

Maternity Services Recommendations

Introduction

In January 2014, the nine CCGs in Hampshire, Dorset, Portsmouth, Southampton and the Isle of Wight asked the Strategic Clinical Network for Maternity, Children and Young People to develop a 5-10 year strategic plan for maternity, neonatal and paediatric services. This proposal was supported by the Strategic Clinical Network Steering Group¹ in February 2014.

The draft strategy entitled 'A Vision-Led Model for Safe and Sustainable Maternity Services' was presented by the Strategic Clinical Network to the Wessex Clinical Senate Council in June 2014 along with a number of research articles and other papers outlining good practice in this area. Presentations were made at the council meeting by a range of stakeholders including acute providers, ambulance trusts, mental health providers, public health and commissioners.

The Strategic Clinical Network asked the Senate Council to provide a strategic view on physical and mental health pathways across obstetrics and maternity services rather than how services should be reconfigured.

The Strategic Clinical Network is also working on a vision-led model for paediatric services. The Senate Council noted that by considering both visions together, CCGs will receive clear direction as to what needs to be commissioned to ensure that maternity, neonatal and paediatric services are safe, sustainable and deliver the best outcomes now and in the future.

¹ The Strategic Clinical Network for Maternity Children and Young People provides clinical system wide strategic leadership across Hampshire, Dorset, Portsmouth, Southampton and the Isle of Wight (Wessex). All NHS providers and commissioners of maternity, children and young people's services in the area (both physical and mental health) are invited to attend quarterly meetings of the Steering Group. Also invited to send representatives are local authorities, public health, health education and the Academic Health Science Network. There is also a broader stakeholder group which includes charitable and voluntary organisations, patients and the public. These stakeholders are invited to attend a couple of meetings a year to discuss specific topics. For more information on the work of the Strategic Clinical Networks in Wessex please see www.wessexscn.nhs.uk/

If there are options for reconfiguration resulting from the vision-led models for maternity and paediatric services, the Senate Council will be asked to review these service changes as part of its assurance role for NHS England.

The Senate Council recommended that the final version of the strategy produced by the Strategic Clinical Network should reinforce the messages in “Commissioning Maternity Services: A Resource Pack to support Clinical Commissioning Groups” which was published in July 2012 by the precursor to NHS England².

Recommendations of the Clinical Senate Council:

In order to achieve the best outcomes for the care of pregnant women, their baby and their family, the Senate Council considered the whole pathway of care under the following categories: Preconception Care, Antenatal Care, Intrapartum Care, Postnatal Care and Service Delivery.

It was noted that the formation of a clinical/operational network had been discussed by the Strategic Clinical Network Steering Group to oversee the implementation of the recommendations and the strategic vision. The Senate Council agreed that a clinical/operational network should be set up by commissioners and it is referred to in several recommendations.

Preconception Care

- 1) Commissioners should actively promote awareness of the positive impact good physical and mental health can have in the period up to two years before conception, outlining how it can help both the birth and the health of the baby. All women of child-bearing age (and if possible their partners and families) should be aware of the health benefits of a conception which is planned and prepared for.

² NHS Commissioning Board ‘Commissioning Maternity Services: A Resource Pack to support Clinical Commissioning Groups’ July 2012 www.england.nhs.uk/wp-content/uploads/2012/07/comm-maternity-services.pdf

- 2) Commissioners should explore the development of a tool to assist women and their partners to get physically and emotionally fit to get pregnant.
- 3) All women of child-bearing age should be aware of the pre-existing physical and mental health conditions which place them in a higher risk category. Women who are categorised as higher risk should be offered pre-conception counselling to help them to make the right choices on place of birth and lifestyle and to ensure that they have the support they need.
- 4) Specific commissioning pathways should be developed for women of child-bearing age with diabetes, epilepsy, mental health, alcohol abuse, drug abuse obesity and other long term conditions.
- 5) A training plan should be developed to enable appropriately skilled staff working in pre-conception and early years to deliver consistent public health messages that mothers and fathers are receptive to in an environment of their choosing.

Antenatal Care

- 6) There should be awareness, early recognition, signposting and early referral to meet the needs of parents (mothers and fathers) with mental health and drug/alcohol problems. Access to perinatal mental health services should be equitable across Hampshire, Dorset, Portsmouth, Southampton and the Isle of Wight and meet national standards.
- 7) Universal Carbon Monoxide screening and universal smoking cessation services should be offered to both expectant mothers and fathers at booking.
- 8) GPs should be supported to redevelop/refresh their ante-natal competencies to allow their greater involvement in maternity care. Mothers should be informed and supported in their choice of maternity care, including access to specialist support where this is required.
- 9) There should be a single accessible patient held electronic record, which sets out plans and expectations and supports the needs of the family.
- 10) All antenatal care should be provided in accordance with the NICE guidelines and as close to home or work as possible.

- 11) Ultrasound scanning should be provided as close to home and work as possible and include individual growth projections. This will require a review of the workforce plans for ultrasonographers.
- 12) The uptake of the 'Healthy Start'³ Programme should be promoted – every contact with health and social care should promote the health of the mother and baby with consistent clear messages. This programme includes maternal vitamin D supplementation for low income families.

Intrapartum Care

(The intrapartum period extends from the beginning of contractions that cause cervical dilation to 1 - 4 hours after delivery of the newborn and placenta)

- 13) Women should be able to choose what type of pain relief they are able to access, their place of birth and where they receive ante-natal and post-natal care. The clinical/operational network should monitor the choices made and measure outcomes to inform improved stratification of clinical need and risk.
- 14) All services should work to increase the number of women who are able to deliver normally and at or near to home.
- 15) Obstetric care should only be provided by Obstetric-led Units that deliver a 24/7 presence. It must include: fully trained specialist doctors, at least two obstetric theatres, anaesthetic and intensive care on site. Interventional radiology and neonatal unit level 2 support must also be available on site 24/7.
- 16) Services providing Obstetric care should be supported by appropriate neonatal facilities. Fully trained paediatric staff should be available on site 24/7, in accordance with the consultant present care model, to support neonatal units.
- 17) In order to maintain the level of competency required to care for both high and low risk mothers who may present in different settings, it is proposed that Stand-alone Midwife-led Units⁴ should be staffed by midwives who perform home births and who also work regular shifts in both Alongside

³ www.healthystart.nhs.uk/

⁴ A Stand-alone Midwife-led Unit is usually not on the same site as an Obstetric-led unit. There are usually no doctors at these units, but GPs may be available and there will be transfer arrangements in case of an emergency.

Midwife-led Units⁵ and Obstetric-led Units so that they maintain the skills and relationships needed to care for both high and low risk mothers (hub and spoke model).

- 18) Enhanced Stand-alone Midwife-led Units (also referred to in the UK as “Midwife-led Plus Units”) may be suitable for some areas with demographic and geographic challenges. In these units, mothers who need a caesarean would be booked in to have one on a specific date (elective caesareans) plus doctors would be there at night (“a hospital at night system”). Midwife-led Plus Units need to be supported by an Obstetric-led Unit at a “hub” hospital.
- 19) Where there are geographical considerations, first time mothers who are low risk should be offered appropriate and adequate advice and support services, with counselling where necessary, to choose an Alongside Midwife-led Unit to improve the chances of a normal birth whilst minimising the risks of transfer in labour. Women having second or subsequent babies or at low risk of developing complications should be offered appropriate and adequate advice and support services, with counselling where necessary, to give birth in a midwife led environment (at home or in a Stand-alone or Alongside Midwife-led Unit).
- 20) Midwife-led Plus Units offer an alternative to Alongside Midwife-led Units where access to the latter is challenging. There should be access to full recovery facilities with resuscitation on site in this type of unit to support elective caesareans.
- 21) An active programme to encourage a vaginal birth after a single caesarean section should be promoted with adequate counselling and support services to assist women in decision making.

Postnatal Care

- 22) The uptake of the ‘Healthy Start’ Programme should be promoted – every contact with health and social care should promote the health of the mother and baby with consistent clear messages.

⁵ An Alongside Midwife-led Unit is on the same site as an Obstetric-led Unit and is usually in the same building or in a separate building on the same site.

- 23) Good working relationships between GPs, midwives and health visitors should be refreshed and reinforced through the commissioning process. This could present a challenge because health visitors will be not be funded by the NHS in the future but by Local Authority Public Health Services. However, this also presents an opportunity because Local Authorities lead on the development of early years (age 0-5) strategies for each area.
- 24) In order to receive optimum care women should spend no more than 48 hours in an Obstetric-led Unit, unless clinically indicated for mother or baby, then go home or step down to a Midwife-led Unit for recovery and post-natal care (most women currently spend less than 24 hours in a unit before going home). All Obstetric-led Units should work in this hub and spoke way with Midwife-led Units.
- 25) Women who lose their babies should have access to emotional and psychological support on a 7 day a week basis. This support should be extended to fathers and partners also.
- 26) Risk assessment should be consistent and pathways should be monitored to avoid the need for emergency transfers. The Strategic Clinical Network should advise on a single standardised risk assessment tool for each setting to be used by all services in Hampshire, Dorset, Portsmouth, Southampton and the Isle of Wight.

Service Delivery

- 27) All maternity services should be commissioned for health outcomes as part of a wider integrated approach from pre-conception to school age and should be consistent with the resource pack for commissioning maternity services.
- 28) A clinical/operational delivery network should be set up to support cooperation and dialogue with commissioners. The network would oversee the implementation of these recommendations with a view to providing access closer to home, using telemedicine and appropriately skilled staff who need not be GPs, midwives or health visitors. The network would also review services from pre-conception to school age and include organisations outside the boundaries who deliver services to people in Hampshire, Dorset, Portsmouth, Southampton and the Isle of Wight.

- 29) The clinical/operational network and commissioners should publish the outcomes for mothers and babies on a regular basis.
- 30) Commissioners, with the assistance of the network, should review the number and outcome of pre and post-natal home visits.
- 31) Commissioning plans need to be integrated and nested in the context of local partnership arrangements (via Health and Wellbeing Boards).
- 32) Standardised risk assessment tools for each setting should be used by all services in Hampshire, Dorset, Portsmouth, Southampton and the Isle of Wight.
- 33) Services in Hampshire, Dorset, Portsmouth, Southampton and the Isle of Wight should provide accurate information on risk, in a way that fosters as much ownership of health issues and personal empowerment as possible.
- 34) The phone line for women in labour currently provided by Hampshire Hospitals in partnership with South Central Ambulance Service to women booked to give birth in Andover, Basingstoke or Winchester should be extended across Hampshire, Dorset, Portsmouth, Southampton and the Isle of Wight. The 24 hour service provided by an experienced midwife via 999 or 111 gives advice to women who call about their birth plan and onset of labour so that they can stay confidently at home in the early stages of labour and/or be advised whether an emergency response is needed.