Supervision in Action – a practical guide for midwives NMC 2009*\(^3\) should be in place.

We will work with our service providers to ensure long term sustainability of maternity services that are flexible to meet changing demands.
19.0 Public sector equality duty

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

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

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

The Women’s Health and Equality Consortium (WHEC) recently undertook a piece of research examining the barriers that women in various groups face when accessing pregnancy care (Briefing: Women’s voices on health: Addressing barriers to accessing primary care, May 2014, WHEC).

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

We will seek assurance that providers:

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

20.0 Financial framework

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

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

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

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

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

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

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

We will ensure work is on-going with partnerships to address the data collection requirements.

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

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

22.0 **Governance arrangements**

This commissioning strategy and its associated implementation plan will be led and monitored by the CCGs.

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

23.0 **Way forward / implementation plan**

Following ratification by the Governance Board in November 2014, all provider services will stocktake their current provision against the commissioning intentions. This stocktake will then clearly identify the current level of service provision and identify inconsistencies and service gaps.

The Strategic Programme Group will then work collaboratively with partners to develop an action plan.

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

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

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

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

Members of the Strategy Programme Group

- Lorna Collingwood-Burke, Chief Nursing Officer, NEW Devon CCG
- Gwen Pearson, Commissioning Lead, C&YP and Maternity, NEW Devon CCG
- Nykayla Stockham, Commissioning Support Manager, NEW Devon CCG
- Sarah Saunders, Contract Accountant, Eastern, NEW Devon CCG
- Keri Ross, Community Relations Manager, Eastern, NEW Devon CCG
- Tina Teague, Eastern Locality Commissioning Lead, Kernow CCG
- Nicola Macphail, Commissioning Transformation Manager, Kernow CCG
- David Priscott, Strategic Workforce Planner, Kernow CCG
- Sue Moreton, Patient Quality & Safety Manager, Kernow CCG
- Toby Cooper, Head of Midwifery, Plymouth
- Gitte Lindberg, Lay Chair of MSLC, Plymouth
- Susan Stock, Head of Midwifery, Plymouth
- Briony Cowan, Directorate Manager, CFS, Plymouth
- Carol Axon, Acting Deputy Head of Midwifery, RD&E
- Tracey Kay, Consultant Obstetrician & Gynaecologist, RD&E
- Jan Walters, Divisional Nurse/Head of Midwifery, RCHT, Cornwall
- Karen Watkins, Consultant Obstetrician & Gynaecologist, RCHT, Cornwall
- Ruth Wellings, Programme Manager, Maternity & Children, Kernow CCG
- Shona Charlton, Commissioning Manager SD&T, Kernow CCG
- Heather Parker, Associate Director of Nursing & Midwifery, SD&T CCG
- Sara Gibbs, Consultant in Public Health, Devon CC
- Julie Frier, Consultant in Public Health Medicine, Plymouth CC
- Caroline Dimond, Consultant in Public Health Medicine, Torbay
- Brian ONeill, Consultant in Public Health (Children), Cornwall CC
- Kirsty Edlin, Public Health Commissioning Manager, NHS England
- Ann Remmers, Clinical Director, SW Maternity & Children, NHS England
- Strategic Clinical Network
- Helen Pearce, Local Supervising Authority Midwifery Officer, NHS England
- Val Smith, Children’s Centre Manager, Devon CC
- Sue Smith, Children’s Centre Adviser, Plymouth CC
- Trudi Webber, Regional Partnership Manager, NCT
- Julie Chandler, Representative, RCM
- Caroline Lee, Partnership Officer, Healthwatch
- Mark Sanford-Wood, LMC representative, Devon LMC
25.0 References

“Delivering Excellence in Maternity Care” (NHS Institute Maternity Improvement Programme, 2011-12)
http://www.institute.nhs.uk/images/documents/Quality_and_value/Maternity%20Improvement%20Programme%20April%202011%20to%20March%202012.pdf

1 NHS outcomes framework indicators and national public health outcomes framework
http://www.england.nhs.uk/ccg-ois/

2 Achieving parity of esteem between mental and physical health (Gov.UK 2013)
http://www.rcpsych.ac.uk/pdf/OP88summary.pdf

3 Kuh Dt, Ben-Schlomo Y, (1997)
http://jech.bmj.com/content/57/10/778.full

4 Promoting Normal Childbirth, (NCT 2010)

5 The Mandate, A mandate from the Government to the NHS Commissioning Board April 2013 to March 2015 (DoH 2013)

6 Promoting Normal Birth (DHS 2011)

7 Introducing the Statutory Duty of Candour (Gov.uk, 2014)

8 Compassion in Practice (DoH 2012)

9 Commissioning Maternity Services, Resource Pack to support CCGs (NHS Commissioning Board 2012)

10 Healthy Child Programme (DoH 2009)

11 The role of GPs in maternity care – what does the future hold? – (Kings Fund 2010)

12 ‘Best Practice for a Sure Start: The Way Forward for Children’s Centres (Report from the All Party Parliamentary Sure Start Group 2013)
http://www.4children.org.uk/Files/ccfc42fe-49eb-43e2-b330-a1fd00b8077b/Best-Practice-for-a-Sure-Start.pdf


14 Midwifery 2020, Delivering Expectations (DoH 2010)


16 Standards for Maternity Care (RCOG 2008),

17 Safe Births: Everybody’s Business (Kings Fund 2008)
18 Maternity Matters (DoH 2007)

19 NSF for Children, Young People and Maternity Services (DoH 2004),

20 Choosing Health (DH, 2004)

21 CNST (litigation for maternity cases).

22 ‘No Health without Mental Health’ (HM Government 2011)

23 Joint Planning and Commissioning Framework for Children, Young People and Maternity Services (HM Gov 2006)

24 Our Health Our Care Our Say (DoH 2006)

25 Making Normal Birth a Reality (RCM, RCOG, NCT 2010)

26 Pledge for better health outcomes for children and young people, (HM Gov 2013)

http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

28 ONS Unexplained deaths in infancy

29 Pregnancy and Complex Social Factors – a model for service provision for pregnant women with complex social factors (NICE 2010)

30 Drug Misuse and Dependence: UK Guidelines on clinical management, (DoH 2007)

31 Obesity in pregnancy
(CEMACE/ RCOG 2010)

32 (Yu et al, 2006)

33 (Chu et al, Ramachenderan et al, 2008)

34 Weight Management before, during and after pregnancy (NICE 2010)

35 Smoking and the young. London: Royal College of Physicians.(RCP (1992)
http://www.rcplondon.ac.uk/publications/smoking-and-young


PH50 Domestic violence and abuse, (NICE Guidance 2014) http://www.nice.org.uk/guidance/ph50/chapter/recommendations

Female Genital Mutilation (WHO Fact Sheet 241) http://www.who.int/mediacentre/factsheets/fs241/en/


Nationally only 50% of the population plan a pregnancy (UCL 2013) http://www.ucl.ac.uk/news/news-articles/1113/2612013-One-in-six-pregnancies-are-unplanned

NICE Guidelines for Antenatal Care CG62 (NICE 2013) http://www.nice.org.uk/guidance/CG62/chapter/introduction


Public Sector Equality Duty 2011

(Briefing: Women’s voices on health: Addressing barriers to accessing primary care, May 2014, WHEC).