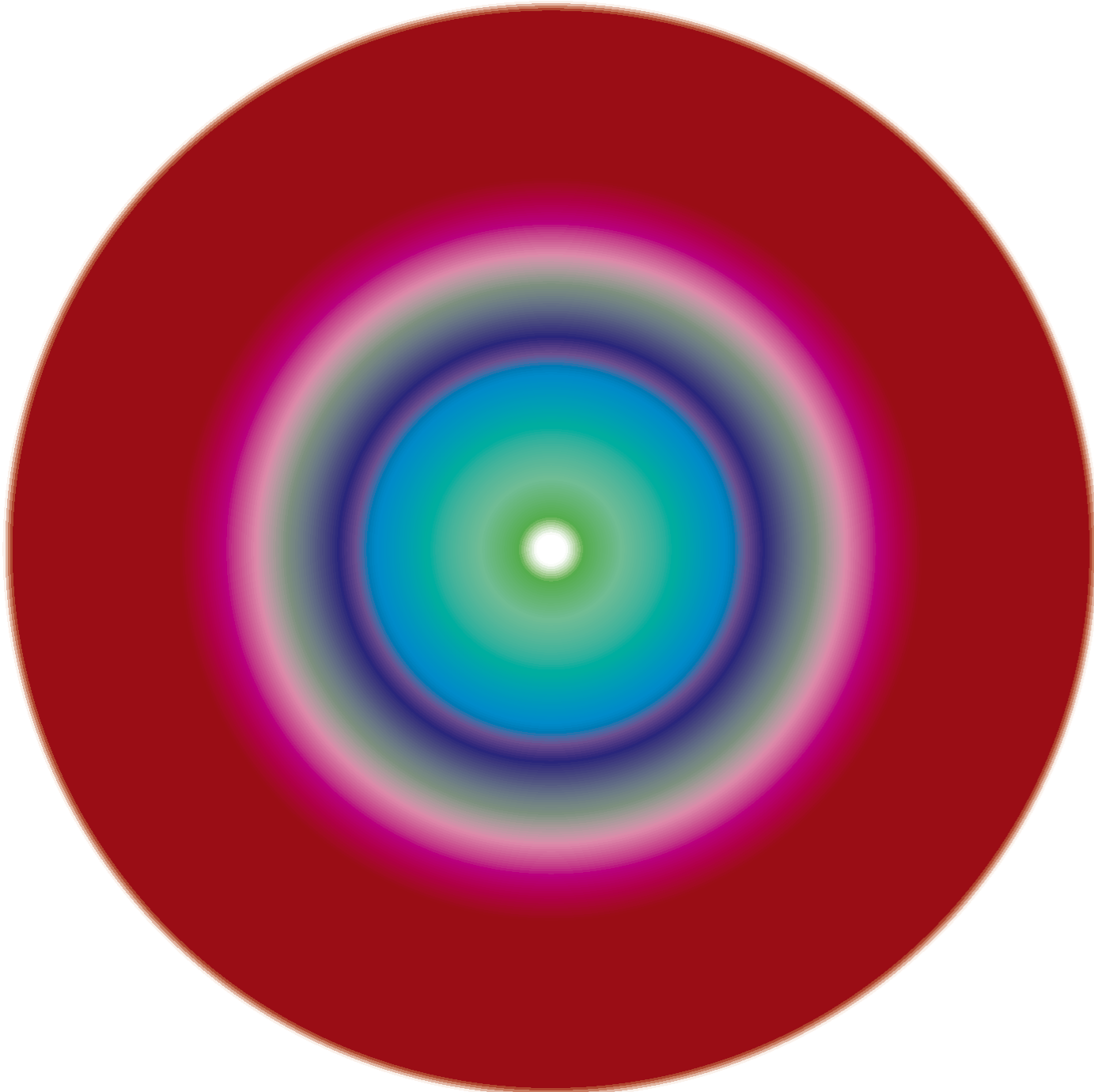




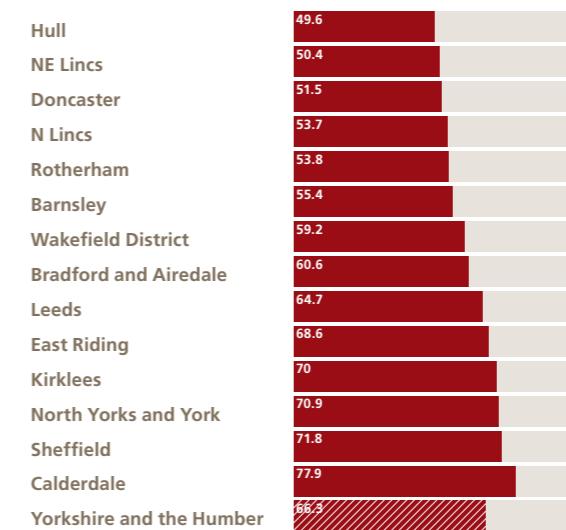
# The Maternity and Newborn Pathway



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NHS Foundation Trust

**Figure 15.** Percentage of mothers initiating breast feeding by Primary Care Trust 2005 - 06 / Source: Department of Health. local data on breastfeeding initiation rates



## Birth – a good start in life

**1**  
All our babies deserve the best start in life. This chapter sets out what the NHS in Y&H should do to help make this happen. We want to build on the best Y&H offers at present and the latest evidence in order to meet the challenges of the next decade.

## The Case for Change

### Inequalities

**2**  
Around 63,000 babies are born in Y&H each year, and this figure is set to rise. From the very start of their lives these babies face major inequalities – for example:

- There is wide variation in uptake of breastfeeding – babies in Calderdale are over 50% more likely to be started on breastfeeding than babies in Hull; see figure 15 opposite. Breastfeeding is known to have many beneficial effects. It protects the mother from breast cancer, ovarian cancer and hip fractures in later life. It reduces childhood obesity, protects the baby from gastroenteritis, ear, chest and urinary tract infections, allergies and diabetes.



“The midwives were lovely”

- There are still relatively high levels of smoking in pregnancy in Y&H compared with the England average.
- Infant mortality rates are twice as high in the most deprived areas of Y&H compared with our least deprived areas.
- The percentage of babies weighing less than 2,500 grams (approximately 1.1lb) varies considerably by local authority area; see figure 16 opposite.

Experience

3 Many women in Y&H are very happy with the care they receive when pregnant, and during and immediately after birth.

4 However, this is not consistent. Women’s expectations are not being met uniformly, with dissatisfaction evident amongst women in some places with some elements of care. The quality of the interaction between women and health professionals is extremely important – it received both the highest praise and the strongest criticism from the women taking part in our focus groups.

Figure 16. Percentage of live and still births <2500 grams by Local Authority 2005 / Source: Compendium of Clinical and Health Indicators – Office for National Statistics Dec 2006

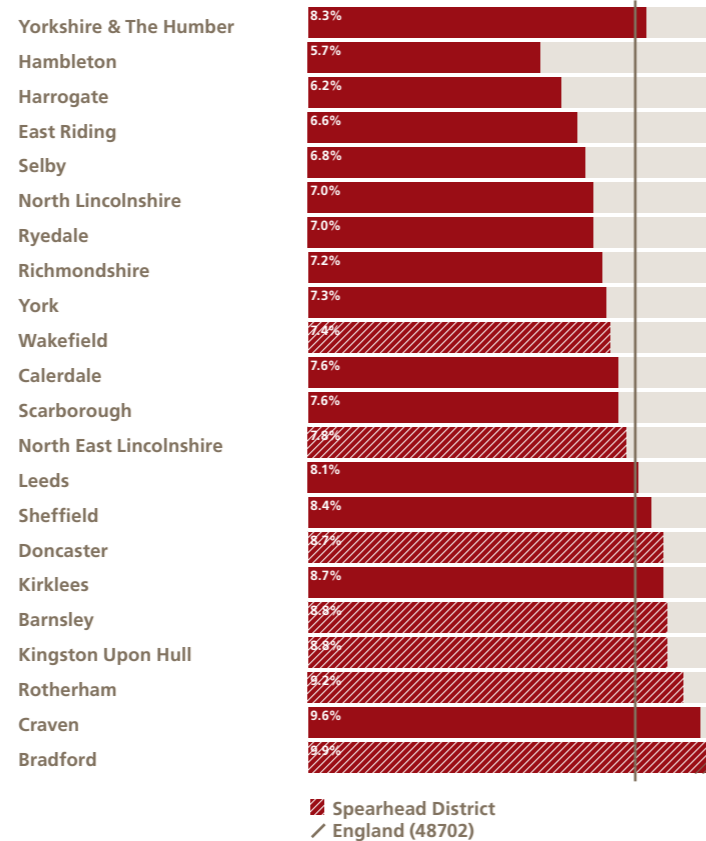
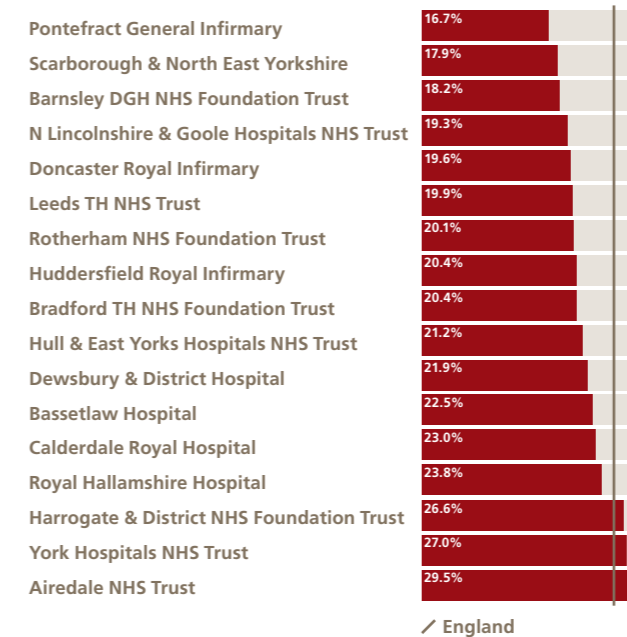


Figure 17. Proportion of deliveries where delivery method was caesarean. Trusts within Yorkshire and the Humber 2005/06 / Source: information Centre, NHS Maternity Statistics 2005/06



Quality Standards

5 It is clear that in Y&H there are some excellent maternity services. But there is also evidence of variation. For example caesarean rates at some hospitals are nearly double that of others in the region.

6 Latest national guidance has not been systematically implemented across Y&H: for example, good practice in reducing caesarean rates is not universal.

7 The 2007 Healthcare Commission report into maternity services reports a range of performance comparing with the best and the least well performing across the country.

8 Services vary widely in the progress that has been made to implement good practice as set by the National Institute for Health and Clinical Excellence (NICE) or the Antenatal and Neonatal Screening Committee Standards.

9 Neonatal mortality varies from 2.3 per 1,000 live births in our least deprived areas to 4.7 per 1,000 live births in our most deprived areas.

**Workforce issues**

**10**  
Clinicians reported that there would be increasing pressures on the workforce in the future. There were two issues:

- More midwives and support workers will be needed in Y&H to meet rising birth rates and to offer more pregnant women the option of a home birth and the choice guarantees set out in Maternity Matters.
- Safer Childbirth, published by the Royal Colleges in 2007, calls for higher levels of both midwifery and medical staff concerned with the care of women in labour.

Coupled with the introduction of the Working Time Directive these issues can make it difficult to achieve full staffing cover for small units.

**11**  
Equally all the feedback from women and their families show there is strong public support for local access to services.

**12**  
Clinicians emphasise that it is really important that services for women and babies need to be safe as well as accessible. Safety is the top priority.

**Fig 18. Safer Childbirth Standards**

	A	B	C1	C2	C3
<b>Size of Unit 2006 Births per year</b>	>2500	2500 - 4000	4000 - 5000	5000 - 6000	> 6000
<b>60 Hour</b>	Units to continually review staffing to ensure adequate based on local needs	End of 2009	End of 2008	Immediate	Immediate
<b>98 Hour</b>	-	-	End of 2009	End of 2008	Immediate if possible
<b>168 Hour</b>	-	-	-	End of 2010	End of 2008
<b>No. units in Y&amp;H*</b>	8	7	2	1	1

\*Excludes Midwifery led units

**Key Recommendations**

**13**  
To improve all maternity and birth services, improve public health and improve services for the most vulnerable, clinicians have advised us that the key recommendations to improve maternity and newborn care are:

- Maternity Matters (published by DH in 2007) should be used as a firm foundation for the future commissioning and delivery of maternity and the newborn services across Y&H.
- Maternity Matters self-assessments in all communities should lead to action plans to address priority gaps identified in these assessments; these should also take account of the Healthcare Commission report mentioned above.
- The workforce recommendations set out in Safer Childbirth should be implemented; PCTs and providers should include this in all subsequent contract negotiations until significant progress is made.
- In particular of our 19 obstetric units, there are 8 units delivering under 2500 births a year. The CPG recommend applying the same standards to these units as if they had 2500 births. All our units currently have 40 hour consultant cover, and should plan therefore to reach 60 hours cover in 2009 at the latest. Outcomes at these smaller units need to be kept under regular review to ensure that women and their babies are not disadvantaged.

Additionally, we would expect the three units with over 4000 births to reach the 98 hour and 168 hour standards as appropriate. (See figure 18 opposite)

- A Y&H Maternity and Birth Commissioning Network should be formed. Early work should focus on agreeing action from the Maternity Matters self assessments, including an escalation policy and procedure to manage demand variations.
- The introduction of the maternity phase of Connecting for Health should be accelerated.
- There should be a radical step up in action to reduce smoking in pregnancy and breastfeeding performance should be improved. Already PCTs are including action to improve breastfeeding and/or reduce smoking in pregnancy in their Local Area Agreements.
- There should be selective introduction of 'caseloading' as a means of targeting vulnerable and disadvantaged women and so ensure that they in particular receive a high degree of continuity of care.

**14**  
We should “get the basics right” by:

- Improving “customer care” and responsiveness to the needs of women during their maternity pathway.
- Improving the quality and consistency of information for pregnant women (in particular vulnerable women, women whose first language is not English, and women with special needs).
- Adopting a more systematic and sustained approach to gathering patient experience data, and using this to inform further action to ensure personalised service delivery.

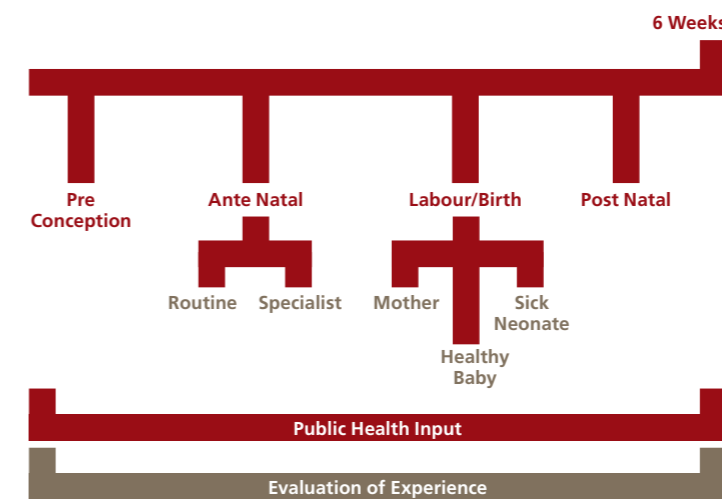
**15**  
There should be a focus on reducing health inequalities and improving health outcomes for both mothers and babies with the aim to reduce infant mortality rates for the manual groups by 20% by 2010.

**16**  
Breastfeeding rates should be improved, with the breast feeding initiation rate increased by 2% in disadvantaged groups with subsequent year on year improvement targets.

**17**  
Transfers and transport: sick neonates deserve the best possible start and, where possible, should be born in a service with the appropriate neonatal expertise.

- Where in-utero transfer does not take place, the reasons should be monitored and improvements made. If ex-utero transfer is required, there needs to be appropriate equipment and up-to-date skilled staff for the transport.
- Commissioners should work with stakeholders to develop regional guiding principles for transfer times when the place of birth alters during labour.

**Figure 19.** The Yorkshire & The Humber Maternity & Newborn Care Pathway.  
Source: Y&H Maternity and Newborn CPG



**The maternity and newborn pathway**

**18**  
The Y&H pathway, developed by the Maternity and Newborn Care CPG considers the journey a woman makes from pre-conception through to routine antenatal care, covering specialist antenatal care, labour, birth and postnatal care, including both the healthy and sick newborn up to six weeks of age (figure 19).

**The Pathway Explained**

**19**  
The key actions we want to take forward at each of the stages shown in the pathway model are described below. Over the next decade, we would aspire to develop the pathways as described and recommended by the CPG below.

**Pre-conception Care**

**20**  
All women and their partners need access to pre-conception information and advice. This includes self help groups such as Foresight and well men and well women clinics offered by primary care, where all women should be offered folic acid 400ug supplement prior to becoming pregnant and up to the 12th week of pregnancy.



21

Pre-conception care should be available to vulnerable groups and those with differing cultural norms in a variety of formats, so that poor outcomes and known consequences of health inequalities are reduced. Better communication links, in particular with faith and community workers, need to be established. National media, (e.g. soap operas, YouTube) might be used to communicate key messages for pre-conception. Alternative formats such as text messages may prove useful to capture the widest possible audience.

#### Routine Antenatal Care

22

The CPG endorsed the Government's key policy document Maternity Matters. This proposes a choice guarantee, so that women and their partners can choose care with a midwife or care with a maternity health care team depending on their circumstances. Information should be given in a manner that is understood by prospective parents with clear explanations of the roles of various healthcare professionals, what to expect from services and provide information to help them make informed choices.

23

There should be an explicit process to offer the option of direct access to midwives as a first point of contact when pregnancy is confirmed. This avoids delay and will ensure early antenatal screening standards are met. Women should have a full booking history taken and their handheld record completed before 12 weeks of pregnancy. This should be further enhanced to form a joint 'agreement' which identifies both rights and responsibilities of women and the healthcare professionals who will provide their care.

24

The CPG recommend that the vision for the next decade is that all women, as a basic entitlement, should have antenatal care provided in line with NICE Antenatal Guidelines by their community midwife, who is often the named midwife. Ongoing assessments of social, medical and psychological state at each point of contact should enable women to assess risk and access additional and targeted care suited to their individual needs. Additional and enhanced care should be offered where low medical but high social needs exist, for example, women with previous substance misuse, where the stress of pregnancy may cause relapse.

#### Specialist Antenatal Care

'All pregnant women need a midwife and some need a doctor too'.

25

The CPG identified that key to improving outcomes is that all women at the first contact in pregnancy should have any complex social and medical care issues identified. The role of children's centres in identifying and supporting pregnant women and mothers with complex social issues which may impact on the health of themselves and their baby is particularly important. Good practice, such as the support given to mothers in children's centres in the Kirklees area, should be widespread.

26

Access to appropriate secondary and tertiary care can be then made without delay. Seamless pathways between maternity and neonatal networks should exist with adequate capacity being available in both obstetric and neonatal units. Alternative facilities should be discussed with women and their partners in case a complication occurs at any point in the pathway when women go into labour. What this means in practice is that choices for women who go into labour early may need to be more limited – with access to a specialist unit – in order to improve outcomes for mother and baby. The evidence shows that in-utero transfers have better neonatal outcomes. If previously informed, most women will accept this.

27

Women who have issues relating to their mental health or have a family history of mental illness should be given the opportunity to discuss their potential needs in the antenatal period within the maternity team. For women with existing perinatal mental illness, accessing specialist care in mother and baby units would avoid separation of mothers and babies. Early recognition and treatment would enable women to return to their home provided that there is sufficient community mental health support available locally. This makes sound economic sense as well as being best for mother and baby.

#### Labour and Birth

28

The CPG endorsed the recommended NICE guidelines about care in labour so that women receive optimal care which meets their aspirations and choices. Maternity Matters outlines the national choice guarantees which must be available to all women by the end of 2009.



29

Whilst there should be discussions in the early stages of pregnancy about the choice of place of birth, an essential component is that women should be able to make choices up to the point of early labour. This is a departure from what happens currently, though has been shown to be successful in Wales and North Devon, where a midwife will visit a woman at home when labour has started, make a holistic assessment, discuss the findings with the woman and her partner and help make a decision at that point about place of birth.

30

Part of the choice guarantee is that women may choose to give birth in any unit. In Y&H clinicians suggested that the aspiration for the next decade is that our hospitals and services are always the preferred choice for mothers – except where there are highly specialised needs which are not catered for by our own hospitals. Commissioning in networks, so that a range of choices are available for women, should support this approach.

31

Once labour has started, women who participated in our focus groups identified the need for open-access to hospital with adequate facilities to support labour when birth is planned for that setting.

32

There should be one-to-one care for women in established labour in all units (after 4cm dilatation of the cervical os). There is overwhelming evidence that this reduces intervention and has better outcomes.

33

Increasingly over the next 10 years, women who choose home birth should have this expectation honoured, and unless there is a clinical need for mother or baby, they should not need to transfer the place of birth to hospital. Optimal numbers of all staff should be available to provide labour care during labour at home with adequate supervision by senior staff if needed. The overriding priority must be the safety of mother and baby.

### Postnatal Care of Healthy Mother and Baby

34

Mothers and babies must be cared for together to promote early attachment, and establish breastfeeding. Information should have been given to women and their families during the antenatal period which outlines the likely length of stay if they do not have a home birth. The advantages of returning home to their family and settling in with a new baby shortly following birth should be encouraged. There is some evidence to suggest that breastfeeding is more successful at home with good support. Some areas, like Mid Yorkshire, have established good systems of peer group support from hospital to home.

35

In the future, during the postnatal period, women should have the choice of accessing care at home, or in a community setting such as a Surestart Children's Centre. The latter provides them with the ability to meet others and avoid social isolation.

36

There are a number of examples of where other premises have been used very successfully for postnatal care/advice, including the North Lincolnshire Town Centre 'shops' where women were invited to attend the venue with or without an appointment for postnatal advice and support, particularly for breast feeding. As more of these 'one-stop shops' for maternity and newborn care become established, and midwives move into these bases, they may become a much wider resource for families.

### The Sick Newborn

37

The CPG was clear that the standard of care for the sick neonate should meet the standards of care as detailed in the Department of Health Expert Working Group 2003. The evidence shows that if transfer is needed the outcomes are better if this is done in utero. However, where this does not occur, a comprehensive transport service is vital. Women and partners must be aware of choices for care, preferably during the antenatal period before the onset of labour.

38

The capacity to repatriate infants to units close to home, as soon as possible, is equally necessary. Where follow-up care may be necessary, requiring the expertise of professionals outside maternity and neonatology, such as in cases of retinopathy of prematurity, commissioners must ensure that service user-focussed care pathways are in place, to facilitate timely treatment within Y&H, which limit journey times for parents.

39

As an essential part of care delivery, for babies who need support within the neonatal unit for a period of time, aftercare should include direct and indirect supervision of parents caring for their babies, in preparation for going home. Support for parents within the home, when the infant is discharged, should be by skilled professionals. Contact with appropriate health/social care agencies must also be in place to achieve confident parenting and ongoing care of the infant. Any such package of care should be in place prior to discharge.

40

The overall challenge, therefore, is to ensure the individual aspirations, expectations and needs of women and families are met through intelligent commissioning and the provision of a bespoke service through which each woman can make informed choices and receive high quality care, at each stage of the pathway.

### Barriers to Change

41

The CPG identified a number of barriers to change.

### Tariffs

42

Although the focus of the CPG has not been on tariffs, the clinical staff who have engaged so far always raised this issue. Nationally, the Foundation Trust Network and other care providers have raised issues of tariffs with the Department of Health. We note the Department of Health have increased the tariff by 8% and increased the tariff for home births. The issue of tariff is particularly important in Y&H where more than a third of our units have less than 2,500 births per year. Local experience suggests that (under tariff as currently constructed) 2,700 births is the point at which maternity units stop needing cross subsidy from other services. It is important to align financial incentives better to help support service development.

### Maternity Information Management and Technology (IM&T)

43

Across Y&H some maternity units are collecting information manually or using systems of variable quality. The CPG wanted to see the introduction of the maternity phase of Connecting for Health accelerated.

### Workforce

44

Although there are only a few units in Y&H that need to increase the consultant obstetric cover from 60hrs per week to 98hrs per week the CPG advised this will not be easy. The implication is that consultants may need to be resident.

There also needs to be an assessment of the appropriate levels and mix of staffing for the non-medical workforce, for example the use of consultant midwives and maternity support workers.

45

The majority of children centres in Y&H have struggled to find accommodation for midwives to work within primary care alongside a multi-agency team without added cost for accommodation. This is a barrier to progress in this area.

### Good Practice

Within Y&H, there are areas of creative practice which the CPG thought should be considered for replication and sharing elsewhere in the region.

Doncaster has been a demonstration site for The Improving Access to Psychological Therapies (IAPT) programme and recently won the Y&H Health and Social Care Award for Service Transformation. This programme seeks to deliver on the Government's 2005 commitment to provide improved access to psychological therapies for people who require the help of mental health services.



It also responds to service users' requests for more personalised services based around their individual needs.

Figure 20 describes how this approach works for women with perinatal health issues in Doncaster.

## Conclusion

46

Pregnancy and birth should be a positive experience. Women told us that labour is the most important episode in the process for them – that they feel vulnerable and need to feel secure and nurtured. They also said that information, care and procedures need to be consistent and standardised – that they want information and advice, but not in a way that alienates them. Maternity and newborn services across Y&H vary widely. By using Maternity Matters as a foundation, the core offer for women will become more aligned across the region. The Maternity and Newborn Care Pathway as described here and supported by numerous external guidelines, will help staff to deliver a service of which present and future generations can be justifiably proud.

47

Our pledge in taking forward this pathway will be to support an increase in breastfeeding rates – with reduced variation across the region.

**Figure 20.** The Doncaster Experience in improving perinatal mental health services.

At booking the midwife asks women 3 questions about their mental health as recommended by NICE and if there is a history of depression or current low mood then a PHQ9 questionnaire is filled in by the woman.

If they are severely depressed or have been previously diagnosed with either bipolar disorder, schizophrenia, previous puerperal psychosis etc. then they are referred to a Community Mental Health team.

If identified as having a low or moderate degree of depression, then they are referred to Improving Access to Psychological Therapies (IAPT).

The service is relatively new, but is providing good outcomes for the majority of women seen with mild depression. The women can be referred by their GP, midwife, or she can self refer.

There is no waiting list with a lot of the contacts being by telephone. The service is also working with the libraries in Doncaster to provide a book prescription service, so that people can borrow self help books.

For further information: Google 'IAPT Doncaster' or contact debby.mcknight@dbh.nhs.uk

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