Commissioning strategy for maternity services 2014 – 2019

Needs assessment / appendices

Northern, Eastern and Western Devon Clinical Commissioning Group

South Devon and Torbay Clinical Commissioning Group

Kernow Clinical Commissioning Group
Appendices

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# Maternity services implementation plan

Maternity services commissioning strategy: example work programme (to be further developed)

<table>
<thead>
<tr>
<th>Outcome reference key*</th>
<th>Key actions 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>1. Development of service specification for maternity services</td>
</tr>
<tr>
<td>2.</td>
<td>2. Development of performance framework, incorporating CCG Indicators and NHS Outcomes</td>
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<tr>
<td>3.</td>
<td>3.</td>
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<td>4.</td>
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<td>5.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective (Examples)</th>
<th>Outcome reference</th>
<th>Action(s) required</th>
<th>Timescale</th>
<th>Responsible lead / stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve pre-conceptual care for women and their partners, particularly women with existing physical / medical health conditions and women with previous history of obstetric / genetic problems</td>
<td>(Link to outcome reference)</td>
<td>Development of pre-conceptual care pathway</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improve early access to midwifery / antenatal care from ** to **</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improve early identification of women with high risk factors and additional needs</td>
<td></td>
<td></td>
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<tr>
<td>Improve the quality and availability of information about maternity services given to women and their partners (the right information at the right time in the right place)</td>
<td></td>
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</tr>
</tbody>
</table>
2 Synopsis of current maternity services

Royal Cornwall Hospitals Trust (RCHT)

Service provision
RCHT provides the maternity service for the majority of residents in Cornwall and the Isles of Scilly and has seen an increase in the birth rate of >20 per cent in the last ten years.

In 2013/14 the maternity service delivered 4,700 babies of which 12 per cent (564) were delivered either at home or in one of the stand alone birth centres.

Staffing
The current midwife to birth ratio is 1:33 (excludes specialist and managerial posts) nevertheless RCHT still provide one to one care in labour for >97 per cent of all labouring women.

Services include the following specialist posts:
- Screening
- Diabetes
- Vulnerable adults
- Practice development
- Bereavement
- Risk Management.

There is 45-hours dedicated consultant cover for the delivery suite.

Facilities
RCHT have three midwifery led units (MLUs), and one alongside midwifery led unit is planned (anticipated opening January 2016).

There are nine birthing rooms on delivery suite, plus 11 antenatal inpatient beds, a bereavement suite and a 25 bedded inpatient postnatal ward.

There are two dedicated obstetric theatres, one of which can be used for high dependency unit (HDU) patients or for labouring women when demand exceeds capacity.

24 hour epidural cover is provided.

Public Health
RCHT have a vulnerable adult’s lead midwife.

Successes
- Clinical Negligence Scheme for Trusts (CNST) level 3
- Breast feeding initiative level 3
- Low caesarean section rate
- High normal delivery rate
- Green flag award for its Down’s Syndrome screening service.

Challenges
- Increasing complexity of women e.g. high BMI, increasing numbers of diabetic women
- Maternity unit too small for current demand
- Ageing and part time workforce.
Royal Devon & Exeter Hospital (RD&E)

Service provision
RD&E maternity services includes the pregnant and newly delivered populations of Exeter, Okehampton, Tiverton, Honiton, Exmouth and surrounding areas.

In 2013/14 4,200 babies were delivered with 23 per cent of women giving birth at home or in a midwife led birth unit.

Staffing
The current midwife to birth ratio is 1:32 (excludes governance, education and managers). One to one care in labour was provided to 98 per cent of all labouring women.

Services include the following specialist posts:
- Screening
- Vulnerable adults
- Practice development
- Risk management
- Teenage pregnancy
- Infant feeding
- Smoking cessation.

There is 60 hours dedicated consultant cover on the labour ward.

Facilities
RD&E have four midwifery led birth units, one within the RD&E maternity unit, and the others at Honiton, Tiverton and Okehampton.

There are 10 birthing rooms (one pool) on the labour ward, two admission rooms and a bereavement suite.

There is one dedicated obstetric theatre with 24 hour obstetric / anaesthetic cover including epidural cover.

There are 43 bedded ante / postnatal inpatient beds plus four transitional care beds.

There is ultrasound scanning and a fetal / maternal assessment unit.

Public Health
RD&E have dedicated specialists for substance misuse, learning disability, hearing / sight / speech disability and asylum seekers.

Successes
- Opening an along-side birth unit in November 2012. (Over 20 per cent of women birth outside of the labour ward)
- Maintaining Baby Friendly accreditation status in 2014
- Introduction of telemetry monitoring in labour to enable high risk women choice to be more mobile and labour / birth in water
- Introduction of midwifery smoking cessation service.

Challenges
- Increasing complexity of pregnant women i.e. obesity, diabetes
- Ageing and part time midwifery workforce
- Financial constraints.
South Devon Healthcare NHS Foundation Trust (SDHCFT)

Service provision
SDHCFT provide maternity services to women in Torbay, Southern Devon and the surrounding areas.

The area covered is 300 square miles and is a mixture of urban, coastal and rural. The total resident population is 275,000; however this swells by 100,000 due to holiday makers. Just under one per cent of these require maternity services.

Staffing
- Midwifery ratio 1:32 (excludes specialist roles)
- The maternity unit has the following specialist midwifery roles:
  - Named midwife for children’s safeguarding supported by an additional safeguarding midwife
  - Public Health midwife
  - Clinical governance lead
  - Audit midwife
  - Infant feeding midwife
  - Education and development lead midwife
  - Antenatal and new born screening co-ordinator.
- There are seven Obstetric and Gynaecology consultants that between them provide 40 hours of consultant Obstetrician presence on the delivery suite
- The service is also supported by maternity care assistants in both the hospital and community settings.

Facilities
- Two midwifery led birthing rooms at Newton Abbot Community Hospital for women assessed as low risk for birth. Staffed 08:00 – 20:00 with maternity care assistants and midwives for women in labour over the 24 hour period. No overnight in-patient facility
- One mixed ante / postnatal ward at Torbay with 20 beds
- Eight birthing rooms on the delivery suite at Torbay, one of which has a birthing pool
- Bereavement suite for women and family.

Public Health
The public health midwife supports the health agenda around obesity / alcohol and substance misuse / domestic abuse and teenage pregnancy. She works closely with the peri-natal mental health team and alongside the children’s safeguarding midwife.

Successes
- Attainment of Clinical Negligence Scheme for Trusts (CNST) level 3
- Attainment of UNICEF Baby Friendly Initiative.

Challenges
- Increasing complexity of maternity care
- Financial climate to adequately fund choice for women in maternity care
- Children’s safeguarding
- Aging workforce
North Devon District Hospital (NDDH)

Medical staff include:
- Seven middle grades
- Six consultants
- SHO’s– usually six or seven GP trainees.

There is 40 hour labour ward cover as per Royal College of Obstetricians and Gynaecologists recommendations.

Staffing
Midwifery ratio: 1:30
There are also specialist midwives for:
- practice development
- clinical risk manager

Service provision
Northern Devon Healthcare NHS Trust covers an area of 934 sq rural miles and provides both hospital maternity services at NDDH and community midwifery services to mothers in their own homes and local towns / villages.

Over 1,600 babies a year are born to mothers who are cared for by staff at NDDH and by midwives working in the community.

Facilities
- Six antenatal beds
- 12 postnatal beds
- Six birth rooms
- Designated obstetric theatre
- Designated anaesthetic room
- Designated post-op recovery service / area
- 24 hour anaesthetic cover including epidural.

Please note there is no MLU and no separate transitional care facility for babies.

Public Health
One senior specialist midwife responsible for operationally and strategically managing the public health agenda including:
- Diabetes
- Teenage pregnancy
- Breast feeding / infant feeding
- Safeguarding
- Domestic abuse
- Smoke cessation (liaison)
- Perinatal mental health (in conjunction with specialist team).

The midwife is also the named midwife for safeguarding children and young people.

Successes
- Low perinatal mortality statistics
- New perinatal mental health service
- Positive National maternity patient survey
- Increasing friends and family test returns demonstrating positive feedback.

Challenges
- Payment by Results tariff deficit
- Relatively high Caesarean section rate
  - (26.9 per cent for 2013/14)
Plymouth Hospitals NHS Trust (PHT)

PHT is located in Derriford, Plymouth. The maternity unit delivers just under 5000 babies each year with care being provided in both the Hospital and Community setting across South West Devon and South East Cornwall.

The department had Clinical Negligence Scheme for Trusts (CNST) Level 3 awarded in March 2014, demonstrating the highest accreditation when safety within a maternity unit is assessed by the National Health Service Litigation Authority.

The unit has also been awarded Baby Friendly status by UNICEF, demonstrating their commitment to supporting women’s feeding choices.

The neonatal intensive care (NICU) in Plymouth is the Level 3 unit for the peninsula and thus attracts the most premature and sickest babies.

Also run from the unit is the neonatal transport system moving babies throughout the peninsula.

The hospital has a labour ward with both midwifery led and obstetric led care accommodated, co-located maternity theatres, a combined ante and postnatal ward and a transitional care ward (TCW) allowing mums to remain with babies that traditionally would have been cared for in a special care environment.

‘Jubilee’ are a dedicated case-loading team providing care to women who book for homebirth, under 18s, those who have experienced a loss after 20 weeks gestation in their previous pregnancy and women who choose to continue with a pregnancy with known significant abnormalities.

The advent of the team has seen a marked increase in the homebirth rate.

A caesarean rate of 20 per cent and compliance with >98 hours consultant presence on labour ward go hand in hand. Epidurals are available 24 hours a day.

The department has a very encompassing website which can be found on the following link: http://www.plymouthhospitals.nhs.uk/Pages/Home.aspx.
3 NHS NEW Devon CCG maternity services strategy development: stakeholder involvement

All three CCGs recognised the importance of having robust stakeholder involvement in the development of the maternity services strategy. Each however, recognised that the approach taken to ensure this would be different in each area and needed to reflect each area’s arrangements.

It was recognised that for consistency of information, one communication plan would be developed and shared.

The key principles underpinning this were:

- Patient and public have an equal voice with professionals
- Every commissioning work plan will include patient and public engagement
- We will engage honestly and transparently taking the time to provide context.

Listening
During January and February 2014 numerous visits / contacts were made with stakeholder groups asking:

- What went well
- What did not work so well?
- How would you improve it?

Stakeholder groups

- Children’s centres
- Social media
- Maternity Services Liaison Committees
- Overview and scrutiny
- Hikmat
  - Hikmat Devon
  - Devon Grapevine
  - Intercom Trust
  - Racial Equality Council
  - Devon Youth Services
- Gypsies and travellers
- Hard to reach groups
- Publicised by Healthwatch
- South West family support

- Online surveys to groups
  - Mums Net
  - NCT Plymouth
  - Nice Mums Devon
  - Green Mums Devon
  - Carousel Project
  - North Devon 4 Mums
  - Plymouth Dads
  - Plymouth Mums
  - NCT Exeter and E.Devon.
## Children’s centres
A total of 35 children’s centres (CCs) were visited across Northern, Eastern and Western Devon by commissioners and communication leads.

<table>
<thead>
<tr>
<th>Northern Devon group visits</th>
<th>Date</th>
<th>No. of attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health centre managers: Torrington (x 2)</td>
<td>19.4.13, 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.5.13</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>20.6.13</td>
<td>1</td>
</tr>
<tr>
<td>Exeter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forches young Mums</td>
<td>7.6.13</td>
<td>10</td>
</tr>
<tr>
<td>Bideford / Torrington young Mums</td>
<td>17.6.13</td>
<td>11</td>
</tr>
<tr>
<td>Forches breast feeding group</td>
<td>21.6.13</td>
<td>13</td>
</tr>
<tr>
<td>Braunton young Mums</td>
<td>27.6.13</td>
<td>7 (incl. 1 Dad)</td>
</tr>
<tr>
<td>Ilfracombe Father’s group</td>
<td>28.6.13</td>
<td>5 (incl. 1 Grandmother)</td>
</tr>
<tr>
<td>Ilfracombe young Mums</td>
<td>12.7.13</td>
<td>5</td>
</tr>
<tr>
<td>Holsworthy CC manager</td>
<td>18.11.13</td>
<td>1</td>
</tr>
<tr>
<td>Holsworthy Breast Feeding Group</td>
<td>18.11.13</td>
<td>2</td>
</tr>
<tr>
<td>Torrington Mother &amp; baby group</td>
<td>25.6.14</td>
<td>10</td>
</tr>
<tr>
<td>Western Devon group visits</td>
<td>Date</td>
<td>No. of attendees</td>
</tr>
<tr>
<td>Ham Lane CC</td>
<td>18.6.14</td>
<td>10</td>
</tr>
<tr>
<td>Ham Lane CC manager</td>
<td>18.6.14</td>
<td>2</td>
</tr>
<tr>
<td>Nemony</td>
<td>15.7.14</td>
<td>7</td>
</tr>
<tr>
<td>Plum Tree</td>
<td>30.7.14</td>
<td>9</td>
</tr>
<tr>
<td>Green Ark</td>
<td>4.8.14</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eastern Devon group visits</th>
<th>Date</th>
<th>No. of attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flying Start, Countess Wear, Chestnut</td>
<td>22.6.14</td>
<td>7</td>
</tr>
<tr>
<td>Parent Forums</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crediton CC manager</td>
<td>30.10.13</td>
<td>1</td>
</tr>
<tr>
<td>Crediton baby group CC</td>
<td>30.10.13</td>
<td>10</td>
</tr>
<tr>
<td>Cullompton CC manager</td>
<td>7.11.13</td>
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</tr>
<tr>
<td>Cullompton baby group</td>
<td>7.11.13</td>
<td>10</td>
</tr>
<tr>
<td>Countess Weir breast feeding CC</td>
<td>7.11.13</td>
<td>2</td>
</tr>
<tr>
<td>Exmouth Little Explorers</td>
<td>7.11.13</td>
<td>11 (9 + 2 fathers)</td>
</tr>
<tr>
<td>Whipton CC manager</td>
<td>5.12.13</td>
<td>1</td>
</tr>
<tr>
<td>Whipton CC</td>
<td>5.12.13</td>
<td>3</td>
</tr>
<tr>
<td>Wilcombe Primary School, Tiverton</td>
<td>15.1.14</td>
<td>20 (17 + 3 dads)</td>
</tr>
<tr>
<td>West Exe CC, Cowick St. Baby Café St Thomas</td>
<td>16.1.14</td>
<td>20</td>
</tr>
<tr>
<td>Baby Oasis, Whipton</td>
<td>22.1.14</td>
<td>6 (5 + 1 dad)</td>
</tr>
<tr>
<td>Bumps &amp; Babes, Silverton</td>
<td>22.1.14</td>
<td>6 (5 + 1 dad)</td>
</tr>
<tr>
<td>Silverton – professionals</td>
<td>22.1.14</td>
<td>2</td>
</tr>
<tr>
<td>Heavitree &amp; Polsloe</td>
<td>23.1.14</td>
<td>7</td>
</tr>
<tr>
<td>Sidmouth CC</td>
<td>31.1.14</td>
<td>20</td>
</tr>
<tr>
<td>Ottery CC</td>
<td>18.2.14</td>
<td>12</td>
</tr>
<tr>
<td>Exeter Mothers &amp; Fathers</td>
<td>26.3.14</td>
<td>2 (tel.call)</td>
</tr>
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</table>
Comments were collated and key themes identified:

**Northern Locality**

**Key themes – what was good:**
- Staff on labour ward were generally considered to be excellent, with many women experiencing a good birth experience
- There was great support for the inclusion of children’s centres and the support they provided
- Generally women felt that midwives were accessible, especially those that had mobile phone access
- Good support with breast feeding.

**Key themes - not so good:**
- Fathers found the service to be inflexible, especially antenatal clinics not fitting in with working Fathers
- Generally a lack of support for Dads who were concerned that their wives may not be listened to
- A number of Mothers mentioned feeling unprepared for both the birth of their baby and the emotional responses they would experience
- Some were concerned that classes were not available for all Mothers; access also seemed to vary according to where you lived; were inflexible and difficult to get to if you were a working parent
- Staffing levels were mentioned with regard to the care received on the postnatal ward with Mothers not liking to call the midwife, being frightened and left alone for long periods
- An almost equal amount of women indicated concerns regarding the attitude of the midwives, feeling that they were not open to the Mother’s comments, directive and judgemental (this last comment came from a number of young parents)
- A number of Mothers mentioned the need for more emotional support.

**Key themes – what could be better:**
- More involvement with children’s centres and earlier referral, especially antenatal
- Parent craft classes more available and more choice
- Support in the evening and at weekends - a helpline?
- More support on the postnatal ward, but not necessarily from a midwife
- More peer support for breastfeeding
- Being better prepared, knowing what could go wrong, e.g. perinatal maternal / infant mental health
- “Bosom-buddies” mentoring – support alternative to midwife (peer support).

**Eastern Locality**

**Key themes – what was good:**
- Continuity of midwife, seeing same one throughout process
- Linking with children’s centres, postnatal care, support and groups
- Happy with choices given, not feeling pressured, able to make informed decisions
- Link with perinatal specialist team
- Confidence in ability of midwives, health visitors, consultants and other health professionals
- Overwhelming majority of good birthing experience
- Ease of access and direct contact with midwife if they had any questions. Phone, text, etc.
- Overall, very positive feedback of labour experience, staff, wards at birth units.

**Key themes – not so good:**
- Postnatal ward at hospital – very busy, appeared short staffed, noisy, often left alone for long periods, lack of continuity during staff shift changes
- Fathers not being able to stay overnight, no refreshments or accommodation. Mothers didn’t want to be seen as nuisance and keep
having to ring bell. Felt isolated and scared
• Pressurised to breastfeed, not discussed other options. Then lack of support with breastfeeding until back in community
• Young mums feeling that services aimed towards older Mothers
• Lack of information upon discharge, i.e. breastfeeding, stitch checks, information about care following C-section
• Attitude of hospital staff, particularly during busy periods
• Antenatal parent craft teaching – not consistent, not available to all, i.e. second-time Mums. Lack of support generally for second-time Mums
• No set times for postnatal home visits – often Mothers were only given short notice or even no notice at all
• Lack of understanding from midwives regarding newly introduced vaccinations, i.e. flu/ pertussis
• Keeping records updated; midwives unable to access medical history, parents not understanding terminology, acronyms, etc.
• Midwives refusing to organise an interpreter
• Express and Echo photographer turning up unannounced

• Rigid schedules for showering, toilets, etc while at labour ward.

**Key themes – what could be better:**
• Named midwives and consistency
• Pre-discharge check regarding tongue tie
• Shorter waiting times for tongue tie treatment
• Providing facilities for Fathers to stay overnight following birth
• Listen to Mums and Dads more. Acute hospitals to add more questions to Friends / Family Test
• Wider range of days / times for antenatal / postnatal classes
• Better midwifery / children’s centre links
• “Bosom-buddies” mentoring – support alternative to midwife (peer supporters)
• Open days at maternity units to encourage people who want to help or train as midwives
• More need for emotional support.

**Western Localiry**

**Key themes - what was good**
• There was extremely positive feedback from users who were under the care of the Jubilee Team at Derriford - a specialist team for high risk patients i.e. those who have previously had a still birth, or who are planning a home birth
• Feedback on midwives was that they had all been very helpful and knowledgeable and patients had a lot of confidence in them
• Antenatal classes very good and patients / partners found these very useful
• Breastfeeding advice was very good and patients felt very well supported, both at the hospital and after they returned home
• Very positive feedback regarding the health visitors. Patients felt that they were knowledgeable, easy to talk to and that they didn’t feel rushed when visited
• Excellent aftercare and support for the baby after returning home, but that some mothers felt that they were just passed back to the on-going care of the GP, without all of their needs always being taken in to account.
**Key themes - not so good:**

- Not always able to see the same midwife throughout pregnancy – no consistency
- The midwife appointment systems were inflexible and were only available in the mornings
- Lack of help and support with breastfeeding
- The rotation requirement meant that some midwives were more knowledgeable in one area (either community or on the labour ward) and struggled when working in other areas
- Some mothers hadn’t been tested for diabetes at an early stage and this had caused problems later in the pregnancy
- Antenatal classes were directed more towards hospital births and there wasn’t as much information for home births
- Several Mothers found that the attitude towards partners on the labour ward wasn’t very supportive or welcoming – Mothers felt vulnerable and isolated when their partners had to leave overnight
- Lack of communication following shift changes
- Midwives busy talking and not quick enough to act.

**Key themes – what could be better:**

- Option for midwife appointments to be available during one or two afternoons per week
- Antenatal classes to be available 6.30-8.30pm so partners could attend
- More support for single mothers in antenatal classes
- Partners to be allowed to stay overnight
- Second-time Mums to receive more support even though they had previous knowledge
- Staff to explain what they were doing when undertaking tests / diagnostics, etc.

**Maternity Services Liaison Committees**

Maternity Services Liaison Committees (MSLC) are the main forum for commissioners to meet with service providers and service users. There are CCG MSLCs in NEW Devon, South Devon & Torbay and Kernow (Cornwall) and these groups will be an important contribution to the development of this strategy.

**Social media**

A survey asking the three key questions was made available online with a total of 127 responses. Extensive publicity of this online survey was made by social media channels such as Twitter, Facebook and the NHS NEW Devon CCG Facebook and Twitter account. This was also targeted to specific parent groups such as:
- Mums Net
- NCT Plymouth
- Nice Mums Devon
- Green Mums Devon
- Carousel Project
- North Devon 4 Mums
- Plymouth Dads
- Plymouth Mums
- NCT Exeter and East Devon.

**Key themes – what was good:**

- Confidence in ability of midwives, health visitors, consultants and other health professionals
- Overwhelming majority of good birthing experience
- Continuity – seeing the same midwife
- Regular contact and support during pregnancy from midwives.

**Key themes – not so good**

- Labour units often looked overwhelmed and understaffed. This meant they
could be inflexible, routines were very strict, women often left unattended for long periods of time

- There also appeared to be issues with staff shift changeovers and a lack of handover
- Issues with medical records not being passed on in a timely manner, or even passed on at all, some reported being lost
- Aftercare on the labour ward was not very good, patients left alone for long periods and lack of support to help with starting to breastfeed
- Some second-time Mums reported that they felt like they were getting no time or support from midwives as they should already know everything
- Some women reported feeling that midwives and consultants were not listening to patients concerns during pregnancy and after the baby was born
- Lack of information following caesarean
- Lack of antenatal appointments.

**Key themes – what could be better:**

- More training for health visitors
- More appointments available for midwives during ante-natal period, and more flexible days / times in each area
- Better staffing in labour wards and more midwives
- Better breastfeeding support in the hospital.

**Healthwatch**

Healthwatch Devon also replicated the key questions highlighting the on-line survey on a regular basis and a good response has been received from Devon and Torbay Councils promoting the message.

**South West Family Support**

The South West Family Support kindly shared with us the results of a young parents consultation undertaken in Ilfracombe and Braunton in March 2013.

Following the consultation with pregnant women and young parents in Ilfracombe the following recommendations are proposed for the development of services in the area:

- Explore the possibility of providing one named midwife or support worker to support young parents throughout their pregnancy
- Create an information pack to be distributed by midwives during 12 week appointment containing information about local agencies that offer support to pregnant women and young parents
- Develop a 12 week antenatal programme targeted at younger parents, working alongside local partners listed in the services section below that can equip pregnant women and young parents with knowledge on the following topics: Preparing for birth and beyond, changes in emotional and physical health, relationship advice, money management, housing and benefit advice and communicating with your baby
- Consider further research to explore ways to engage those harder to reach pregnant women that do not attend antenatal classes or young parents groups
- Explore the development of an online social network for pregnant women / young parents to access local support
- Consider ways to improve access to sex education and contraception advice
• Continue to consult with young parents throughout the development of future services.

For a full report contact: Hayley.margieson@actionforchildren.org.uk

Hard to reach vulnerable groups
Engagement was carried out with hard to reach groups. It was agreed with Healthwatch Devon that some focus work with hard to reach and vulnerable groups would be undertaken to ensure that their feedback was collected through this process.

Details of the online survey and information about how to be involved in the engagement process were shared with the following groups:
• Hikmat Devon – for black, minority and ethnic communities
• Devon Grapevine - for black, minority and ethnic communities
• Intercom Trust – for lesbian, gay, bisexual and transgender communities
• Racial Equality Council – for gypsies and travellers
• Devon Youth Services – for young people.

As most of these organisations did not have regular face-to-face parenting groups, we looked at ways in which we could be engaged in the process. For some groups, it involved sharing the details of the online survey for them to cascade through their distribution lists, while for others, it will involve attending groups or meetings as and when they come up.

Hikmat Devon has already completed a number of focus groups with their members around maternity services and will be sharing their findings with us very shortly.

Gypsies and travellers
Feedback for gypsy and traveller groups was reported through the Racial Equality Council at Devon County Council.

The feedback from this group suggested that there was a difficulty for gypsies and travellers to access current appointment systems for midwives. This was because all routine appointments had to be booked with a midwife too far into future and traveller families were not always sure when they would still be around.

“Could a same-day bookable appointment be introduced?”

Feedback from this group also suggested that several patients had received inappropriate comments from midwives around individual circumstances, relating to their status as being a gypsy / traveller.

“Could Diversity training be an action? It was suggested that there should be some information about gypsies and travellers easily accessible to people working in maternity services, particularly midwives going out on visits. In that way they can inform themselves a bit about the background of these communities”.

Some patients found that they had midwives who didn’t want to come to travellers sites for postnatal visits.

Key themes – what was good:
• Generally involvement with the midwives was good with families feeling supported
• Most respondents agreed they were offered enough information
• Enormously impressed by rapid response in an emergency.
Key themes – not so good:

- Nobody was offered an interpreter
- Negative experiences in giving birth included trying to get you to bath / shower too quickly
- Being left alone
- Too fixed schedules
- Attitude of midwife towards travellers.

Key themes – what could be better:

- Same day bookable appointments
- Diversity training
- Information pack about gypsies and travellers for midwifery services
- Greater access to an interpretation service
- There was a common thread of having no choice for showers, toilets, etc. to complaints about routine times

Same sex parents

When the CCG produced the online survey for maternity services, there was a big push through the Intercom (South West Lesbian, Gay, Bi-sexual, Trans-sexual Advocacy Service), Rainbow Families (same-sex parents group) and Proud2Be (LGBT support service) Twitter pages.

Same sex parents were asked to provide their feedback using our online survey and tell us about their experience of maternity services.

It was not known how many same-sex parents completed the survey at this time as it is anonymous and didn’t ask for any personal information. However, it was hoped to do some more targeted work in this group in the future.

Intercom and Proud2Be don’t have specific parent groups at this time, but we would like to do some group work with Rainbow Families soon.

To ensure robust stakeholder involvement we:-

- Listened
- Included everyone’s comments wherever possible
- Rechecked with all of those that contributed to ensure we had interpreted the discussions accurately.
Summary of engagement

- 20 baby groups attended. All children’s centres covered.

- Online survey circulated to Torbay Parent Participation Forum members.

- Three questions asked via MSLC Facebook page.

- Publicised by Healthwatch Torbay and Devon.

- 100+ mums and dads engaged with face to face.

- Online survey posted on social networking sites - Netmums & Nicemums Devon.

- Online survey posted on our website and Twitter.

- Three questions added to the Friends and Family test.

- Online survey advertised in Herald Express.

Gypsy and traveller families

Penny Dane, community development worker for Health Promotion Devon spoke to three mums who had given birth locally in the last two years. Two mums delivered their babies at Torbay Hospital and one delivered at the Royal Devon & Exeter Hospital. All three received community midwifery care from South Devon & Torbay midwives.
## South Devon & Torbay CCG engagement timetable

<table>
<thead>
<tr>
<th>Children centre</th>
<th>Group attended</th>
<th>Who attended</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teign Valley</td>
<td>Baby Club</td>
<td>Scarlett Curtis</td>
<td>14.1.14</td>
</tr>
<tr>
<td>Dartmouth</td>
<td>Child Health Clinic</td>
<td>Scarlett Curtis</td>
<td>15.1.14</td>
</tr>
<tr>
<td>Kingsbridge</td>
<td>Bosom Buddies</td>
<td>Scarlett Curtis</td>
<td>15.1.14</td>
</tr>
<tr>
<td>Paignton</td>
<td>Special Needs Support Group</td>
<td>Scarlett Curtis</td>
<td>16.1.14</td>
</tr>
<tr>
<td>ABC</td>
<td>Early Days &amp; Breastfeeding Support</td>
<td>Jo Curtis</td>
<td>20.1.14</td>
</tr>
<tr>
<td>Teignmouth</td>
<td>Early Days</td>
<td>Scarlett Curtis</td>
<td>21.1.14</td>
</tr>
<tr>
<td>Teignmouth</td>
<td>Young Parents Drop in</td>
<td>Scarlett Curtis</td>
<td>21.1.14</td>
</tr>
<tr>
<td>Moors Edge</td>
<td>Twins &amp; Triplets Drop in</td>
<td>Scarlett Curtis</td>
<td>22.1.14</td>
</tr>
<tr>
<td>Sunshine</td>
<td>Under 5’s Health Clinic</td>
<td>Scarlett Curtis</td>
<td>23.1.14</td>
</tr>
<tr>
<td>Paignton</td>
<td>Dads Club at Parkside</td>
<td>Scarlett Curtis</td>
<td>25.1.14</td>
</tr>
<tr>
<td>Treehouse</td>
<td>Stay &amp; Play</td>
<td>Scarlett Curtis</td>
<td>28.1.14</td>
</tr>
<tr>
<td>Dawlish</td>
<td>Early Days</td>
<td>Scarlett Curtis</td>
<td>28.1.14</td>
</tr>
<tr>
<td>Moors Edge</td>
<td>Baby Group</td>
<td>Jo Curtis</td>
<td>28.1.14</td>
</tr>
<tr>
<td>Torquay</td>
<td>Baby Weighing at Watcombe</td>
<td>Scarlett Curtis</td>
<td>29.1.14</td>
</tr>
<tr>
<td>Totnes</td>
<td>Bumps &amp; Babes</td>
<td>Shona Charlton</td>
<td>31.1.14</td>
</tr>
<tr>
<td>Totnes</td>
<td>Stay &amp; Play at Harbertonford</td>
<td>Jo Curtis</td>
<td>31.1.14</td>
</tr>
<tr>
<td>Brixham</td>
<td>Bambi group at Furzeham</td>
<td>Jo Curtis</td>
<td>31.1.14</td>
</tr>
<tr>
<td>Paignton</td>
<td>Bambi group at Paignton Library</td>
<td>Jo Curtis</td>
<td>17.2.14</td>
</tr>
<tr>
<td>Torquay</td>
<td>Bambi 6+ mths at Echo Centre</td>
<td>Scarlett Curtis</td>
<td>18.2.14</td>
</tr>
<tr>
<td>Torquay</td>
<td>Bambi 0-6 mths at Echo Centre</td>
<td>Scarlett Curtis</td>
<td>18.2.14</td>
</tr>
</tbody>
</table>

### Area covered
Online survey
The online survey was created by NHS NEW Devon CCG and used jointly to circulate the maternity questions to each CCG’s respective areas.

All together there have been 131 responses to the online survey, 37 of which relate to South Devon & Torbay CCG (SDTCCG)

SDTCCG posted the survey on their website and tweeted links to the survey.

The survey was re-tweeted by Nice Mums Devon, Mumsnet, Menstalk, Torbay Family Information Service, Dr Sam Barrell and Keri Ross.

Nice Mums Devon also posted the survey on their Facebook page which spurred a number of responses to the survey.

SDTCCG posted a link to the survey on the website Netmums.

Healthwatch Torbay distributed the online survey via their usual methods and advertised it on their website.

Bob Jope from Torbay Community Development Trust included information and a link to the survey in his column for the Herald Express which was published on the 13 February 2014.

Torbay Parent Participation Forum also published it on their website and circulated it to their members.

Key themes - what was good:
- Excellent midwives who are friendly, informative, supportive and approachable
- Seeing the same midwife.

Key themes – not so good:
- No continuity of care
- Lack of breastfeeding support
- Lack of midwife appointments, they need to be more flexible.

Key themes – what could be better:
- More flexibility around visiting hours for Fathers
- Improve access to midwife appointments, perhaps some appointments available in the evenings.

Face to face

Key themes - what was good:
- Excellent community midwives and labour ward– supportive, helpful, down to earth, very nice, fantastic, brilliant, excellent, caring, in my zone, lovely, amazing, they listen
- The Peri-Natal Mental Health Service is brilliant and offer very good support
- Mums with pregnancy related conditions such as gestational diabetes felt they were monitored well and received good care.

Key themes – not so good:
- Dads not being allowed to stay after the birth if outside of visiting hours
- Mums feeling pressurised to breastfeed, which in some cases has led to them feeling depressed. More reassurance when Mums are doing things right rather than concentrating on the negatives and criticising
- Staff on labour ward were stretched and busy, some Mums felt like they were rushed and simply on a conveyor belt. Some felt antenatal appointments were quite restrictive too.
Key Themes - what could be better:

- More flexibility around visiting hours, especially for Dads straight after the birth. Also talk Dads through procedures so they feel involved
- More positive help and less pressure around breastfeeding. There isn’t enough support around bottle feeding. Antenatal classes need to consider those who cannot breastfeed
- Continuity of care - having the same midwife or at least a midwife from your allocated team to deliver your baby.
4 Best practice for a sure start

Below is a summary of the recommendations of the All Party Parliamentary Sure Start Group:

1. A holistic approach is required to ‘the age of opportunity’ and should be a priority for future delivery. Children’s centres should continue to provide advice, support and services to all families with children under five but with a renewed focus on conception to age two.

2. Local Authorities, Health and Wellbeing Boards and their local partners must make greater use of pooled budgets to allow for more innovative commissioning of perinatal and children’s centre services, taking a more holistic and preventative approach to working with families, particularly in these straitened times.

3. Registration of births should take place in children’s centres – no legislation is required but cross-Government political commitments will be needed to make it happen.

4. The systematic sharing of live birth data and other appropriate information between health and children’s centres must be put in place.

5. All perinatal services should be delivered under one roof with midwifery, health visiting and children’s centre services all being accessed from the children’s centre.

6. Government must put early intervention at the heart of the 2016/18 Comprehensive Spending Review, with a commitment to shifting two to three per cent of spending from late interventions to earlier interventions each year.

7. Jobcentre Plus (JCP) must become a full delivery partner for Sure Start children’s centres with JCP advisers delivering sessions in key centres.

8. Retention of open access play sessions that are a vital component of the children’s centre offer, providing as they do stimulating and safe play environments for babies and children.

9. Children’s centres must continue to play a key role in childcare – either providing it themselves or working with local providers, actively supporting childminders to achieve high quality provision and being hubs of local childcare information for parents. In the future, children’s centres may want to consider becoming childminder agencies, in light of recent proposals in the Children and Families Bill.

10. Children’s centres will be crucial to ensuring that eligible parents take full advantage of the new offer of 15 hours of free childcare for two year olds.

11. All centres should develop a volunteer force.

12. The Department for Education / Cabinet Office should evaluate how children’s centres can develop more comprehensive volunteer programme, based on best practice around the country.

13. Centres (or clusters of centres) should appoint a senior member of staff, preferably an ex-volunteer, as a volunteer coordinator, who can develop an accredited training programme for volunteers; and recruit and support volunteers.

14. Centres should harness the potential of volunteers to undertake outreach to harder to engage communities – making best use of their knowledge.
and credibility within their own community.

15. During ‘stay and play’ and other appropriate sessions centre staff should support and facilitate parents to play with their babies and children in ways that encourage their development – emphasising the benefits of talking to children and affectionate praise.

16. Centres should either provide or promote local singing and story sessions which encourage parents to sing with their babies and children and promote the benefits of reading even to very young children.

17. Ante and postnatal groups in centres should encourage parents to speak to their baby, particularly in affectionate tones, despite the fact that they are not yet able to reply. They should help parents overcome any sense of shyness or embarrassment about doing so, particularly in public.

18. Dads should be encouraged to take up an active role in their baby or child’s life, particularly in communicating with them. Centres should approach Dad as an equal partner in parenting who has a key role to play in supporting their child’s development.

19. The Department for Education should provide advice materials for children’s centres to give to families explaining the benefits of engaging with their babies.

20. All interventions from children’s centres should be evaluated.

21. Children’s centres should undertake an annual review of which interventions work to inform service planning.

22. Children’s centres should “base-line” families’ needs when they first start working with them, in order to enable them to evaluate their impact more effectively.

23. Children’s centres should measure and compare outcomes for the children and families they work with over the longer-term, at least until the point that the child starts school.

24. Local authorities should monitor relative performance of children’s centres in their area, and share information on best practice.

25. Local commissioners and children’s centre providers should monitor emerging evidence from the Big Lottery Better Start programme to inform and develop their practices.
5 The NHS outcomes framework (2013/14)

The indicators in the NHS outcomes framework are grouped around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve.

For each domain, there are a small number of overarching indicators followed by a number of improvement areas for the NHS and additional specific measures for CCG’s, all focused on improving health and reducing health inequalities. Those related to this strategy are:

- **Reducing deaths in babies and young children** (infant mortality, neonatal mortality and stillbirths). Domain 1.6: Preventing people from dying prematurely

- Additional CCG indicators:
  - Antenatal assessment <13 weeks, maternal smoking at delivery, breastfeeding prevalence at six to eight weeks

- **Improving women and their families’ experience of maternity services.** Domain 4.5: ensuring people have a positive experience of care

- **Improving the safety of maternity services** (admission of full-babies to neonatal care). Domain 5.6: Treating and caring for people in a safe environment and protecting them from avoidable harm. No CCG measure at present

- **Early Years High Impact Area 1:** Transition to parenthood and the early weeks

- **Early Years High Impact 2:** Maternal (Perinatal) mental health

- **Early Years High Impact 3:** Breastfeeding (Initiation and Duration).
6 Understanding our population

Numbers of births and projected births
Birth rates in Cornwall & Isles of Scilly, Plymouth and Torbay are expected to remain static over the next seven years, with Devon seeing a gradual decline in numbers towards 2021 (see figure 1).

Figure 1: Projected number of births in the Peninsula

Source: Office of National Statistics
Figure 2 is based on Devon County Council’s intelligence about the numbers of births expected in the county until 2030.

Exeter City Council and North Devon District Council are both expected to see a rise in the number of births 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.
Fertility rates

The demand for maternity services is affected by the number of babies being born to women aged 15-44.

Figure 3 shows the substantial variation in fertility rates across the peninsula.

Rates in Exeter and South Hams are statistically significantly lower than National and South West rates. Rates in Torbay and Mid Devon are above the South West average.
7 Overall birth rate by age

The number of babies born to women age 40 or above rose by 85 per cent between 2001 and 2012 (Royal College of Midwives State of Maternity Service, 2013); this pattern is mirrored locally. For instance in Devon County Council areas there was a doubling in the numbers of babies born to women aged 40 and over between 2001 and 2012 (see figure 1).

Across the South West Peninsula there is substantial variation in teenage conception rates although all areas have seen a steady decrease in rates over the last five years. Rates of teenage conceptions in 2012 in the Peninsula were above the South West average but below the England average.

Torbay and Plymouth both have rates that are higher than the South West and England average (see figure 2).
Teenage pregnancy / older parents

Older mothers place greater demands on maternity services with a greater likelihood of complications from medical conditions such as diabetes, high blood pressure and other chronic diseases and have a greater likelihood of the need for medical intervention.

On the other hand women who give birth in their teens when compared to women in their twenties are more likely to give birth prematurely, and premature births are associated with increased new born health problems including mortality and long term disability.

Figure 2: Teenage pregnancy rates in the South West

Under 18 Conception Rate by South West Local Authority, 2012

- North Somerset: 17.5
- South Glos: 17.6
- Bath and NES: 18.0
- Gloucestershire: 20.9
- Wiltshire: 21.5
- Dorset: 22.1
- Poole: 22.7
- Somerset: 24.4
- Cornwall: 26.1
- Bournemouth: 26.6
- Devon: 27.4
- Swindon: 27.8
- Bristol: 28.5
- Torbay: 39.5
- Plymouth: 39.5

Rate per 1,000 females aged 15-17
# 8 Ethnicity

## Table 1: Percentage of deliveries by ethnicity of mother in Devon, Plymouth, Torbay and Cornwall

<table>
<thead>
<tr>
<th>Ethnicity (2010-2011)</th>
<th>Devon</th>
<th>Plymouth</th>
<th>Torbay</th>
<th>Cornwall</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>90.7</td>
<td>93.1</td>
<td>90.5</td>
<td>94.0</td>
</tr>
<tr>
<td>Asian and Asian British</td>
<td>1.3</td>
<td>1.1</td>
<td>2.1</td>
<td>0.8</td>
</tr>
<tr>
<td>Black and Black British</td>
<td>0.0</td>
<td>0.8</td>
<td>-</td>
<td>0.2</td>
</tr>
<tr>
<td>Chinese or other</td>
<td>0.6</td>
<td>2.9</td>
<td>0.8</td>
<td>0.5</td>
</tr>
<tr>
<td>Mixed</td>
<td>0.5</td>
<td>0.4</td>
<td>0.9</td>
<td>0.6</td>
</tr>
<tr>
<td>Not known</td>
<td>1.2</td>
<td>-</td>
<td>4.8</td>
<td>1.0</td>
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<tr>
<td>Not stated</td>
<td>5.7</td>
<td>1.6</td>
<td>1.0</td>
<td>3.0</td>
</tr>
</tbody>
</table>

**Source:** ChiMat (Hospital Episode Statistics (HES), The NHS ICHSC)
9 The Marmott Review: Fair society, healthy lives

In November 2008 Professor Sir Michael Marmot was asked by the Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010.

These strategies include policies to:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill-health prevention

![The conceptual framework diagram](image)
10 Social deprivation

Socio-economic status is strongly associated with health outcomes for mothers and their babies.

Nationally infant mortality rates are highest for mothers in socio-economic classification groups describing routine and manual occupations (5.7 deaths per 1,000 live births) and lowest for women in higher managerial, administrative and professional occupations (2.2 deaths per 1,000 live births).

Similar patterns can be found for perinatal mortality rates with 9.0 deaths per 1,000 total births in socio-economic groups describing routine and manual occupations compared with a perinatal mortality rate of 5.2 deaths per 1,000 total births to those in higher managerial, administrative and professional occupations (ONS - Office for National Statistics 2012).

Deprivation varies across local authority areas in the South West peninsula. Torbay and Plymouth have above the national average levels of urban deprivation. All rural areas of the peninsula with the exception of East Devon and Teignbridge have above the national average score for rural deprivation, which is associated with issues of social isolation, a low wage economy, high housing and living costs and greater distance to travel to services.

Figure 1: Index of multiple deprivation (IMD) scores in Devon by District and level of rurality

![Graph showing Index of Multiple Deprivation Average Score in Devon by District and Rurality](image)

NB: Higher scores indicate greater deprivation

Figure 2: Multiple deprivation
The tables below identify the top 10 most deprived wards in NHS NEW Devon CCG and the top most deprived wards in each of the localities (and provide the average IMD score for each ward identified).

St. Peter and the Waterfront is the most deprived ward in NHS NEW Devon CCG. This ward is ranked 267 out of 7,589 wards nationally for deprivation. The most deprived wards in the CCG are included in the most deprived decile for wards nationally. In rank order, they are:

- St. Peter and the Waterfront
- Ilfracombe Central
- Tormohun
- Round-with-Hye
- Devonport

Within NHS NEW Devon CCG, nearly half of the top 10 most deprived wards are found in the Western and South Devon & Torbay localities.

<table>
<thead>
<tr>
<th>2010 electoral ward</th>
<th>score</th>
<th>Locality</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Peter and Waterfront</td>
<td>45.12</td>
<td>Plymouth</td>
</tr>
<tr>
<td>Ilfracombe Central</td>
<td>45.01</td>
<td>N. Devon</td>
</tr>
<tr>
<td>Tormohun</td>
<td>44.65</td>
<td>Torbay</td>
</tr>
<tr>
<td>Roundham-with-Hyde</td>
<td>43.99</td>
<td>Torbay</td>
</tr>
<tr>
<td>Devonport</td>
<td>42.66</td>
<td>Plymouth</td>
</tr>
<tr>
<td>Ham</td>
<td>39.21</td>
<td>Plymouth</td>
</tr>
<tr>
<td>Ellacombe</td>
<td>38.03</td>
<td>Torbay</td>
</tr>
<tr>
<td>Honicknowle</td>
<td>37.53</td>
<td>Plymouth</td>
</tr>
<tr>
<td>Central Town</td>
<td>36.54</td>
<td>N.Devon</td>
</tr>
<tr>
<td>Watcombe</td>
<td>36.15</td>
<td>Torbay</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ilfracombe Central</td>
<td>45.01</td>
</tr>
<tr>
<td>Central Town</td>
<td>36.54</td>
</tr>
<tr>
<td>Forches &amp; Whiddon Valley</td>
<td>28.69</td>
</tr>
<tr>
<td>Bideford East</td>
<td>26.37</td>
</tr>
<tr>
<td>Yeo Valley</td>
<td>26.15</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priory</td>
<td>34.45</td>
</tr>
<tr>
<td>St David’s</td>
<td>31.76</td>
</tr>
<tr>
<td>Newtown</td>
<td>27.31</td>
</tr>
<tr>
<td>Whipton &amp; Barton</td>
<td>27.24</td>
</tr>
<tr>
<td>Mincinglake</td>
<td>26.56</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Peter and Waterfront</td>
<td>45.12</td>
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<td>Ham</td>
<td>39.21</td>
</tr>
<tr>
<td>Honicknowle</td>
<td>37.53</td>
</tr>
</tbody>
</table>
South Devon & Torbay CCG

South Devon & Torbay CCG has four of the top 10 most deprived electoral wards in Devon:

Table 1

<table>
<thead>
<tr>
<th>Name</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tormohun</td>
<td>44.65</td>
</tr>
<tr>
<td>Roundham-with-Hyde</td>
<td>43.99</td>
</tr>
<tr>
<td>Ellacombe</td>
<td>38.03</td>
</tr>
<tr>
<td>Watcombe</td>
<td>36.15</td>
</tr>
</tbody>
</table>

By locality their demographic overview average deprivation score is:

Table 2

<table>
<thead>
<tr>
<th>Locality</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Torquay</td>
<td>29.2</td>
</tr>
<tr>
<td>Paignton &amp; Brixham</td>
<td>23.9</td>
</tr>
<tr>
<td>Coastal</td>
<td>19.3</td>
</tr>
<tr>
<td>Newton Abbot</td>
<td>16.2</td>
</tr>
<tr>
<td>Moor to Sea</td>
<td>16.1</td>
</tr>
<tr>
<td>CCG average</td>
<td>21.8</td>
</tr>
<tr>
<td>England average</td>
<td>21.5</td>
</tr>
</tbody>
</table>
11 Maternal obesity

*NICE Guideline 27 (2010)* 'Weight management before, during and after pregnancy' makes six recommendations to minimise the risks to women and their babies associated with overweight and obesity. These relate to:

- preparing for pregnancy in women with a Body Mass Index (BMI) of 30 or more
- supporting women during pregnancy
- supporting women after childbirth
- women with a BMI of 30 or more after childbirth
- community-based services
- professional skills.

We propose to audit local compliance with these recommendations.

Table 1 shows us that the completeness of this data is poor and not sufficient for drawing correlations.

Collecting data on the BMI of women at booking is very important in order to establish what proportion of women may need further support during pregnancy.

It will also support commissioners in understanding the scale of the work that needs to be done to reduce the number of women who begin their pregnancy overweight and to track the effectiveness of interventions to address this issue.

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Under 18</th>
<th>18.5-25</th>
<th>26-30</th>
<th>31-35</th>
<th>Over 35</th>
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<td>East Devon</td>
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<td>55.0%</td>
<td>16.8%</td>
<td>6.1%</td>
<td>7.7%</td>
<td>11.7%</td>
</tr>
<tr>
<td>Exeter</td>
<td>3.2%</td>
<td>51.3%</td>
<td>18.2%</td>
<td>6.8%</td>
<td>6.9%</td>
<td>13.6%</td>
</tr>
<tr>
<td>Mid Devon</td>
<td>3.4%</td>
<td>49.7%</td>
<td>19.9%</td>
<td>8.7%</td>
<td>7.9%</td>
<td>10.3%</td>
</tr>
<tr>
<td>North Devon</td>
<td>1.8%</td>
<td>49.5%</td>
<td>18.6%</td>
<td>8.8%</td>
<td>5.5%</td>
<td>15.7%</td>
</tr>
<tr>
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<td>2.8%</td>
<td>51.7%</td>
<td>22.9%</td>
<td>11.2%</td>
<td>7.0%</td>
<td>4.4%</td>
</tr>
<tr>
<td>S.Devon &amp; Torbay</td>
<td>3.3%</td>
<td>54.7%</td>
<td>22.0%</td>
<td>-</td>
<td>7.0%</td>
<td>13.0%</td>
</tr>
<tr>
<td>Torridge</td>
<td>3.0%</td>
<td>50.0%</td>
<td>20.0%</td>
<td>11.1%</td>
<td>6.5%</td>
<td>9.4%</td>
</tr>
<tr>
<td>West Devon</td>
<td>2.5%</td>
<td>53.6%</td>
<td>19.5%</td>
<td>7.5%</td>
<td>7.5%</td>
<td>9.4%</td>
</tr>
</tbody>
</table>
12 Smoking in pregnancy

Smoking in pregnancy causes an increased risk of stillbirth (Royal College of Physicians 1992). Table 1 (below) shows that in Plymouth, Torbay and Devon those women who were smoking at delivery were more than twice as likely to have a still birth than women who were not smoking. Birth weight of babies is also affected by smoking during pregnancy.

Table 1 shows that 12 per cent of women who were smoking at delivery had a low birth rate baby (under 2500 grams) compared to only 6.2 per cent of women who were not smoking at delivery.
Figure 1: Smoking at delivery

Trend in Smoking at Time of Delivery
Source: Health and Social Care Information Centre
Figure 2: IMD and smoking at delivery

% of Mothers Smoking at Delivery in Devon by Index of Multiple Deprivation Quintile (2011-12 births)
13 NICE smoking recommendations

Background
Helping pregnant women who smoke to quit involves communicating in a sensitive, client-centered manner, particularly as some pregnant women find it difficult to say that they smoke.

Such an approach is important to reduce the likelihood that some of them may miss out on the opportunity to get help.

The NICE recommendations refer to NHS Stop Smoking Services and also apply to other, non-NHS services that offer help to quit and operate to the same standard.

NHS Stop Smoking Services are local services funded by the Department of Health to provide accessible, evidence-based and cost-effective support to people who want to stop smoking.

The professionals involved may include midwives who have been specially trained to help pregnant women who smoke to quit.

Effective interventions
The recommendations mainly cover interventions to help pregnant women who smoke to quit. These are listed at the beginning of recommendations 4 and 5.

Interventions for partners are covered in recommendation 7.

No specific recommendations have been made for those planning a pregnancy or who have recently given birth. This is due to the lack of evidence available on stop-smoking interventions for these groups.

It does not constitute a judgement on whether or not such interventions are effective or cost effective.

Whose health will benefit?
These recommendations should benefit women who smoke and who:

- are planning a pregnancy
- are already pregnant
- have an infant aged under 12 months.

They should also benefit the unborn child of a woman who smokes, any infants and children she may have, her partner and others in her household who smoke.
Recommendation 1
Identifying pregnant women who smoke and referring them to NHS Stop Smoking Services – action for midwives.

Recommendation 2
Identifying pregnant women who smoke and referring them to NHS Stop Smoking Services – action for others in the public, community and voluntary sectors.

Recommendation 3
NHS Stop Smoking Services – contacting referrals.

Recommendation 4
NHS Stop Smoking Services – initial and ongoing support.

Recommendation 5
Use of Nicotine Replacement Therapy and other pharmacological support.

Recommendation 6
NHS Stop Smoking Services – meeting the needs of disadvantaged pregnant women who smoke.

Recommendation 7
Partners and others in the household who smoke.

Recommendation 8
Training to deliver interventions.
Domestic abuse

NICE Guidance 2014 (PH50) recommends:

- Information in waiting areas and other suitable places about the support on offer for those affected by domestic violence and abuse should be clearly displayed. This includes contact details of relevant local and national helplines. It could also include information for groups who may find it more difficult to disclose that they are experiencing violence and abuse.

- Frontline staff in all services should be trained to recognise the indicators of domestic violence and abuse and ask relevant questions to help people disclose their past or current experiences of such violence or abuse. The enquiry should be made in private on a one-to-one basis in an environment where the person feels safe, and in a kind, sensitive manner.

- People’s safety should be prioritised and regularly assessed to determine what type of service someone needs - immediately and in the longer term.

- Those responsible for safeguarding children, and commissioners and providers of specialist services for children and young people affected by domestic violence and abuse should address the emotional, psychological and physical harms arising, as well as their safety. This includes the wider educational, behavioural and social effects.

Specific training should be provided for health and social care professionals in how to respond to domestic violence and abuse.

To provide the right response staff must be able to identify, risk assess and refer to specialist services to ensure a coordinated response to risk and needs of women and their children.

In Cornwall, the estimated prevalence of domestic abuse experienced by women during pregnancy is 319 per year which is significantly higher than the number of women being identified (2012/13 - only 39 referrals assessed as standard, medium or high risk were received from Midwifery).

During 2012/13, there were 39 women assessed at high risk and discussed at the Multi Agency Risk Assessment Conference (MARAC) during their pregnancy.

High Risk is defined as ‘A risk which is life threatening and/or traumatic, and from which recovery whether physical or psychological can be expected to be difficult or impossible’.

Female genital mutilation (FGM)

The Female Genital Mutilation Act 2003 made it illegal for UK residents (in England and Wales) and permanent residents to practice FGM within or outside the UK (there is different legislation for Scotland).

The act also made it illegal for someone to take a British Citizen aboard to perform the operation whether or not it is against the law in that country. It is also illegal to assist in carrying out FGM abroad.

FGM constitutes child abuse and 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.

The UK Government’s Every Child Matters: Change for Children Program, which includes the Children’s NSF7 and is supported by the Children Act 2004, requires all agencies to take responsibility for safeguarding and promoting the welfare of every child.
15 Infant feeding

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 and Isles of Scilly have higher rates of breastfeeding initiation than the Peninsula average as well as the England and South West average.
Figure 2: Breastfeeding initiation rates by Local or Unitary Authority

% of Mothers Initiating Breastfeeding by Local or Unitary Authority
(Births in 2011-12)

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plymouth</td>
<td>70%</td>
</tr>
<tr>
<td>Torbay</td>
<td>70%</td>
</tr>
<tr>
<td>East Devon</td>
<td>70%</td>
</tr>
<tr>
<td>Exeter</td>
<td>70%</td>
</tr>
<tr>
<td>Mid Devon</td>
<td>70%</td>
</tr>
<tr>
<td>North Devon</td>
<td>70%</td>
</tr>
<tr>
<td>South Hams</td>
<td>80%</td>
</tr>
<tr>
<td>Teignbridge</td>
<td>80%</td>
</tr>
<tr>
<td>Torridge</td>
<td>80%</td>
</tr>
<tr>
<td>West Devon</td>
<td>80%</td>
</tr>
</tbody>
</table>
Perinatal and infant mortality and maternal mortality

Perinatal and infant mortality
Higher rates of perinatal and infant mortality are associated with deprivation and this pattern is borne out locally.

Between 2010 and 2012 North Devon and Plymouth had statistically significantly higher rates of perinatal mortality (babies that are stillborn or die with seven days of birth) when compared with national and South West rates (see figure 1).

Rates of infant mortality vary between districts and other than Cornwall which has a higher rate than the South West average, all other areas show no statistically significant difference to rates in England and the South West (see figure 2 on page 44).

High rates of deprivation are associated with higher rates of smoking, alcohol and drug use which all contribute to preterm birth and low birth weight which in turn are the leading causes of death in children.

Maternal mortality
The death of a mother from pregnancy related causes is a very rare event in the UK. Maternal mortality is defined as the death of a woman aged 15-44 while pregnant or within 42 days of the end of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

Figure 1: Perinatal mortality

Maternal mortality is defined as the death of a woman aged 15-44 while pregnant or within 42 days of the end of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.
Figure 2: Infant mortality

Infant Mortality - Mortality in Infancy Within 1 Year of Birth
2010-2012 Source: Health and Social Care Information Centre

- Red line: England
- Green line: South West
The great expectations programme

This is a parenthood course available in Plymouth and also in Cornwall and Isles of Scilly.

The core syllabus provides information on the key learning outcomes for the parent education programme ensuring consistent messages are delivered to parents and a consistently high standard is promoted.

Participants can expect to learn more about:

- Positive lifestyle choices
- How to connect and communicate with their baby before and after birth
- Developing a closing and loving relationship with their baby
- Understanding and responding to their baby’s needs
- Overcoming challenges
- Strategies for managing time
- Changes in relationships
- Making new friends and finding support when needed.
What is an HRG?
Healthcare resource groups (HRGs) are a unit of measurement and a unit of payment for inpatient care. The commissioner pays for each patient spell using HRGs, where a spell is the period from admission to discharge at a provider hospital.

Patients are allocated into HRGs based on similar diagnoses and/or undergoing similar procedures using similar amounts of resource. When a hospital treats a patient, their diagnosis and treatments are recorded and put onto the system, known as clinical coding. This information determines to which HRG the patient is assigned.
19 Low birth rate babies

Nationally the proportion of babies that are born with a low birth weight (<2500 grams) is strongly correlated with deprivation; the higher the level of deprivation in an area, the higher the proportion of babies with a low birth weight.

Low birth weight is also associated nationally with higher levels of perinatal and infant mortality.

There are statistically significantly higher rates of low birth weight babies in Plymouth, West Devon and Torridge compared with the South West, although nowhere in the Peninsula has statistically significant rates compared to the England average, see figure 1.