Strategy for the Delivery of Maternity Services in North East Essex
2011 – 2014
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<tr>
<th>Title:</th>
<th>Strategy for the delivery of Maternity Services in North East Essex</th>
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<tbody>
<tr>
<td>Published by:</td>
<td>NHS North East Essex</td>
</tr>
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</tr>
<tr>
<td>Publication Date:</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; November 2011</td>
</tr>
<tr>
<td>Description:</td>
<td>The document sets out a framework for the future configuration and delivery of maternity services for the population of North East Essex.</td>
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<tr>
<td>Lifetime:</td>
<td>2011 - 2014</td>
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Executive summary

This Maternity Services Strategy strives to ensure modern, responsive NHS maternity services are available within North East Essex that are centred on the needs of women and their families.

The overarching aim for driving forward maternity services in North East Essex is to continue to improve the quality of the service, concentrating on safety and working towards better outcomes and satisfaction for all women and their babies. Services need to be delivered in an appropriate setting by skilled maternity professionals with the required level of experience and training. All women should have an appropriate choice of place and type of birth according to their individual needs and wishes.

The Strategy will 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 poorer outcomes.

Some of the key outcomes to be achieved for maternity services through this Strategy are:-

1. To enhance the maternity experience by ensuring mothers, babies and their families receive the best quality care in the most appropriate setting for their needs
2. To adopt the underpinning principle that pregnancy and childbirth are normal life events and actively promote health and wellbeing
3. To ensure all mothers are offered an informed choice for location of antenatal, delivery and postnatal care
4. To ensure all mothers have equitable and early access both to antenatal services and more specialist services where necessary with an emphasis on those families with the greatest social needs
5. To provide continuity of care through the building of relationships with women to understand and meet their needs and those of their partners throughout pregnancy and afterwards and to strive to achieve one-to-one midwifery care in established labour
1.0 Introduction

This Strategy has been developed to facilitate the commissioning and provision of excellent maternity care that is comprehensive, inclusive, flexible and responsive to the clinical and social needs of women and their families.

For the majority of women, pregnancy and childbirth is a normal and uncomplicated experience but the service must also be able to provide for women who need more specialist care as a result of health and social care issues. Safe and high quality standards for maternity care must be adhered to (Safer Childbirth, 2007; Standards for Maternity Care, 2008). Maternity care should also have a ‘choice guarantee’ for women and their partners (Maternity Matters 2007).

2.0 Overarching Aim

The underpinning principle will be that pregnancy and childbirth are normal life events. The main priority is to provide accessible, safe, high quality care for all new parents and their babies within North East Essex. Within this framework all women will have the services of a midwife but some may need medical advice too.

Although some women will need to have access to high quality specialist services such as obstetric-led delivery and specialist neonatal care, this Strategy sets an alternative direction of travel for the commissioning and provision of maternity services towards one that starts with the premise that pregnancy is a normal physiological event. Maternity services will therefore be planned and delivered as community based services, integrated with primary care and embedded in the wider community provision, with a focus on health and wellbeing.

This Strategy provides the catalyst for further development of clear guidelines for the management of women who experience variations from the norm which may otherwise lead to an increased prevalence of caesarean sections and instrumental deliveries.

Care will be based on an ongoing assessment of social, as well as clinical risk, with targeted outreach support for the most vulnerable women. Midwives will be the lead professional, with enhanced public health skills and an infrastructure which includes a support workforce, working within clear pathways, to provide women with a network of social and clinical support. This will result in improved satisfaction, stronger engagement with self care support systems and fewer health professional interventions.

When pregnancy is known, women and their partners have direct access to a midwife or to their General Practitioner. Self-referral into the local midwifery service is a choice that will facilitate earlier access to maternity services.

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1 RCOG, RCM, RCA, RCPCH (October 2007) Safer Childbirth; Minimum Standards for the Organisation and Delivery of Care in Labour; Published by the RCOG Press
2 RCOG (June 2008) Standards for Maternity Care; Published by the RCOG Press
3 DH (April 2007) Maternity Matters: choice, access and continuity of care in a safe service; DH Publications
3.0 **Expected Outcomes**

- Provision of informed choice around the type of care received available
- Enhanced access to services whilst ensuring continuity of care and support
- Better management and reduction of clinical risk through the application/adherence to national clinical guidelines, public health principles and standards of care
- Pregnancy and birth as safe and satisfying as possible for both mother and baby whilst supporting new parents to have a confident start to family life
- An improvement in the quality of service, safety, and satisfaction for all women and their partners
- Minimisation of health risks associated with less than optimal lifestyle choices such as alcohol misuse, poor diet and nutrition and smoking during pregnancy

4.0 **Scope**

This Strategy covers all aspects of maternity care (excluding IVF and neonatal services as these areas fall outside the direct remit of Maternity Services) from preconception to postnatal care. The Strategy covers a 3-year period.

5.0 **National Policy**

The national policy context on the improvement and development of maternity services is detailed in Towards Better Births (2008)\(^4\), Maternity Matters (2007)\(^5\), Midwifery 2020 (2010)\(^6\), NICE guidelines (2008)\(^7\) and the NSF for Children, Young People and Maternity Services (2004)\(^8\) and Choosing Health (DH, 2004)\(^9\). The Joint Planning and Commissioning Framework for Children, Young People and Maternity Services (2006)\(^10\) 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)\(^11\) sets out a vision of an individualised maternity service comparable with other maternity policies with a focus on access, choice and information.

Parents who are fit and healthy at the start of pregnancy generally have healthier babies, however half of pregnancies are unplanned and some women delay seeking advice even when they know they are pregnant.\(^12\)

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\(^4\) HCC (July 2008) Towards better births; A review of maternity services in England; Commission for Healthcare Audit and Inspection

\(^5\) DH (April 2007) Maternity matters: choice, access and continuity of care in a safe service; DH Publications

\(^6\) Midwifery 2020 Programme (September 2010) Midwifery 2020; Delivering expectations

\(^7\) NICE (June 2008) Antenatal care; routine care for the healthy pregnant woman; revised reprint June 2008 & further revised reprint June 2009; RCOG Press

\(^8\) DH (September 2004) National service framework for children, young people and maternity services; DH Publications


\(^10\) DFES & Department of Health (March 2006) Joint Planning and Commissioning Framework for Children, Young People and Maternity Services; Department for Education and Skills and Department of Health

\(^11\) DH (2006) Our Health, Our Care, Our Say; DH Publications

\(^12\) DH (2004) National Service Framework for Children, Young People and Maternity Services; DH Publications
In 2005, the government underlined the importance of providing high quality, safe and accessible maternity care through its commitment to offer all women and their partners a wider choice of type and place of maternity care and birth. Building on this commitment four national choice guarantees were made available to all women by the end of 2009, and women and their partners now have opportunities to make well informed decisions about their care throughout pregnancy, birth and the postnatal period. The national choice guarantees within Maternity Matters (2007)\textsuperscript{13} are:

1. Choice of how to access maternity care (direct booking with midwife or via GP)
2. Choice of type of antenatal care
3. Choice of place of birth: depending on their circumstances, women and their partners will be able to choose between 3 different options:
   - Home birth
   - Birth in a local facility under the care of the midwife
   - Birth in consultant led unit (a birth in a hospital supported by a local maternity team including midwives, anaesthetists and consultant obstetricians. For some women this will be the safest option).
4. Choice of place of postnatal care

\textsuperscript{13} DH (April 2007) Maternity matters: choice, access and continuity of care in a safe service; DH Publications
6.0 Choice

Choices must be offered within safe parameters. Assessment of need and flexible services that are aligned and responsive to individual needs are the key building blocks for the development of future maternity services.

There is evidence to suggest that women who receive regular care from a known midwife during their antenatal period are more likely to choose a non-obstetric setting for birth. There are many contributory factors to making such a decision however, including the continuous care of a professional who supports and understands the physiology of normal birth.

There is a wealth of evidence highlighting the significant contribution that midwives can make to maternal and infant health. The interaction between midwives and pregnant women can greatly benefit the latter including the promotion of antenatal care.

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14 Adapted from: DH (April 2007) Maternity Matters: Choice, access and continuity of care in a safe service; DH Publications
16 Midwifery 2020 Programme (September 2010) Midwifery 2020; Delivering expectations
screening, promoting healthier lifestyle choices and promoting breastfeeding.

Midwives are the primary providers of maternity care in the UK. The Cochrane Review\textsuperscript{17} was undertaken to establish whether there are differences in morbidity and mortality, effectiveness and psychosocial outcomes between midwife-led and other models of care. The main results (11 trials/ 12,276 women) indicated that women having midwife-led models of care were less likely to experience antenatal hospitalisation, episiotomy and instrumental delivery.

Proximity to maternity services is also a key consideration for all women, especially for those with a complex pregnancy or social disadvantages, in order to avoid costly and excessive travelling. Regardless of the care setting, the distance travelled for women from their locality (work, home etc.) is an important factor especially where it becomes too onerous to travel. If women are located close to their provider it has the additional benefit of enabling continuity of care/carer before and after birth.

7.0 Local Policy

NHS East of England, through their vision Towards the Best Together (2008)\textsuperscript{18} developed pledges to deliver a better experience for patients, improve health and reduce health inequalities. A range of regional initiatives are supporting the achievement of these pledges. The initiatives for maternity and newborn are to:-

- Ensure all 17 acute trusts retain an obstetric unit with a co-located midwife led unit
- Work towards one-to-one midwifery care in established labour by recruiting at least 160 additional midwives
- Maximise care for all ill babies by increasing level 3 intensive care cots, increasing the number of level 1 special care units and reducing the number of level 2 dependency units
- Offer preconception care and advice to women with pre-existing health problems and lifestyle issues
- Guarantee women direct access to midwives and choice of antenatal care
- Promote normality of birth and guarantee choice on where to give birth, based on assessment of safety of mother and baby
- Guarantee choice of postnatal care to women especially those most in need
- Establish networks covering maternity and neonatal services

\textsuperscript{18} NHS East of England (March 2009) Towards the Best, Together
NHS North East Essex (NHS NEE) pledges that by 2014 through partnership working we will ensure:-

- Every woman has the choice of how to access maternity services; this includes self referral to the local midwifery services or accessing this through their GP
- Every woman has a choice of type of antenatal care; this includes early contact with women by midwives or an obstetrician to ensure they offer a convenient first pregnancy appointment before the 12th complete week of pregnancy
- The choice of place of birth, depending upon their circumstances; women and their partners will be able to choose between three different options. These are home birth, birth in a local midwife-led facility or a hospital birth with on-site specialist support
- The choice of place of postnatal care including home or community settings
- Every woman will be supported by a midwife she knows and trusts throughout her pregnancy and after birth
- One-to-one midwifery care in established labour
- Continued promotion of normality:
  - Reduction in caesarean section rates
  - Explore the future usage of Harwich and Clacton midwife-led units as part of a revised model of service delivery. This will form part of a public consultation for future service reconfiguration to be undertaken in late 2011/early 2012 (see Paragraph 10.0)

- Utilisation of the Birthrate Plus (BR+)\(^\text{19}\) evidence-based workforce planning tool to provide and inform on the required midwifery workforce for the defined population of Colchester and Tendring
- Reduction in the level of pregnant women who smoke during pregnancy
- Increased rate of breastfeeding initiation as well as the sustenance of breastfeeding to between 3-6 months

\(^\text{19}\) http://www.birthrateplus.co.uk/
8.0 Current Service Provision

8.1 Demographics

NHS NEE is made up of Colchester Borough Council and Tendring District Councils with a scattered distribution of urban and rural communities. The maternity service within North East Essex also provides care to pregnant women who live in the surrounding areas which include Colne Valley/Halstead.

8.2 Socio-Economic Status

The Index of Multiple Deprivation (IMD) is the main indicator of deprivation at a small area level and comprises seven domains denoting social or material deprivation which are combined into one index. The analysis is at lower super output area (LSOA). These areas contain typically 1000-1500 people. This allows pockets of deprivation to be seen that would otherwise be masked at a higher geography.

Figure 2: Deprivation in NE Essex, IMD 2007

According to the IMD 2007, of the 354 local authorities, Colchester is ranked at 224 and Tendring at 103 of the most deprived. Tendring includes an LSOA that is ranked 3rd most deprived in the country and also has further LSOAs that are in the 10% most deprived nationally.

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20 Digital Mapping Solutions from Dotted Eyes. © Crown Copyright 2008. All rights reserved. Licence number 100019918
9.0 Current Service Model

Maternity services are available to all women within the NHS NEE boundaries. The geographic area totals 620 square miles. Colchester provides a base for the Army Garrison, while Clacton is a busy tourist centre and Harwich is a working port.

Overall, the number of women of child-bearing age across North East Essex is increasing. The size of the North East Essex female population aged 15-44 years is predicted to increase by 16% for 2008, rising to 73,300 in 2020. In North East Essex, between 2001 and 2007, the number of live births occurring to resident women increased by 20%. In 2009/10 there were 3,521 births in North East Essex. Birth rate for the whole service provided by Colchester Hospital University Foundation Trust (CHUFT) including parts of Mid Essex was 4,052.

**Figure 3: Number of Births by Mother’s Residence**

CHUFT has a busy maternity service providing care to over 4,000 women per year. It serves a diverse and growing population through community and hospital based services, taking pride in promoting midwifery by delivering holistic women-centred care.

The teams work flexibly to deliver a choice of care models which include midwife-led care at Clacton, Harwich and Halstead, Midwifery Group Practices (Valley and Iceni) and traditional models of care for high/low risk women across the District.

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21 Digital Mapping Solutions from Dotted Eyes. © Crown Copyright 2008. All rights reserved. Licence number 100019918
There are midwives specialising in normality, teenage pregnancy, diabetes, child protection, parent education, risk management, antenatal screening, infant feeding, smoking cessation, practice development and education. This supports achievements in meeting with national and local initiatives with care taken to ensure that this is not to the detriment of maintaining continuity of care.

Maternity services are currently provided across North East Essex from 4 sites:-

1/ Colchester Hospital Consultant-Led Unit

This Unit is used primarily for women with complications identified in their previous medical history, previous birth experiences or their current pregnancy or labour. It is located within the main hospital setting.

Obstetricians, paediatricians and anaesthetists are available 24 hours a day and operating theatres are also available for caesarean sections to be undertaken as required.

2/ Colchester Hospital Co-located Midwife-Led Birthing Unit (Juno Suite)

Midwife-led Birthing Units (MLBUs) are staffed and led by midwives and are designed for women experiencing “low risk” pregnancies. They may be “co-located” or “stand alone”.

The Juno Suite is a co-located MLBU which is located alongside the consultant-led unit and contains 4 additional delivery rooms, one of which contains a birthing pool. The Juno Suite is open 24 hours a day, 7 days a week.

If unforeseen or complicated circumstances necessitate and there is a change in risk status, there is direct and instant access to the co-located maternity services and consultant-led unit within the hospital setting.

3/ Clacton Hospital and Harwich Fryatt Hospital Midwife-led Stand Alone Birthing Units

There are 2 stand alone MLBUs located at Clacton and Harwich and staffed by midwives 24 hours a day, 7 days a week.

As with the Juno Suite, they are designed for women experiencing “low risk” pregnancies although midwives do see high and low risk women in the antenatal period at these Units. They offer a safe environment in which to labour and give birth but in the case of any change in risk status women will be transferred to the consultant-led unit at Colchester by ambulance.

The stand alone MLBUs at Clacton and Harwich also offer antenatal care and parent education provision and there is the facility for short-stay postnatal care if required.
4/ Halstead Birthing Centre

A birthing centre has the same facilities as a MLBU but has no inpatient stay facilities.

At the Halstead Birthing Centre women will be admitted once in labour and will go home when comfortable after the baby’s birth, usually a few hours post delivery whereupon the centre will close. Halstead Birthing Centre is staffed by the Valley Team of midwives.

In the case of any concerns women will be transferred to the Consultant-led unit by ambulance.

Antenatal and postnatal care is carried out in a location other than the Birthing centre.

5/ Home Births

In addition to the above there is also the provision for home births.

A planned home birth is a safe option for women with low risk pregnancies. A midwife will help in preparation for the birth and two midwives will attend the birth in the woman’s home to assist with labour and delivery. A birthing pool can be hired or bought for use at home.

In the case of any concerns during labour or birth, the woman will be transferred to the local consultant-led unit by ambulance (as with the midwife-led stand alone birthing units and the birthing centre).

10.0 Proposed Service Model

Maternity services will continue to provide responsive care to meet the diverse needs of all women and families based upon the philosophy that childbirth is a normal life event rather than an isolated clinical episode, meeting the woman’s psychosocial as well as their physiological needs.

Services will be delivered flexibly and as far as possible in a community setting with sensitivity to individual needs and being responsive to cultural differences. Effective involvement and referral mechanisms are essential therefore to ensure a networked approach between service providers.

National guidance and evidence-based practice will be utilised (NSF Standard 11\(^2\), Maternity Matters\(^3\)) and the CNST Clinical Risk Management Standards for Maternity Care\(^4\). There will also be systems in place to ensure the regular review and monitoring of the service. This will include feedback and action plans resulting from extensive

\(^3\) DH (April 2007) Maternity matters: choice, access and continuity of care in a safe service; DH Publications
\(^4\) NHS LA (March 2010) Clinical Negligence Scheme for Trusts; Maternity; Clinical Risk Management Standards; Version 1; 2010/11
women and partner satisfaction surveys, ensuring that women and their partners are informed and can contribute to service planning, implementation, review, evaluation and development.

There are systems in place which will continue to further strengthen the opportunities for continuing professional development for staff, access to statutory supervision and the comprehensive management of new and existing staff, incorporating strategies for risk management, education and training.

Maternity services will continue to support the public health agenda to improve the health of the population through effective and consistent health promotion and education.

Although maternity services are available to all women within the North East Essex district boundaries, there have been concerns about the sustainability of the 24/7 MLBUs located at Clacton and Harwich because of the low numbers of deliveries taking place there. In Quarter 1 of 2011/12, as a percentage of the total births that took place during this period for CHUFT, Clacton MLBU had 6.56%, Harwich MLBU 4.41% and the Juno Suite had 12.9%.

The birth rate continues to rise bringing more women into Colchester to deliver but there has only been a small increase in the use of the stand-alone MLBUs.

Through formal consultation, NHS NEE is proposing changes to the current configuration of maternity services in Colchester. This will facilitate the development of the existing service and deliver an improved service for women and their families that is sustainable financially and allows additional investment in maternity staff to address the increasing birth rate.

The proposed consultation covers the options for a future model for provision of maternity services for CHUFT. The achievement of an affordable clinically safe maternity service for local people is a joint objective for both CHUFT as the provider and NHS NEE (the PCT) as the main commissioner of maternity services.
11.0 Pre-conception Services

In order to optimise maternal health prior to conception, women will have the opportunity to access specialist preconception services. The overall objective is to increase the awareness of healthy behaviours that benefit the infant, the mother, women in general, their families, the community as a whole and thereby the whole health economy.

The long term effects of the early intrauterine environment are now well accepted (Barker Hypothesis)\(^{25}\) and therefore pre-pregnancy care provides women and healthcare professionals with a unique opportunity to impact on maternal health and long-term child health.

Pre-pregnancy education includes information on improving general health, weight and nutrition before conception and in the early part of pregnancy and may be delivered by GP practices, pharmacists and other primary healthcare professionals. There must be emphasis on the importance of healthy lifestyles and risk assessment through early screening to ensure that potential problems are identified well in advance of the pregnancy and are minimised.

Planned preconception care should incorporate:-

- Current personal health and immunity (to minimise the risk of acquiring any infection during pregnancy)
- Dental health - there is some evidence that having health teeth and gums help women to have a healthy baby\(^{25}\)
- Family health - to identify any inherited illnesses in the woman's family or in the family of the intended father of the baby
- Lifestyle - toxins can affect pregnancy and are common in industries where women traditionally work such as organic solvents, pesticides and sterilising agents.

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

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

There is a need to increase professional and public awareness of the importance of preconception health behaviour and of individual's use of preconception services using

\(^{25}\) BMJ (February 2001) The fetal origins of adult disease; BMJ 2001; 322: 375 doi: 10.1136/bmj.322.7283.375 (Published 17 February 2001)

\(^{26}\) http://www.springerlink.com/content/t455439hu3443r3n/fulltext.html
information and tools appropriate for varying ages, literacy levels and cultural and linguistic contexts. Women need to know that health conditions and medications can affect pregnancy outcomes and that pregnancy can affect a woman’s health.\(^{27}\)

It is important that any woman with a past or chronic illness is reminded opportunistically that in some conditions, planning a pregnancy can minimise the effects of the illness. Examples include:

- Women with diabetes
- Women with hypertension
- Women on anti-epileptic medication
- Women with congenital or acquired heart disease
- Women on oral anticoagulants
- Women on thyroid replacement therapy
- Women with mental health problems

Since less than 50% of the population ‘plan’ a pregnancy\(^{28}\), every opportunity will be taken to provide public health information. For example, in primary care whenever a girl or a woman of child bearing age not using a reliable method of contraception attends and similarly, when a woman of childbearing age attends who is on any another regular medication. The opportunistic distribution of information and social health marketing campaigns about planning pregnancies and raising public awareness of what measures to take in the pre-pregnancy period is essential.

12.0 Accessing antenatal services

Women will be able to choose their point of entry into maternity services from local venues which are accessible and conveniently placed e.g. children’s centres and primary care locations.

Midwives will accept initial self referrals into the maternity service once pregnancy has been confirmed. They will also work with other professionals such as pharmacists, community nurses and a range of other professionals who are part of the wider maternity health network, including children’s centres.

First contact with women should be made as soon as a referral has been received as the impact of late booking can result in poor outcomes. For midwives undertaking direct referrals it is vital to inform the GP of the woman’s pregnancy. GPs delivering antenatal and postnatal care for women who choose to have their care managed by their GP should ensure they communicate regularly with the woman’s midwifery team and/or named midwife. It is essential that there are safe and defined rapid transfer protocols/pathways in place when risks have been identified. GPs should also ensure that they are linked in with the local maternity network.

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Women will continue to have the choice of visiting GP surgeries to access maternity care and related services. As the main providers of primary care and often the first point of contact for pregnant women and women planning pregnancy, GPs have an important role in providing maternity care to women, from pre-pregnancy advice through to antenatal and postnatal care and GP performance relating to the undertaking of this will be monitored through the Primary Care Commissioning Annual Performance Visits.

Women who choose to have care from their GP should be linked to a named midwife and/or team of midwives so they can access midwifery support and advice. In all cases, it is important that medical and social information relating to a woman’s pregnancy, baby and family is shared between maternity services and the woman’s registered GP.

It is equally important to recognise that although pregnancy and birth are normal life events for most women, when specialist care is required, it must be readily available and of the highest possible quality. This means ensuring that all women can have immediate transfer to secondary care obstetric services that are fully integrated with primary/community care services to ensure a seamless pathway. Local referral policies/guidelines will be in place for use by midwives when needing to refer a woman to obstetric care. Practice must be based on available evidence and according to relevant clinical guidelines.

Pregnancy and the first years of life are one of the most important stages in the life cycle. This is when the foundations of future health and wellbeing are laid down and is a time when parents are particularly receptive to learning and making changes.

Maternity services are key to delivering early intervention and preventative work and to making a significant contribution to the delivery of integrated services for children.

**National/ Local Guidance**

All women should access maternity services for a full health and social care assessment of needs, risks and choices by 12 weeks and 6 days of their pregnancy to give them the full benefit of personalised maternity care and improve outcomes and experience for mother and baby. 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.

The national target for booking assessment is that by the end of 2008/09 all PCTs would be expected to be achieving 80% with a year on year increase aiming to achieve at least 90% by 2010/11. These percentages are in relation to the requirement for:

- Increasing early access for women to Maternity Services and the percentage of women in the relevant PCT population who have seen a

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29 DH (Oct 2009) Healthy Child Programme: Pregnancy and the first five years of life; DH Publications
30 DH (April 2007) Maternity matters: choice, access and continuity of care in a safe service; DH Publications
Midwife or maternity healthcare professional for health and social care assessment of needs, risks and choices (known as the booking assessment) by 12 weeks and 6 days (90 days) of pregnancy.

13.0 Antenatal Care

Women will have the choice of a range of venues where antenatal assessments can take place.

Antenatal care commences with a booking assessment to plan the care needed during pregnancy as defined by the agreed risk assessment and management policies. Most women will receive community based midwife-led care for the remainder of their antenatal assessments. The dynamic needs assessment is predominant throughout the antenatal period and facilitates informed choice. Care will be provided in line with NICE Guidelines for Antenatal Care (2008)\textsuperscript{32} particularly in relation to attendance schedules and offers of screening tests. Women needing additional care will be referred to the consultant obstetrician for a plan of care which may subsequently enable shared care between the consultant and the midwifery team or alternatively, total consultant care. This additional care will include:

- Early pregnancy assessment services, especially catering for complications in early pregnancy
- Antenatal day care which monitors high risk pregnancy on an out-patient basis, which will continue to be provided locally

Some women, as appropriate to their medical condition, may be transferred to a tertiary centre or for specialist services and support i.e. mental health.

If onward referral is necessary, it is the role of the midwife to ensure that the woman continues to access midwifery care as appropriate to her needs and that specialist care does not exclude her from receiving such care. Wherever possible, continuity of care should not be disrupted because specialist input is required.

14.0 Giving birth

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 3 different options:-a home birth; birth in a local facility under the care of a midwife or birth in a consultant-led unit.

In line with the focus on normality and following risk assessment, all women will be offered the opportunity to choose a home birth and will be provided with appropriate information to enable them to make an informed choice. Women should also be informed about what emergency care can be provided in and out of the hospital setting.

\textsuperscript{32} NICE (June 2008) Antenatal care; routine care for the healthy pregnant woman; revised reprint June 2008 & further revised reprint June 2009; RCOG Press
by midwives and paramedics. NICE guidance\textsuperscript{33} states that if a woman gives birth in a midwife-led unit or at home, there is a greater chance of a normal birth.

Where a woman chooses to give birth at home there will be a pathway in place to ensure that if there are complications, the woman and baby can be transported safely and quickly to a consultant–led unit. With the increased choice being provided it is anticipated that there will be an increase in home births across the review area.

The woman’s level of risk should be assessed close to the time of birth. If the pregnancy is low risk or becomes low risk, the woman should not be excluded from the choice of giving birth in settings outside of an obstetric unit.

Where a home birth is not suitable for the individual woman or is not her choice of place of birth, the birth can take place within a midwife-led unit. This will be co-located within an obstetric unit or as a stand-alone midwife unit.

One-to-one care in labour, ideally from a midwife the woman knows, is recommended in NICE guidance\textsuperscript{34}, and by the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists\textsuperscript{35}. Many women cite one-to-one care in labour as the most important factor for them in having a positive birth experience.

During the antenatal period, women will have the opportunity to fully discuss the various options available to them in relation to pain relief to help them achieve a positive birth experience.

Safe transfer is essential for all women regardless of risk status. NICE Intrapartum guidance\textsuperscript{36} makes recommendations on indicators for intrapartum transfer of women to another birth setting. In all cases the risks and benefits should be assessed when considering transfer to an obstetric unit, bearing in mind the likelihood of birth during the transfer.

\textbf{National/ Local Guidance}

One-to-one care in established labour is specified in ‘Safer Childbirth’\textsuperscript{37} (Paragraph 4.1.5) - outlining that ‘UK maternity services policies should state that maternity services should develop the capacity for every woman to have a designated midwife to provide care for her when in established labour for 100% of the time’. It is also specified in ‘Towards the Best, Together’\textsuperscript{38} to ‘guarantee one-to-one midwifery care in established labour and recruit the necessary number of additional midwives to do this’.

The NHS East of England recommends Trusts should aim to deliver a minimum of 20% of women at home or in a MLBU. To date, in the East of England, there are four Trusts who deliver between 20-26% of their women either at home or in a MLBU and

\textsuperscript{32} NICE (September 2007) Intrapartum care: Care of healthy women and their babies during childbirth  
\textsuperscript{33} NICE (September 2007) Intrapartum care: Care of healthy women and their babies during childbirth  
\textsuperscript{34} RCOG, RCM, RCA, RCPCH (October 2007) Safer Childbirth; Minimum Standards for the Organisation and Delivery of Care in Labour; Published by the RCOG Press  
\textsuperscript{35} NICE (September 2007) Intrapartum care: Care of healthy women and their babies during childbirth  
\textsuperscript{36} RCOG, RCM, RCA, RCPCH (October 2007) Safer Childbirth; Minimum Standards for the Organisation and Delivery of Care in Labour; Published by the RCOG Press  
\textsuperscript{37} NHS East of England (March 2009) Towards the Best, Together  

\textbf{Maternity Services Strategy-North East Essex} 21
three of those deliver 20+% in their MLBU. In Quarter 1 of 2011/12 23.06% of deliveries at CHUFT had taken place in the MLBU.

15.0 Newborn and Neonatal Care

All babies receive care from midwives following birth, continuing after transfer home with visiting midwives assessing both mother and baby before handover of the baby to the health visitor.

The Newborn Infant Physical Examination (NIPE) will be undertaken for all babies. As a result of increasing rates of fertility and the availability of assisted conception, more and more babies require specialist neonatal care each year and access is required to the highest level of neonatal care which covers a wide range of specialist support. Care for the vast majority of less vulnerable babies is provided locally within a network of care. CHUFT was designated a level 2 BAPM (British Association of Perinatal Medicine) Standard Neonatal Unit in March 2011.

16.0 Postnatal Care

After going home, women and their partners will have a choice of how and where to access postnatal care. This will be provided in hospital, at home and in a community setting, such as a Children’s Centre.

Inadequate postnatal support, advice and treatment can impact considerably upon a mother and baby’s health outcomes, her relationships with family and friends, and her parenting capabilities. It is recognised that effective postnatal provision can alleviate and in some instances avert poor postnatal outcomes such as low breast feeding initiation and continuation rates, postnatal depression and in some extremes postnatal mortalities.

All women will be transferred home to the care of a community midwife, with timely communication to GPs and the wider primary care team. Women, who deliver in birthing centres/MLBU’s will be able to go home within hours of the birth. If women have had a complicated birth they will be offered care on the postnatal ward. Early transfer home will be encouraged for women who do not have complications.

All units will work in accordance with the North East Essex/ East of England guidance in relation to length of stay (shown below). This will ensure that postnatal care is promoted and supported as early as possible, initially in the home and subsequently within the individual community setting. These guidelines are implicit with promoting normality of maternity care and subject to women’s preferences and choice:-

- Normal delivery with no complications, 3 hour discharge or less (dependent upon time of day)
- Instrumental delivery with no complications, 24 hour discharge
- Elective caesarean section with no complications, 24 hour discharge

39 http://www.nice.org.uk/guidance/qualitystandards/specialistneonatalcare/specialistneonatalcarequalitystandard.jsp
41 Caesarean section – NICE clinical guideline, April 2004 p84
A small number of women may require a longer stay in hospital and this will be determined by the individual circumstances.

The newly delivered mother will be assessed by the midwife within a maximum of 24 hours of transfer home and a plan of care agreed with her. In identified situations this may need to be sooner and new mothers should be made aware of how to contact a midwife earlier if required prior to leaving hospital or birthing unit. An agreed postnatal plan can be offered either in the home or in Children’s Centres/other community venues according to the woman’s needs. Midwives and maternity support workers will ensure smooth transition of care to health visitors as part of the Primary Care Team, with continued support from the maternity support worker as required by individual need, for the medium term. Longer term support will be provided by health visiting and support staff in Children’s Centres. The midwife will undertake the role of the key worker in assessing the need to access further individual and specific support from the multidisciplinary team as required. Midwifery care will continue to be available as necessary, for those women who require it, with a formal hand-over of care to the health visitor.

Locally agreed pathways will be utilised (and developed as necessary) to ensure appropriate referral back into the acute setting if problems are identified during routine postnatal screening examinations.

The frequency and duration of postnatal visits will cater for individual medical, mental health and social needs identified by the dynamic health needs assessment, and on women’s choice. This information should be included in the postnatal transfer (discharge) plan of care.

17.0 Management of Low Medical and Social Risk Women

Midwives will be the lead professional for all healthy women with straightforward pregnancies and will be the co-ordinator of care for all women during their intrapartum and postnatal periods. (Midwifery 2020)

National/Local Guidance: Caesarean Section Rates

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

The Department of Health have advised that applying evidence-based good practice and innovative models of care leads to lower caesarean section rates and a better experience for women when a caesarean section is appropriate. In addition, through their work with clinicians in maternity units, applying best practice to the management of pregnancy, labour and birth, there is a belief that a caesarean section rate consistently below 20% with aspirations to reduce that to 15% is achievable.

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42 Midwifery 2020 Programme (September 2010) Midwifery 2020; Delivering expectations
43 NHS Institute for Innovation and Improvement (2006) Focus on Caesarean Section
44 NHS Institute for Innovation and Improvement (2006) Focus on Caesarean Section
National guidance requires a reduction of 2% in caesarean section deliveries if the existing ratio exceeds 20%.

The NHS East of England stance however is that Trusts below the East of England average should reduce their caesarean section rate by 1% and those above the average by 2%. The current East of England average is 25.4%. The rate for 2010/11 at CHUFT was 25.75%.

18.0 Management of High Risk/ Complex Care

The changing profile of women who become pregnant has increased the number of women who may be considered high risk.

For women with complex pregnancies, there is shared input between obstetrician, midwife and other specialists who develop a plan of care. Some women choose an obstetric setting for personal and cultural reasons: this choice should be met as midwife-co-ordinated care can and should take place in an obstetric setting.

It is recognised that for those women with complex needs, specialist midwives will be required to provide specialist care. In these instances the named midwife should continue to provide support as appropriate and ensure a seamless handover to the specialist midwife so the continuum of care is maintained.

Within the acute setting, the development of evidence-based clinical pathways allied with robust governance and risk management processes, will result in an appropriate and safe level of medical intervention.

The provision of MLBUs focuses care within the low-risk pathway thereby facilitating the drive to reduce medical intervention where appropriate and safe to do so and concurrently increases choice for women.

The same criteria should be applied to assessing appropriateness of women for a safe midwife co-ordinated birth whether the setting is at the woman’s home or in a stand-alone or co-located MLBU. There should be no difference in exclusion criteria between home, co-located birthing unit and stand-alone unit as there is currently no evidence available that suggests one setting is safer than the other.

Antenatal and postnatal care should be personalised and adapted to individual needs. This should include the development of stronger outreach midwifery support and breastfeeding services for vulnerable and disadvantaged families. Care should be based on an ongoing assessment of social as well as clinical risk, with targeted outreach support for the most vulnerable women.

Women and their partners may choose antenatal care to be provided by midwives in the community or by the maternity team. However, for some women, care from a team of maternity professionals, including midwives, obstetricians and other specialists, will be the safest option. For others, who have complex social needs, maternity care can best be provided in partnership with other agencies. These could include children’s services, domestic abuse teams, substance misuse services, drug and alcohol teams,
youth and teenage pregnancy support services, learning disability services and mental health services.

Antenatal care will be provided by the appropriate specialist obstetrician in the acute setting or in an alternative community setting.

Intrapartum care will be provided in the obstetric unit where care will be managed by a consultant working in collaboration with midwives. Individual care needs will be determined and planned according to the presenting problem. The lead provider in this situation will be the appropriate consultant obstetrician.

If a woman who has complications chooses to give birth in a midwife-led setting against medical advice then it should be a fully-informed decision with knowledge and understanding of the associated risks and benefits and the potential for emergency transfer.

19.0 Safeguarding Children and Vulnerable Adults

Women, the unborn, children and young people will be assessed and supported if they are thought to be in need of additional support or in need of protection.

Working Together to Safeguard Children 2010, NICE, Care Quality Commission 2010, provide statutory and non statutory guidance on ensuring that safeguarding needs of children and young people and adults are recognised and responded to by health care workers.

The ability to recognise potential indicators and signs of abuse is imperative but it is recognised that early intervention for mothers, babies and families in securing additional support may reduce the need for child protection/adult protection.

The Common Assessment Framework (CAF) is a key part of delivering frontline services that are integrated and focused around the needs of children and young people. The aim is to identify, at the earliest opportunity, a child or young person’s additional needs which are not being met by the universal services they are receiving and provide timely and co-ordinated support to meet those needs.

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46 NICE clinical guideline 89 When to suspect child maltreatment www.nice.org.uk/nicemedia/pdf/CG89NICEGuideline.pdf

47 NICE public health guidance 28 – Promoting the quality of life of looked –after children and young people www.nice.org.uk/guidance/PH28

48 Care Quality Commission 2010 Essential Standards of quality and safety March 2010


Pregnancy can increase a woman’s risk of domestic abuse\textsuperscript{51} consequently it is important for health care workers to be aware of safeguarding issues not only for children but also pregnant women and the unborn child.

Midwives play a key role in assessing women’s risk of domestic abuse and assessing whether they require additional support through the use of the CAF. GP’s also play a pivotal role in ensuring that midwives are aware of any safeguarding issues. Safeguarding women, the unborn and children and young people can be a complex issue and requires close co-operation and multi agency working.

\textbf{20.0 The Public Health Agenda}

Midwives have a vital role to play in improving health and social wellbeing for all women and reducing health inequalities. Vulnerable groups include immigrant families, traveller families and young parents, and there is good evidence of poorer obstetric outcomes for socio-economically disadvantaged women and babies which may have effects throughout the whole of life.

There is a negative lifelong impact of poor early bonding and attachment and feeding practice which impacts on our society in terms of increased levels of violence and obesity. Increasing rates of intervention, particularly caesarean section, have an impact on women’s expectations and experience of childbirth.

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\textsuperscript{52}

Each midwife has the opportunity to influence the woman and subsequent life chances for her child from pre-conception to the postnatal period. (Midwifery 2020)\textsuperscript{53}

\textbf{20.1 Health Inequalities}

A baby born into a low social class is 60\% more likely to have a low birth weight (below 2.5g) than a baby born into a high social class\textsuperscript{54}.

On the index of deprivation affecting children, the LSOA in Jaywick is the 39\textsuperscript{th} most deprived on the IMD, 2010. The children affected by poverty are more likely to live in urban areas of the county\textsuperscript{55}. NHS NEE is keen to improve overall health and wellbeing of the population, whilst reducing inequalities of unfairness in health outcomes between different groups of the population we serve. This means that the

\textsuperscript{52} Chu L, Seed M, Howse E, et al; Mesenchymal hamartoma: prenatal diagnosis by MRI. Pediatr Radiol. 2010 Dec 1. [abstract]
\textsuperscript{54} http://download.cabinetoffice.gov.uk/social-mobility/opening-doors-breaking-barriers.pdf
\textsuperscript{55} http://www.poverty.org.uk/20/index.shtml
services that are purchased must meet those key needs; be value for money; of the highest quality; improve the journey of the patient with choice and convenience and give the best possible experience whilst receiving the highest standard of care from professionals.

20.2 Breastfeeding

Breast milk provides not only the optimum and complete nutrition for the development of healthy infants, but babies who are not breast fed are many times more likely to acquire infections in infancy and to develop obesity in later life. The aim is to create a culture in which breastfeeding is the routinely accepted way to feed a baby in North East Essex.

Breastfeeding is a key determinant of health but while it is known that around 70-80% of mothers living in North East Essex choose to start breastfeeding their babies, this is not indicative of sustained or beneficial breastfeeding.

Medical evidence has demonstrated a wide range of benefits to mother and baby from breastfeeding. Breast milk provides the optimal nutrition for infants and offers health benefits as well as immunity from infections.

Sustainability of breastfeeding to 6-8 weeks requires partnership working to ensure that women are supported to continue breastfeeding. The approach to increasing and sustaining breastfeeding rates is via a multi-agency workforce consisting of the statutory and voluntary sector partners to include health visitors, midwives, maternity support workers and breastfeeding peer supporters, Children’s Centre staff, GPs and practice nurses. Continuity of support should be provided from antenatal education through to postnatal support and should flow seamlessly across organisations so that women receive best practice in breastfeeding support. Families must have access to this skilled and continuous support to sustain exclusive breastfeeding for at least six months, followed by the timely introduction of safe complementary feeding and sustained breastfeeding for as long as desired.

A 3 year initiative to support breastfeeding has been commissioned in North East Essex comprising a team of breastfeeding peer supporters who aim to contact all new mothers within 48 hours of notification being received of discharge. Peer supporters attend the postnatal wards every day to support new mothers and collect discharge details to continue to offer support once mother and baby are home.

Both Maternity and Children’s Community Services are currently working towards the Baby Friendly Initiative (BFI).

The BFI works with the health-care system to ensure a high standard of care in relation to infant feeding for pregnant women and mothers and babies. Support is

58 http://live.unicef.org.uk/babyfriendly/
provided for health-care facilities that are seeking to implement best practice and an assessment and accreditation process recognise those that have achieved the required standard.

CHUFT and NHS NEE are working closely together to achieve full accreditation (Level 3). CHUFT were the first acute Trust in the East of England to achieve Level 2 BFI status and will be assessed for Level 3 accreditation in June 2012.

National/ Local Guidance

The aim is to increase breastfeeding initiation rates and deliver a 2% year on year increase with an initiation rate target of 77.80% by 2011/12.

20.3 Smoking

Women will be supported to have as healthy a pregnancy as possible. This will include lifestyle support e.g. help to stop smoking, dietary and exercise advice. Currently, between a quarter and a third of pregnant women in North East Essex are smoking at the time of delivering their baby.

 Provision of support for smoking cessation and for breast feeding represents two interventions which can improve a woman’s experience of maternity care and the long-term health outcomes for women and babies. Support provided needs to be by health visitors and midwives undertaking the appropriate training and working closely with peer groups and volunteers to provide this support.

There should be a flexible approach to the transition to care provided by health visitors to allow mothers to work with whichever health professional they feel is best placed to support them. There have been a significant number of initiatives implemented to address this including:

- A 2 year commissioned Social Marketing Strategy targeting key areas of communication skills training for midwives, a Communication Strategy and the development of a magazine for local women
- A designated workstream of the Maternity Services Implementation Group targeting smoking in pregnancy
- Collaborative working across all providers and commissioners to target smoking in pregnancy as a priority in 2009/10
- Introduction of an “Opt Out” referral pathway
- Nicotine Replacement Therapy now prescribed under a Patient Group Directive on antenatal and postnatal wards
- The introduction of Carbon Monoxide Monitoring
- Midwives are now able to access Level 2 Smoking Cessation training
National/ Local Guidance

The NHS Modernising Health & Social Services National Priorities Guidance (2000-2003)\(^{59}\) aims to achieve a 1% reduction per year in the proportion of women who continue to smoke during pregnancy. This can be measured by the proportion of women known to be smokers at the time of delivery.

20.4 Teenage Pregnancy

Meeting the needs of young women and their partners more effectively will improve the life chances of the young parents.

Although teenage parents can vary widely in their social backgrounds, family circumstances and life experiences, teenagers who become parents are disproportionately likely to have a history of disadvantage and social exclusion.

Teenage pregnancy rates were falling but although they have dropped in Colchester more recently they appear to be rising in Tendring:

<table>
<thead>
<tr>
<th>Year</th>
<th>Colchester</th>
<th>Tendring</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001-03</td>
<td>36.5</td>
<td>42.6</td>
</tr>
<tr>
<td>2004-06</td>
<td>35.3</td>
<td>36.8</td>
</tr>
<tr>
<td>2005-07</td>
<td>35.9</td>
<td>40.5</td>
</tr>
<tr>
<td>2007-09</td>
<td>32.4</td>
<td>41.5</td>
</tr>
</tbody>
</table>

Rates are per 1000 female population aged 15-17 years of age

Source: Office for National Statistics and Teenage Pregnancy Unit

Because pregnant teenagers and young fathers often have complex needs outside the remit of maternity services, specialist services will be available for pregnant teenagers and arrangements in place for support in the community. Maternity services staff should have the knowledge and skills to engage with teenage mothers and fathers.

It is important for maternity services to take forward innovative approaches to midwifery care to promote engagement and rapport and to clearly present the teenage parents’ point of view to others followed by teaching and educating in the attempt to reduce social exclusion and to promote integration.

Reaching and supporting these young people effectively is only possible if maternity services for them are planned and delivered in partnership with the other agencies that can meet their needs.

Providing an information service to other professionals, parents and young people regarding current and best practice in the prevention of teenage pregnancy and support for teenage parents is an essential part of maternity services.

The midwife is a point of contact for her colleagues caring for pregnant teenagers and for the multi-agency network.

20.5 Maternal Obesity

Obesity during pregnancy is a risk factor for adverse maternity outcomes\(^60\). By reducing weight prior to pregnancy, obstetric complications and health problems for the offspring should also be improved.

There is substantial evidence that obesity in pregnancy contributes to increased morbidity and mortality for both mother and baby. For example, the CEMACH Maternal Death Enquiry; Why Mothers Die (2004)\(^61\) found that approximately 35% of women who died who had a recordable Body Mass Index (BMI) in the 2000-2003 triennia were obese (i.e. had a BMI of 30 or greater). The CEMACH Perinatal Mortality Report (2005)\(^62\) found that approximately 30% of the mothers who had a stillbirth or a neonatal death were obese.

Women with a high BMI should be encouraged to lose weight prior to conceiving with continued weight reduction and exercise firmly in the control of the individual herself, but with support from the midwife and other professional colleagues.

Women affected by maternal obesity need to be treated with dignity and respect and there needs to be open discussions regarding their care and about the risks involved during pregnancy. While it is useful to have protocols and guidelines in place for the management of obese women, the maternity and obstetric team need to be able to adapt to individual circumstances.

NHS NEE were successful in becoming part of a National pilot for a Maternity MEND (Mind, Exercise, Nutrition, Do it!) project\(^63\) – based upon the MEND schemes which run for young people.

The aim of this will be to target obese/overweight women 12 weeks after giving birth and support them to adopt a healthier attitude towards diet/exercise within the postnatal period and will be evaluated fully before this is decided to be offered nationally.

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\(^60\) CEMACH/RCOG Guideline (2010) Management of Women with Obesity in Pregnancy
\(^62\) CEMACH (April 2007) Perinatal Mortality 2005; Confidential Enquiry into Maternal and Child Health; CEMACH: London
\(^63\) http://www.mendprogramme.org/
20.6 Perinatal Mental Health

Women’s mental health requires special considerations in view of women’s greater likelihood of suffering from depression and anxiety disorders and the impact of mental health problems on childbearing and childrearing too.

The perinatal period is classed as the period of time from conception to one year after the birth of the child and represents a time of increased risk for mental ill-health for women due to the profound biopsychosocial changes taking place. During the perinatal period women are more likely to experience rapid onset and/or sudden deterioration of mental health. Perinatal mental health problems are recognised as a major public health issue. (Austin et al, 2008)⁶⁴

The indicative benchmark is that 12% of women who give birth will require antenatal and postnatal mental health services (NICE 2007)⁶⁵ – in North East Essex this equates to between 400 and 500 women per year.

There is a wealth of overlapping recommendations from advisory bodies and central government arguing strongly for the development of dedicated Perinatal Mental Health Services in each Trust, (NICE 2007⁶⁶, CEMACH 2007⁶⁷, DH 2002⁶⁸). Other recommendations are PSA12 Indicator 4 proxy measure 4 - Improve the health and well being of children and young people⁶⁹ and the Healthy Child Programme (DH 2009)⁷⁰.

Mental disorder during pregnancy and the postnatal period can have serious short and long-term consequences for the health and well being of the woman, her baby and other family members.

As perinatal mental health cuts across a number of speciality areas, there has tended to be limited acknowledgement of the need for specified provision of mental health support in the perinatal period. In 2009 NHS NEE Public Health Directorate commissioned health needs assessments to support this as a priority which clearly demonstrated the need for local services within the stepped care model for the perinatal period. There is a need therefore for this to be actioned collaboratively as a priority initiative and to develop an integrated pathway which will result in:-

- Improvement of equity and quality of perinatal mental health care that demonstrates value for money
- Identification of an optimum care pathway for women

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⁶⁵ NICE (2007) Antenatal and postnatal mental health services; NICE clinical guideline 45
⁶⁶ NICE (2007) Antenatal and postnatal mental health services; NICE clinical guideline 45
• Established systematic approach to prevention, detection and successful treatment of women at risk from or suffering from perinatal mental health disorders
• Timely and appropriate care
• Clear referral and management protocols within existing stepped care mental health frameworks
• Improved communication systems between professionals
• Identification of training needs/competencies and skills for professional groups

Each woman and her partner need a midwife they know and trust to co-ordinate their physical and emotional care through pregnancy and until the end of the postnatal period. (Midwifery 2020)\textsuperscript{71}

Antenatal and postnatal care pathways must ensure that every woman is offered a service to actively promote and maintain her mental health and wellbeing. Information and education will be made available to women and their families on how to access appropriate services to meet their needs.

\section*{21.0 Workforce}

Providing quality midwifery care depends on the availability of a workforce of practising, skilled midwives who can lead and contribute to the care of the woman as part of the multidisciplinary team. Workforce planning is multi-faceted and is influenced by variables which impact on the complexity and intensity of care delivery. These include a woman’s choice, risk status, model of care and geography, the projected birth rate, midwives’ working and retirement patterns.

At present, more midwives are currently working part-time hours and this trend has increased year-on-year for the last ten years. In addition, estimates of the projected birthrate have, in the past, underestimated growth with a consequent impact on the workload for maternity care and midwives. Such variation should be taken into account in workforce planning projections and consideration of alternative scenarios.

The plan for staffing and skill mix levels needs to reflect the local model of care, case mix, the needs of women, their families and service redesign. The totality of midwifery care has an impact on and implications for antenatal, intrapartum and postnatal provision within secondary care, as well as in primary care and community settings. Promoting effective skill mix within the maternity team will be key to delivering national and local guidelines, improving the working lives of midwives and other staff delivering maternity services and improving continuity of care to women.

Towards Safer Childbirth\textsuperscript{72} suggests that the number of midwives required to provide care in the clinical area is dependent on workload activity. Reorganisation of service models provides the opportunity to address local staffing issues and look at innovative

\textsuperscript{71} Midwifery 2020 Programme (September 2010) Midwifery 2020; Delivering expectations
ways to resolve recruitment and retention issues as well as creating more efficient and effective use of resources.

It is important to ensure that the maternity services have suitably trained staff working within their scope of practice and competencies. Changing skill mix has the potential to release midwifery clinical time for where it is essential that midwives provide the care. This can be achieved through the introduction of maternity support workers. The role of the Maternity Care Assistant (MCA) is to assist midwives to support women in labour, maintain a safe and clean environment, assist midwives and other professionals in their clinical practice and support parents with newborn care.

The contribution of MCAs is maximised when they are appropriately trained, managed and supervised by midwives, while operating as an integral part of the maternity care team. The key principle in incorporating MCAs within the workforce skill mix is to complement not to substitute for midwives. In the interest of improving quality of care, it is essential that the flexibility of this role is shaped by the needs of women in any birth setting. In a “high risk” labour ward environment they may require further training to undertake other roles such as ‘scrub’ role in assisting in the obstetric theatre.

The role of the consultant obstetrician on the labour ward is to ensure a high standard of care from women and their babies with complex medical or obstetric needs and to be available for the acute, severe and often unpredictable life-threatening emergencies which are a feature of obstetric practice.

Safer Childbirth specifies that when units have more than 4000 births a year, they should achieve the 60-hour target of consultant presence by the end of 2008. CHUFT exceeded this number in 2010/11 and now provides 60-hour consultant presence.

22.0 Data Collection

It is essential that there is accurate and timely data collection to support maternity services. Further developments in measuring quality outcomes must not increase the administrative burden on midwives and should be directed towards using the results to improve practice and reward the provision of quality midwifery care. (Midwifery 2020)

23.0 User involvement and Clinical Engagement

Strengthening/enhancing the contribution and involvement from women and their families in the design, planning and decision-making process will result in service users working as partners with planning, commissioning and service providers.

Women and their families should be involved with the planning and design of their local services, to ensure their experiences of maternity services are taken into account

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73 Sandall, J et al (2011) Staffing in Maternity Units: Getting the Right People in the Right Place at the Right Time; King’s Fund
74 RCOA, ROM, RCOOG, ROPCH (October 2007) Safer Childbirth; Minimum Standards for the Organisation and Delivery of Care in Labour; RCOG Press
75 Midwifery 2020 Programme (September 2010) Midwifery 2020; Delivering expectations
and their expectations of future service provision will be met. Existing structures such as Maternity Services Liaison Committees (MSLC) can provide an essential link into local communities and should be appropriately supported as per national guidelines. Voluntary organisations providing maternity services within the locality have unique design expertise and experience and should therefore be involved with service planning and design.

Responding to women’s experiences of care will drive quality improvement and this will result in an increased focus on social models of care with women and families' needs at the very heart of midwifery and maternity care (Midwifery 2020)\(^7\).

NHS NEE already hosts a MSLC which brings together commissioners, providers and users of maternity services to plan, monitor and improve local maternity services. It is envisaged that this group will play an active part in the implementation of the Maternity Strategy in North East Essex. For CHUFT, engaging with Governors and members on planning and development of services is a significant opportunity for user involvement.

\section*{24.0 Maternity Networks}

Maternity services provided by CHUFT extend to women beyond the catchment of NHS NEE with many women from Halstead and the Colne Valley (part of NHS Mid Essex) and a small number from across the Suffolk border choosing the Trust’s maternity services.

It is important that in delivering this Strategy full account is taken of maintaining choice for women from neighbouring areas to access the Trust’s services and for the strategies of those commissioners to recognise these geographic flows.

Maternity networks can have an essential role in facilitating the provision of high-quality maternity services through multi-organisational working and providing leadership across a sector. Networks can support best practice and ensure that clinical pathways are of a consistently high quality across the region. They also form a key strand of the government’s health policy.

There was a recent agreement in principle by the East of England SHA Operational Board for the creation of a Managed Clinical Maternity and Newborn Network. To commence work on the creation of the network, a Shadow Network Board will be put in place to replace the previous Maternity and Newborn Clinical Programme Board. It is anticipated that the Shadow Network Board will operate as a working group until March 2012 when it is expected that the new Network will become fully operational.

At the heart of this work is the commitment to promote normality of birth and give women choice on where to give birth, based on an assessment of safety for both the mother and the baby and a clear pathway for escalation for high risk women and babies.

It is proposed that there should be an overarching sub regional Maternity and Newborn Network Board encompassing strategic overview and performance management, and

\footnote{Midwifery 2020 Programme (September 2010) Midwifery 2020; Delivering expectations}
focusing on best practice and pathways of care across the East of England, with 3 local networks focusing on choice and user involvement.

25.0 Conclusion

The vision for maternity services is to deliver an excellent universal service that provides care tailored to the individual needs of each mother and family unit.

Services should be designed so that pregnant women have easy access to and a choice of services that are safe and of a high quality. Maternity care must be as safe as possible and should be monitored within the context of national and local guidance and standards, protocols and pathways. It is vital to focus on clinical and quality outcomes and on the experience of pregnant women and their families.