Title: Maternity Services – Strategic priorities, Quality and Safety
Agenda Item: 8

1 Purpose

This report provides information to the Governing Body on the role of the Clinical Commissioning Group (CCG) in commissioning and monitoring maternity care. It includes information on the systems in place for assurance of clinical quality and safety in maternity services for the Bristol area. It also asks members to approve the draft Maternity Services Strategy for the Bristol, North Somerset and South Gloucestershire (BNSSG) area.

This report is accompanied by the draft Joint BNSSG Maternity Strategy and an overview of key maternity statistics for the area.

2 Background

Bristol CCG is responsible for commissioning both community and hospital based maternity services. Services are provided by North Bristol NHS Trust (NBT) from Southmead and Cossham Hospitals, and by University Hospitals Bristol NHS Foundation Trust (UHB) from St Michaels Hospital. Both Trusts operate out of a number of community midwifery bases and also support home births. Both main maternity hospitals offer both consultant and midwife led care and are linked to a Tier 3 Neonatal Intensive Care Unit (NICU). Cossham Birth Centre is a stand-alone midwife-led unit in Cossham Hospital.

Bristol CCG works in partnership with South Gloucestershire and North Somerset CCGs to co-ordinate our commissioning of maternity services. Both Trusts have catchment areas which cross CCG boundaries, and at the moment UHB is providing clinical management of maternity services at Weston General Hospital (Ashcombe Birth Centre and community bases). We have a joint Maternity Services Liaison Committee (Maternity Voices) across the area which includes around 35 lay representatives from a range of community organisations and also has a website and Facebook page to allow individual women to comment on services.

Bristol saw a steady increase in the birth rate in the period 2001-2 to 2011-12, rising from 4,600 births to 6,900. However there has been a reduction in the last two years with 6500 births in 2014-15.

Current priorities for maternity services are set out in the draft Maternity Services Strategy which is attached to this report, and is summarised in section 3 below.
There is a particular focus on how we assure quality and safety in maternity services, which is a response to the Kirkup Report into failings in maternity services at Furness General Hospital (Kirkup 2015). This highlighted the tragic consequences which can result when maternity services are not commissioned and provided to the highest standards. In particular it identified issues relating to:

- Clinical competence
- Poor inter-professional relationships
- Failure to investigate incidents adequately, conflict of interest and lack of openness and honesty
- Poor risk assessment and care planning

It is also clear from the investigation that there was no active commissioning involvement in maternity services in Cumbria. The two Primary Care Trusts which covered the area did not have a maternity strategy or service specification, and issues in maternity services were not picked up through performance monitoring arrangements. There was also no Maternity Services Liaison Committee for the area.

3 Maternity Strategy and current priorities

Bristol CCG does not have an up to date Maternity Strategy. A draft Joint Maternity Strategy for the BNSSG area has been developed for approval by the commissioners and providers. This is largely a refresh of existing local and national priorities, but provides an update of action plans against these priorities.

An in-depth review of Maternity and Neonatal Services for the BNSSG area took place between 2006 and 2009. A review panel was established, with involvement from commissioners, all providers and service user and third sector organisations. The outcome of the review was to agree some common standards and priorities for maternity and newborn services. These have been retained in the new Strategy and Action Plan.

The review considered but rejected the option of reconfiguring maternity services, although it did support the need for additional midwife led birth centre capacity. Following the review a stand alone Birth Centre was established in Coßham Hospital, and a midwife led birth unit in St Michaels’s Hospital.

There have not been any major changes in national policy on maternity services since that review, with the emphasis remaining on ensuring choice and safety.

The draft Strategy will be kept under review, particularly if there are any changes from the national review of Maternity Services which is being led by Baroness Cumberlege.

Infant Mortality Action Plan and Public Health priorities

The number of perinatal and infant deaths (including stillbirth, neonatal death and death up to age two) is very low. However there are some identifiable risk factors which are addressed in the Infant Mortality Action plan which is an appendix to the Maternity Strategy.

These link very strongly with public health priorities in particular
Maintaining the recent reduction in teenage pregnancies
• Reducing rates of smoking during and after pregnancy
• Reducing maternal obesity

While there has been very good progress over recent years in reducing the teenage pregnancy rate, the issues of smoking and obesity are harder to address. Rates of smoking in pregnancy have reduced and are below the national average but this improvement has now reached a plateau.

Maternal obesity is an issue of concern which needs to be addressed as part of a wider obesity strategy.

**Place of birth and capacity issues**

Ensuring sufficient capacity in maternity services has been a challenge over the last few years, particularly during the period of rising birth rates up to 2012. The opening of two midwife-led birth centres in 2013 added eight beds to the capacity.

The Birthplace in England study (Birthplace in England Collaborative Group 2011) found that for women at low risk of complications, planning birth in a midwife-led unit was associated with better outcomes for the mother without any increased risks to the baby. The same was true for women planning a homebirth if they had had a baby before, but for first time mothers there was a slightly increased risk of adverse outcomes for the baby when planning a homebirth, but not when planning birth in a midwife-led unit. The NICE Intrapartum guidelines (December 2015) were updated in line with these findings to recommend that low risk women give birth in midwife-led environments.

Bristol CCG, in collaboration with Maternity Voices, the BNSSG maternity care providers and the other local CCGs, is currently conducting an evaluation to assess the impact of the changed provision of midwife-led birth facilities across the area and to estimate the potential demand for further midwife-led capacity which could result from the updated NICE guidance.

**Continuity of Midwife care**

Improving the continuity of midwife care in the antenatal and postnatal period has been identified as a national priority. There is also evidence that it is associated with better clinical outcomes and greater satisfaction with care.

An audit in 2013 of nearly 400 maternity records from NBT, UHB and WAHT demonstrated wide variation in the number of different community midwives seen during pregnancy: the mean number was 3.50 at NBT, 3.63 at UHB and 3.12 at Weston Area Health Trust, however this mean varied greatly by team from fewer than two to almost five. The accompanying survey showed that women rated seeing the same midwife highly.

An action plan was agreed with provider Trusts with the aim of reducing the average across all teams to no more than three different community midwives during the antenatal period. A re-audit will be performed within the next few months.

Results from the Friends and Family Test at both Trusts indicate lower levels of satisfaction with post-natal care.
**Perinatal Mental Health**

Ensuring appropriate services for women who experience mental health problems during and after their pregnancy is a high priority both locally and nationally. This work is led through the CCG Mental Health Steering Group. We are currently undertaking a review of the local pathway and this will inform commissioning priorities for future years.

The CCG will be required to produce a Transformation Plan for Perinatal Mental Health, although guidelines for this have not yet been published and we do not know what the financial allocation will be to support this work.

### 4 Quality and Safety

There are a range of systems and processes in place to provide assurance on the quality and safety of maternity services in the BNSSG area. Feedback is reviewed quarterly at the maternity joint commissioning meeting, which is attended by all BNSSG commissioners and providers, and public health representatives from the local authorities and NHS England when relevant. Where necessary issues would be escalated through the individual Trust contract review meeting or to the CCG Quality and Governance Committee.

Both Trusts have reviewed the Kirkup report and provided Bristol CCG with a response which outlines the clinical governance systems they have in place, and actions planned in response to the report’s recommendations.

**Inspections**

The Clinical Negligence Scheme for Trusts (CNST) inspections have been discontinued but until 2013 these offered a high level of assurance. Both UH Bristol and NBT achieved level 3 (the highest level). This means they passed assessment on their clinical governance processes as well as numerous care processes, based on their clinical guidelines, audit of maternity records and action planning in response, as well as record checks by inspectors.

Both Trusts were judged as having strong clinical governance in the Care Quality Commission (CQC) inspections undertaken in autumn 2014, with good risk assessment and care planning in place. Maternity Services at UHB were rated ‘good’ overall. NBT’s maternity service at Southmead was rated as ‘needs improvement’, primarily due to staffing levels and issues with the physical environment. In response, NBT have funded and recruited extra staff, which has seen maternity unit closures reduce. NBT’s maternity service at Cossham was rated ‘outstanding’.

While no inspection process can give total assurance, these inspections and all the work that goes into preparing for them require a service-wide focus on quality and safety. However they are only a spot check at a point in time and therefore need to be balanced with other evidence.

**Outcomes monitoring**

Commissioners also receive data on a range of outcomes and quarterly highlight reports directly from the Trusts, and use additional data from NHS England/ Public Health England, Hospital Episode Statistics (HES) and the Office of National Statistics (ONS), both to validate the figures received from the Trusts and to benchmark against other core cities and national figures. The South West
Strategic Clinical Network for Children and Maternity has agreed a framework for benchmarking against other, similar services and will apply statistical process control methods to the data to help discern between normal and abnormal variation.

The CQC monitors a number of maternity-related outcomes nationally. They will inform Trusts if one of their outcomes falls outside of the expected range and request a response/investigation.

Both Trusts submit information about perinatal and maternal deaths to the MBRRACE programme of the National Perinatal Epidemiology Unit (NPEU), which provides detailed national reports on themes and lessons learned, and gives feedback to the Trusts. In the recently published report on perinatal deaths, the perinatal mortality rate for Bristol CCG was up to 10% lower than the UK average and the overall rate for the BNSSSG area was more than 10% lower than the UK average. For confidentiality reasons and because maternal deaths are rare, the reports on the investigation into maternal deaths do not give details by provider or CCG.

We have noted that maternal deaths appear to occur more frequently in the BNSSG area than the national average. There were five reported in 13/14, four in 14/15, and three so far 15/16, from a birth population of 12,000, compared with 1 in 10,000 overall nationally. However, it is possible that this is due to chance due to the rarity of maternal deaths. These deaths also include women who received antenatal care outside the BNSSG area but who were transferred to the regional specialist facilities. The majority of these deaths did not relate to direct clinical care, but involved complex social factors, or pre-existing serious medical conditions. The CQC does not monitor trends in maternal deaths and there is no national system to identify outliers, although CQC inspection teams may review the response made by a Trust when a death has occurred.

Incidents are reported to the CCG via STEIS based on an explicit set of criteria. Investigation reports are scrutinised by the CCG Quality Team for thoroughness. Details of serious incidents and maternal deaths are reviewed at the quarterly Maternity Joint Commissioning meeting.

However because of the lack of any systematic review process, it has been suggested that the CCG support the Trusts to commission an independent review of deaths which have occurred in the last three years to see if there are any common lessons.

**Working relationships and training**

There is a good working relationship between the providers and commissioners, with open discussion of incidents and issues. We hold quarterly joint meetings which aid area-wide collaboration and sharing of best practice. As many women will move between the different maternity services it is essential to have common processes and standards in place.

Both Trusts monitor staff attendance at their training days in obstetric emergencies and other mandatory training. Training includes dealing with emergencies in the midwife-led unit and the community. The training is multi-professional, which promotes good working relationships and effective teamwork.
Maternity services user feedback, strategy and service specification

Channels for maternity service users to feed back or complain are well signposted. We recognise that this may be more difficult for some groups than others, and not all will have the confidence to speak up if something is not right; we try to address this through Maternity Voices.

We have a detailed maternity service specification which sets out the requirements for the service, including quality standards and performance reporting.

5 How have service users, carers and local people been involved?

The CCG supports Maternity Voices in order to ensure good service user involvement. Each Trust also has mechanisms for service user feedback and involvement which are described in this report.

6 Implications on equalities and health inequalities.

An equalities impact assessment will be prepared when the Strategy is approved by all commissioners and providers.

<table>
<thead>
<tr>
<th>Please indicate below the age group/s covered by the service/affected by the issue discussed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children/Young People</td>
</tr>
</tbody>
</table>

7 Evidence Informed Commissioning

The Maternity Strategy is informed by current evidence including the Birthplace in England study (Birthplace in England Collaborative Group 2011) which confirmed the safety of midwife-led units for women at low risk of complications.

Although there are no trials evaluating the effect of continuity of care specifically in the antenatal period alone, there is good quality evidence that compared with standard maternity or hospital-based care, midwifery-led continuity models of care in pregnancy and during labour are associated with a number of benefits which are likely to be at least partly attributable to antenatal continuity of care: increased satisfaction with care

- women reporting they feel better informed, prepared, in control and involved in decision making
- reduction in preterm birth and fetal loss up to 24 weeks
- reduced antenatal admissions
- increased breastfeeding initiation
- reduced maternity care costs

(NICE 2008, Sandall et al 2013, Tracy et al 2013)

8 Financial Implications

Maternity Services are now funded by a pathway tariff so that the provider receives a single payment for the whole ante-natal period, the birth episode and
the post-natal period. There are three levels of payment for ante-natal and postnatal care: standard, intermediate and intensive, based on any additional clinical or complex social needs. The birth episode is funded as either with or without complications.

This system is intended to encourage providers to focus on early preventative care and to avoid unnecessary hospital activity. The only exception is that the commission does cover the cost of excess bed days if a woman has to stay in hospital following the birth.

Public Health in Bristol fund two specialist midwife posts (one in each Trust) for women with drug and alcohol problems. These services are commissioned through Safer Bristol. The CCG currently funds two Teenage Pregnancy Midwives. The future arrangements for these posts are being reviewed in order to inform commissioning intentions for 2016-17.

Neonatal care is now commissioned by NHS England.

9 Legal implications

There are no legal issues raised in this paper

10 Risk implications, assessment and mitigation

Set out here all risks associated with the paper/proposals, the outcome of any risk assessment and actions taken to mitigate those risks.

11 How does this fit with Bristol CCG’s Operational Plan or Strategic Objectives?

Commissioning high quality maternity services is an essential function of the CCG which contributes to long term health outcomes.

12 Recommendation(s)

12.1 Members are asked to approve the BNSSG Joint Maternity Strategy

12.2 Members are asked to note the arrangements in place for monitoring of quality and safety in maternity services

Inge Shepherd, Programme Manager Children and Maternity Commissioning
Andrea Blotkamp, Maternity Commissioning Project Manager
6 August 2015

Alison Moon, Director of Quality and Transformation

Glossary of terms and abbreviations

<table>
<thead>
<tr>
<th>MBRRACE-UK</th>
<th>Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Confidential enquiries into maternal and perinatal deaths conducted by the NPEU (National Perinatal Epidemiology Unit)</td>
</tr>
</tbody>
</table>
The numbers of maternal deaths are so small that analyses of rates even on the basis of a CCG area will not be able to detect any except the most major differences as statistically significant, so the NPEU does not conduct such analyses of maternal death rates. They do monitor deaths within units, and escalate concerns to the medical director and HQIP as per the HQIP standard concerns protocol, which requires them to escalate individual cases which they consider to meet one of the following criteria:

- Death (child or adult) attributable to abuse or neglect, in any setting, but no indication of cross agency involvement (i.e. no mention of safeguarding, social services, police or Local Safeguarding Children Board).
- Staff member displaying:
  - Abusive behaviour (including allegations of sexual assault)
  - Serious professional misconduct
  - Dangerous lack of competency but it is not clear if the incident has been reported to senior staff
- Standards in care that indicate a dysfunctional or dangerous department or organisation, or grossly inadequate service provision.

<table>
<thead>
<tr>
<th>STEIS</th>
<th>Strategic Executive Information System</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>National system to report serious incidents according to the criteria set by the National Patient Safety Agency</td>
</tr>
<tr>
<td></td>
<td>National Framework for Reporting and Learning from Serious Incidents Requiring Investigation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NRLS</th>
<th>National Reporting and Learning System</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The database of patient safety information, to identify and tackle important patient safety issues at their root cause.</td>
</tr>
</tbody>
</table>

| Indirect and direct maternal deaths | Direct maternal deaths were due to complications directly caused by pregnancy; indirect maternal deaths were not directly due to pregnancy causes, but by medical or mental health problems that were made worse by pregnancy (e.g. epilepsy, suicide or flu) |

<table>
<thead>
<tr>
<th>NPEU</th>
<th>National Perinatal Epidemiology Unit</th>
</tr>
</thead>
</table>
Joint Maternity Strategy 2015-2020
Bristol, North Somerset and South Gloucestershire

Introduction

For most women and their families, having a baby is a momentous but normal life event. It is also the most common reason for hospital admission in England (National Audit Office 2014), and for many people it is their first experience of healthcare beyond what is provided by their GP. High quality care before, during and after pregnancy can have a large impact on the short and long term health and wellbeing of women and their children. National policy continues to stress the need for choice, continuity and accessible and coordinated care as set out in Maternity Matters (2007), against a backdrop of an increased birth rate and increasing complexity and organisational change. Intervention rates and litigation costs have risen steadily and inequalities remain associated with variation in access to the maternity services and in outcomes for mothers and babies (MBRRACE-UK 2014).

Maternity care in Bristol, North Somerset and South Gloucestershire (BNSSG) is provided by three NHS Trusts: University Hospitals Bristol NHS Foundation Trust (UHBristol), which runs St Michael’s Hospital in Central Bristol, North Bristol NHS Trust (NBT), which runs Southmead Hospital in North Bristol and Cossham Birth Centre in Kingswood, and Weston Area Health NHS Trust (WAHT), which runs Ashcombe Birth Centre in Weston-super-Mare. WAHT’s maternity services are managed by UHBristol on behalf of WAHT. Each Trust also provides community-based midwifery services. There is considerable movement of women between the services and a long history of collaboration between the three Trusts as well as between the three BNSSG Clinical Commissioning Groups (CCGs).

This joint maternity strategy formulates the aims and objectives shared by the BNSSG maternity service providers and commissioners, Maternity Voices (the BNSSG Maternity Services Liaison Committee) the local authorities across the area and NHS England. The strategy includes priorities for the whole area, as well as addressing more local needs in particular areas and communities; the emphasis may be on different objectives in different areas.

The overall aims of the joint BNSSG maternity strategy are:

- to align the strategic aims and objectives of maternity service users and the organisations involved in maternity care across the BNSSG area, and national guidance
- to improve equality of access to services across the area/consistency of service provision
- to promote a shared philosophy of care

Recent history and current situation

Maternity and newborn services across BNSSG underwent an extensive review from 2006 to 2009 with input from maternity service users, staff and the public, to ensure that every parent and baby has the best possible experience of birth and early days. Although the review did not recommend any changes to the configuration of the maternity services, a number of areas of service improvement were identified. As a result there has been an increase in midwife-led units in the area, with the opening of Cossham Birth
Centre and St Michael’s Midwife-led Unit, giving women more choice in where to give birth and helping to keep birth normal for women at low risk of complications. Other progress includes improved interpreting services to support families whose first language is not English, collaboration between the maternity units and support charities to improve care for bereaved parents, an increase in the number of women who start breastfeeding and the re-establishment of the Maternity Services Liaison Committee.

In recent years, the annual number of births in the area has increased by 20% and although this has now levelled off, some areas continue to have a high birth rate. In addition, women using the maternity services have increasingly complex needs and national guidance has expanded the groups for whom increased levels of care are recommended (for example broadening the indications for labour induction). Against this backdrop the challenge is to build on good practice and to continue work on areas which need further development, ensuring continuing responsiveness to the feedback from the women who use the maternity services and their families.

Deprivation

Bristol, North Somerset and South Gloucestershire differ in terms of population characteristics and levels of deprivation, but there is also great variation within these three areas from very affluent to very deprived, as shown on the map below.

% living in income deprived households reliant on means-tested benefit  (higher score = more deprived)

(Income Domain score from the Indices of Deprivation, 2010. Interactive version showing actual figures for each area is available at [http://www.localhealth.org.uk/#z=311452,200691,78336,46522;v=map4;i=t1.income_dep;i=en](http://www.localhealth.org.uk/#z=311452,200691,78336,46522;v=map4;i=t1.income_dep;i=en)).
The proportion of children living in relative poverty (i.e. in households where income is less than 60% of median household income before housing costs) has decreased only slightly in Bristol between 2006 and 2011, and although lower than in England overall, has very slightly increased in North Somerset and South Gloucestershire during this period (Public Health England 2014).

**Population**

The proportion of births to women who were born outside of the UK also varies across the area; South Gloucestershire and North Somerset have a lower proportion than England overall, and Bristol a similar proportion, but with more women of African origin than the England average. Around two thirds of the women born in the European Union are from countries which joined the EU from 2004 onwards, particularly from Poland. Locally, the majority of women born in Africa are from Somalia, while the majority of women born in Asia are from Pakistan and India (Office of National Statistics 2013). The make-up of the population of women of childbearing age evolves continuously though and recently Bristol has seen an increase in women from Vietnam, some of whom may have been trafficked.

% of live births by mother’s country of birth 2013

[Bar chart showing % of live births by mother’s country of birth 2013 for South Gloucestershire, North Somerset, Bristol, and England, with categories for UK, EU, non-EU Europe, Middle East and Asia, Africa, and Rest of the world.

Birth trends and service capacity

The annual number of births across the BNSSG area increased by about 20% between 2000 and 2010 but has now levelled off. However, parts of Bristol and North Somerset continue to have a high birth rate compared to the England average, particularly parts of Northern North Somerset, Weston-super-Mare, East Bristol and North West Bristol, as shown on the map below. Bristol births are projected to keep increasing slightly over the next 5 years and beyond, while North Somerset and South Gloucestershire births are projected to remain stable (Office of National Statistics 2014). More detailed projections produced by the Bristol Public Health Intelligence Unit based on actual live births in the period 2009-2013 estimate that births in Bristol South, East and North will continue to increase, while those in Bristol West will decrease. Slight increases are also predicted for the Northern half of North Somerset, with a decrease in the South, and slight increases in the North and South of South Gloucestershire. See appendix 1. These projections need to be treated with caution as they are linear forecast based on historical trends and do not take into account other factors. Based on more recent overall figures, increases may be smaller than predicted.
The BNSSG area has historically faced challenges in providing enough maternity beds to cover peaks in demand. This is partly due to the increased local birth rate, but also because both St Michael’s and Southmead are regional Tier 3 NICU units. Such units need to be able to accept pregnant women whose babies are identified as needing intensive care, sometimes from other areas.

The number of maternity unit closures to new admissions at NBT and UHBristol was amongst the highest in the South of England during 2011/12 and 12/13 (Local Supervising Authority report for the South of England 2013). WAHT had very few closures. The opening of Cossham Birth Centre and St Michael’s Midwife-led Unit has added capacity to the maternity services, but the number of maternity unit closures in the Bristol area remained high in 2013/14, particularly at NBT. Extra midwives have been recruited in autumn 2014 at both NBT and UHBristol.

The Royal College of midwives recommends a midwife to births ratio of 1 to 29.5, and Safer Childbirth (2007) recommends 168 hours of consultant presence on delivery suite per week for units with 5000 births or more. While only one unit in the country currently meets this requirement of 24/7 presence, service capacity and the impact of the increased staffing numbers will be monitored - also in view of the plans for new housing across the area. The provision of maternity services for North Somerset will be kept under review as the future of Weston Area Health NHS Trust, which is due to be taken over by another NHS healthcare provider, is decided (the acquisition process is anticipated to be completed in the summer of 2015).

**Total population 2012 and crude fertility rate 2008-2012** (number of live births per 1000 females aged 15-44, represented by the blue shading; the orange circles represent overall population size per ward)
Outcomes

The BNSSG area overall has better outcomes than the national average for several key indicators and has sometimes caught up from a worse starting position (e.g. the reduction in under-18 conceptions); see charts on next page. However, the good overall outcomes mask wide variation within the area, both in outcomes and in the provision of some services, such as breastfeeding support, weight management support and perinatal mental health services. Additionally, the BNSSG area mirrors national trends with nearly half of pregnant women now overweight or obese, the increasing age at which women have their first baby and the increasing number of pregnant women with pre-existing medical conditions.

<table>
<thead>
<tr>
<th>All figures are % and source PHE unless otherwise stated</th>
<th>Low birth weight at term (2012)</th>
<th>Breastfeeding initiation (2013/14)</th>
<th>Breastfeeding at 6-8 weeks (2013/14)</th>
<th>Smoking at the time of delivery (2013/14)</th>
<th>Under 18 conceptions as % of 15-17 yr old females (2012)</th>
<th>Stillbirth rate (ONS 2013) * = overall regional rate</th>
<th>Infant mortality rate (2010-12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Somerset</td>
<td>1.8</td>
<td>81</td>
<td>47</td>
<td>11.8</td>
<td>1.75</td>
<td>0.37</td>
<td>0.39</td>
</tr>
<tr>
<td>South Gloucestershire</td>
<td>2.3</td>
<td>77.3 (2012/13)</td>
<td>47.9</td>
<td>9.3</td>
<td>1.76</td>
<td>0.4</td>
<td>0.22</td>
</tr>
<tr>
<td>Bristol</td>
<td>2.3</td>
<td>82.2</td>
<td>58.5</td>
<td>12.7</td>
<td>2.85</td>
<td>0.4</td>
<td>0.29</td>
</tr>
<tr>
<td>Birmingham</td>
<td>3.9</td>
<td>68.4 (2012/13)</td>
<td>52.3</td>
<td>9.3</td>
<td>3.0</td>
<td>0.49 *</td>
<td>0.67</td>
</tr>
<tr>
<td>Leeds</td>
<td>3.1</td>
<td>74.8</td>
<td>51.6</td>
<td>13.2</td>
<td>3.75</td>
<td>0.51 *</td>
<td>0.39</td>
</tr>
<tr>
<td>Liverpool</td>
<td>2.9</td>
<td>53.2</td>
<td>31.2</td>
<td>17</td>
<td>3.57</td>
<td>0.5 *</td>
<td>0.47</td>
</tr>
<tr>
<td>Manchester</td>
<td>3.4</td>
<td>68.1</td>
<td>42.1 (2010/11)</td>
<td>12.5</td>
<td>4.5</td>
<td>0.5 *</td>
<td>0.5</td>
</tr>
<tr>
<td>Newcastle</td>
<td>3.3</td>
<td>67.7</td>
<td>45.4</td>
<td>16.6</td>
<td>3.31</td>
<td>0.5 *</td>
<td>0.41</td>
</tr>
<tr>
<td>Nottingham</td>
<td>3.5</td>
<td>68.9 (2012/13)</td>
<td>48.8</td>
<td>18.5</td>
<td>3.77</td>
<td>0.42 *</td>
<td>0.47</td>
</tr>
<tr>
<td>Sheffield</td>
<td>2.8</td>
<td>77.7 (2012/13)</td>
<td>49.5</td>
<td>13.8</td>
<td>3.03</td>
<td>0.51 *</td>
<td>0.46</td>
</tr>
<tr>
<td>England average</td>
<td>2.8</td>
<td>73.9</td>
<td>47.2 (2012/13)</td>
<td>12</td>
<td>2.77</td>
<td>0.46</td>
<td>0.41</td>
</tr>
<tr>
<td>English core city average</td>
<td>3.2</td>
<td>69.2</td>
<td>48.2</td>
<td>14.2</td>
<td>3.47</td>
<td>0.46</td>
<td>0.46</td>
</tr>
</tbody>
</table>

Areas which could be improved include the number of women who smoke at the time of birth in Bristol and North Somerset, breastfeeding initiation and continuation in South Gloucestershire, and continuation overall, and women’s experience of maternity care, particularly postnatal care. Stillbirth figures need to be treated with caution due to small local numbers and lack of historical data for local trends, but the possible upward trend in North Somerset women will be monitored.

![under-18 conceptions per 1000 females aged 15-17](source: Public Health England)
Maternity services funding and configuration

The NHS reorganisation in 2013 split the responsibility for commissioning maternity services between several organisations:

<table>
<thead>
<tr>
<th>Service</th>
<th>Organisation funding and responsible for the service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity services, including antenatal care, birth and postnatal care</td>
<td>Commissioned and funded by the Clinical Commissioning Groups; payment based on national maternity pathway tariff</td>
</tr>
<tr>
<td>-Neonatal services</td>
<td>Commissioned and funded by NHS England</td>
</tr>
<tr>
<td>-Inpatient Mother and Baby Units (these are specialised mental health units)</td>
<td>Commissioned by NHS England, funded through the maternity pathway tariff (for detailed guidance on exceptions see references at end of this document)</td>
</tr>
<tr>
<td>-Some very specialist services</td>
<td></td>
</tr>
<tr>
<td>-Antenatal and newborn screening and immunisation programmes (i.e. associated with maternal and neonatal care that is part of the national screening programme)</td>
<td></td>
</tr>
<tr>
<td>-Fetal medicine</td>
<td></td>
</tr>
</tbody>
</table>
Public health elements of maternity care, such as -

- Breastfeeding support
- Weight management support
- Smoking cessation services

Local Public Health departments in the Local Authority (LA)

The payment system for the services has also changed: previously, maternity services were largely paid for actual care given. Since April 2013, the Trust which is lead provider of a woman’s ante- or postnatal care is paid a fixed amount based on an assessment at the start of the ante- or postnatal period to allocate the woman to a standard, intermediate or intensive pathway. If a woman on the standard pathway develops a complication and needs additional care, no further payment will be made. Payment for intrapartum (birth) care depends on whether a woman experienced certain complications, but payment for a caesarean section without complications is now the same as for a normal birth without complications. While the new system is intended to encourage keeping pregnancy and birth normal, it can be costly for a Trust like WAHT with only midwife-led provision, as it has to pay other Trusts for the cost of caring for its women on the standard antenatal pathway if they develop complications which necessitate referral to an obstetrician. (See also the resources section at the end of this document).

The recently published NHS Forward View (2014) includes the intention to review future models for maternity units, in view of the Birthplace in England study and reports suggesting fewer women would prefer to give birth in obstetric units than currently do (nationally this is over 85%, locally just under 80%); it aims to ensure that tariff-based NHS funding supports women’s choices, including making it easier for groups of midwives to set up their own NHS-funded midwifery services.

In addition to the maternity services and specialist services, women and their families continue to receive care from their GP and the continuity provided by the GP can play an important role in pre-conception advice, management of pre-existing conditions and communication in case of safeguarding issues.

Quality and safety

Until April 2014, maternity services were assessed against the Clinical Negligence Scheme for Trusts (CNST) standards to ensure that systems were in place to maintain safety and quality. At their last assessment, WAHT was level 1 (2013), meaning guidelines and risk management processes were documented, and NBT (2012) and UHBristol (2013) were both level 3, the highest level, meaning guidelines were being implemented in practice and monitoring demonstrated at least 75% adherence.

This system is no longer in place and the Care Quality Commission (CQC) is now responsible for inspecting hospital and maternity services. UHBristol and NBT were inspected in autumn/winter 2014 and WAHT will be inspected in May 2015. UHBristol’s maternity services were rated ‘Good’ for being caring, safe, responsive and effective, and ‘Outstanding’ for being well led (overall rating ‘Good’). NBT’s maternity services at Southmead were rated ‘Good’ for being caring, effective and well-led, and ‘Requiring improvement’ for being safe and responsive. The latter was focused on staffing levels and some care environments being too cramped for the increased numbers of people using the service (overall rating ‘Requires improvement’). Although an integral part of part of NBT’s maternity services, maternity services at Cossham were reported on separately; they were rated ‘Good’ for being safe, effective and well-led and ‘Outstanding’ for being caring and responsive (overall rating ‘Outstanding’).
In addition, the lead Clinical Commissioning Group for each Trust (Bristol CCG for UHBristol, South Gloucestershire CCG for NBT and North Somerset CCG for WAHT) reviews the Trust’s performance at its monthly Quality and Governance Committee meetings. This review includes serious incidents, complaints, and Friends and Family Test (FFT) scores.

While CNST was an assessment of processes rather than outcomes, the South West Strategic Clinical Network aims to provide maternity services with a means to assess their performance by comparison of their outcomes with other, similar, maternity units through the development of a regional maternity dashboard. This will allow identification of unexplained variation and sharing of best practice.

**BNSSG shared principles for maternity care**

- Meeting needs of individuals and communities, and ensuring equitable access to services
- Keeping birth normal for low risk women, without delaying appropriate multidisciplinary care for those with risk factors or complications
- Focus on prevention of physical and mental problems, promotion of healthy behaviours, and safeguarding mother and baby

**Identified priorities/aims**

The aims and objectives listed in the table at the end of this document were identified by the three CCGs, the maternity service providers, the South West Strategic Clinical Network and representatives from Public Health, in discussion with maternity service users.

1. Improve maternal health and reduce variation in outcomes across the area
2. Reduce rates of perinatal and infant mortality and morbidity, and reduce variation across the area
3. Improve emotional and mental health and wellbeing of pregnant women and new mothers
4. Improve women and families’ experience of maternity care

**Reviewing progress**

Progress against objectives will be monitored both by the providers themselves via their own monthly dashboards and clinical governance procedures, and via quarterly reporting to Bristol CCG, to be discussed at the Joint Maternity Commissioning and Maternity Voices (MSLC) meetings. The latter reporting mechanism is due to be replaced by the South West Strategic Clinical Network regional maternity dashboard by the end of 2014.
How will we achieve our aims?
(See also table at the end of this document for further detail)

1. Improve maternal health and reduce variation in outcomes across the area

1.a. Reducing risk-taking behaviour and increasing healthy behaviours

Main issues:
- Smoking rates at the time of birth remain high in Bristol and North Somerset, particularly in areas of high deprivation
- Breastfeeding initiation rates in the BNSSG area are higher than the England average, but in South Gloucestershire and North Somerset this is no longer the case by 6-8 weeks
- Nearly half of pregnant women are overweight or obese at booking
- The reorganisation of the NHS has moved public health commissioning related to the above to the Local Authorities, creating challenges for service coordination and data collection

Actions to address the issues:
- The Clinical Commissioning Groups, Local Authorities, maternity service providers and NHS England will collaborate to improve support service availability and consistency. Where possible, Local Authorities may commission the maternity services to fulfil some public health roles, such as smoking cessation, breastfeeding and weight management support, as is currently the case in North Somerset
- Review smoking cessation action plan (2011) including use of CO monitors at booking for all women and at follow up, including at the time of birth and after birth for known smokers (including plan for implementation and reporting CO monitoring at and after birth)
- Access to breastfeeding (telephone) advice out of hours, sustain/expand peer support
- Continue the successful work on reducing under-18 conceptions, and use any transferable strategies in other areas
- The Family Nurse Partnership (FNP) has been launched to support young first-time parents
- Identify variation in outcomes amongst different groups of the population and target interventions, building in particular on successful schemes within the area
- Continue funding of substance misuse clinics and specialist midwives
- Collaborate on/influence wider factors to support healthy lifestyle – e.g. through the local Health and Wellbeing Boards, and other regional or national bodies

1.b. Reducing adverse outcomes and harm to women

Main issues:
- Safeguarding challenges in the area include protecting people from domestic abuse, the increasing number of trafficked women and the substantial number of women affected by or at risk of female genital mutilation (FGM)
- Local rates of postpartum haemorrhage (PPH) appear relatively high compared to elsewhere in the South West – this could partly be due to a higher proportion of women with risk factors and to measurement accuracy, but it would be useful to look into this as it can impact on women’s postnatal wellbeing
- Maternal deaths are very rare in the UK but although deaths from pregnancy-related causes (‘direct deaths’) have halved in the last decade, maternal deaths from non-pregnancy causes
such as pre-existing medical conditions or psychiatric problems (‘indirect deaths’) have not reduced (MBRRACE-UK 2014); local maternal deaths are also very rare and more commonly indirect, and addressing them requires action across a wide range of services, including public health, primary and secondary care, as well as the maternity services.

**Actions to address the issues:**

- **Safeguarding:** build on the successful FGM work in the area, share pathways for trafficked women (developed by UH Bristol), and continue to monitor effectiveness of information sharing between agencies.
- **PPH:** investigate associated factors locally through the providers’ PPH fora and use the South West Strategic Clinical Network to compare rates with other services and share good practice.
- **Maternal deaths:** ensure learning from any deaths is shared across the area, within the maternity services but also particularly with other services, including other clinical services, A&E, mental health and social services, and with any services which have contact with women in the preconception period, such as GPs and pharmacies.

**1.c. Effective information sharing**

**Main issues:**

- Difficulty in obtaining timely and comprehensive data to support service provision, development and commissioning at the most useful level of detail (for example identification of variation in outcomes amongst different groups of the population needs public health access to fine-grained data). The Trust information departments face increasing pressures, there is a considerable amount of duplication, and current data protection legislation has made access to patient-level or postcode-level data more problematic, even when identifiers have been removed.
- Women have access to their paper record in the form of the yellow book, (which currently is the most complete record of her care), but not to their electronic records. This dual record keeping is a time-consuming duplication and can cause discrepancies and incompleteness of both. Non-maternity clinicians do not have access to women’s maternity record unless she brings her paper record (yellow book), and even if available, often do not document in this.

**Actions to address the issues:**

- Inventorise information needs and set up routine reporting most suited to each organisation, removing duplication as much as possible, with information sharing between organisations who use the same data (even if at different levels of detail), e.g. between the CCG and the LA.
- Work towards a joint electronic maternity record, shared with the woman, and (with her consent) with the GP and other non-maternity clinicians, ensuring interoperability and use of national information standards (including the Maternity Services Data Set).

**2. Reduce rates of perinatal and infant mortality and morbidity, and reduce variation across the area**

**Main issues:**

- Local stillbirth rates are in line with the England average and infant mortality rates are slightly lower, but England rates for both are high compared to most European countries (Euro Peristat 2013), and rates vary with ethnic group and level of deprivation.
• Local preterm birth rates are similar to national and European rates and the increase in multiple births and women with medical conditions and improvements in neonatal care are a factor in preterm birth rates, but preterm birth is also more common in women under 20 or over 40 and among Caribbean women
• Early booking rates are lower among women born outside of the UK
• The challenge to reduce risk-taking behaviours which are associated with a higher risk of prematurity, low birth weight and perinatal mortality, and increase healthy behaviours – see 1.a
• Admission of term babies to neonatal care is included as an indicator in the NHS Outcomes Framework, but it is acknowledged that this number will be influenced by referrals from across the region if a Trust has a level 3 neonatal unit, like UHBristol and NBT (so, like preterm births, this should be monitored by woman’s CCG area, rather than by Trust)

Actions to address the issues:

• Smoking cessation, breastfeeding and weight management support – see 1.a
• Maternal and newborn screening and immunisations – improve uptake of vaccinations in pregnancy; pilot alternative delivery models in collaboration with NHS England
• Improve pre-conception care, in particular for women with pre-existing physical or mental health issues; work with GPs, pharmacies and mental health services
• Investigate reasons for late booking and poor attendance to enable targeted action to improve access to antenatal care
• Family planning; maintain low/falling teenage pregnancy rates by sustaining local interventions, including reduction of second pregnancies
• Child protection – ensure documentation of children at risk (e.g. of FGM) and communication of concerns with GP, Health Visitor and other agencies
• Participation in national and regional initiatives like the RCOG’s ‘Each baby counts’ and development of stillbirth prevention care bundle via the SWSCN, which recommends a combined approach of smoking cessation interventions, fetal movement monitoring, better interpretation of monitoring of babies’ heart rate, and improved detection of growth restricted babies

3. Improve emotional and mental health and wellbeing of pregnant women and new mothers

Main issues:

• The management of mental health problems during pregnancy needs to take account of the needs of the woman and her baby. Maternity, mental health and early years services should work together effectively to meet these needs
• There is a good evidence base from the ALSPAC Children of the 90s research programme that antenatal depression has long term effects through childhood and into adulthood. There are some services in place for women who have pre-existing mental health needs or who develop problems during or after their pregnancy but there are gaps in services, particularly in pre-conception advice, community care, pathways between services, and support for particular groups
• A regional study identified variation and areas for improvement in the care of parents who have lost a baby
Actions to address the issues:

- We will develop a clear, actively commissioned pathway for anyone involved in the care of a woman who is pregnant or thinking of becoming pregnant, and has existing mental health issues or develops mental health issues during or after pregnancy (up to the baby’s first birthday)
- A Health Integration Team (HIT) has been established to address perinatal mental health, bringing together providers, commissioners and academics. The South West Strategic Clinical Network for Children and Maternity (SWSCN) also has a perinatal mental health subgroup. Both are reviewing current service provision
- The HIT will also review the effectiveness of the screening questions which midwives ask all women and make recommendations for improvement
- Implement recommendations from the InSight study and further develop bereavement care pathway

4. Improve women and families’ experience of maternity care

Main issues:

- Women tend to be relatively less satisfied about their postnatal care whilst in hospital compared to their care during labour and birth and their ante- and postnatal care in the community (as suggested by Friends & Family Test results, CQC Surveys and feedback via Maternity Voices)
- Service pressures have led to high numbers of maternity unit closures at NBT and UH Bristol, compared to other maternity units in the South of England (Local Supervising Authority report for the South of England, 2013)
- Continuity of care is valued and advocated in national policy but local women see on average 3 or 4 different community midwives during pregnancy, and if they have a named midwife, this is often not the person they see most (BNSSG Continuity of antenatal care audit report 2013)
- There are a good range of options for place of birth across the area, but it is likely more women would be suitable to give birth in midwife-led environments than currently do so
- Feedback via Maternity Voices and maternity service user reps suggests labour induction can be a very negative experience for some women. Rates at both UH Bristol and NBT are higher than the national average

Actions to address the issues:

- Explore peer support for postnatal care in hospital and the community
- Review staffing and bed capacity, including skill mix
- Re-audit continuity of antenatal care to review effectiveness of actions from previous audit
- Avoid unnecessary admissions, and ensure women are seen and give birth in most appropriate environment, e.g. through exploring the possibility of midwife telephone triage in collaboration with the ambulance service
- Ensure all women are informed about their options for place of birth across the area, about the NICE place of birth recommendations, and what is and is not available in different settings
- Review current patterns of choice of place of birth and potential/future demand for different birth settings and locations
• Investigate the factors associated with the high induction rates at UHBristol and NBT, and the different patterns in elective and emergency caesarean sections, and share good practice. Explore offering outpatient induction to women at low risk of complications.
• Improve the birth environment and experience for women at higher risk of complications, e.g. ‘keeping normality at the heart of complexity’ project at NBT.
## Aims

<table>
<thead>
<tr>
<th>Objective</th>
<th>How will this be addressed?</th>
</tr>
</thead>
</table>
| a. Reduce risk taking behaviours which impact on maternal and infant health, and increase healthy behaviours | • See below for smoking cessation  
• Drug clinics and specialist midwives  
• Family Nurse Partnership (FNP) to support young first-time parents  
• Continue the successful work on reducing under-18 conceptions, and use any transferable strategies in other areas  
• Healthy Start vouchers and vitamins – ensure uptake  
• Ensure provision of weight management support for obese women during and after pregnancy, reduce pre-conception obesity levels and reduce nutritional inequalities  
  o Work with the three local authorities on consistent weight management support provision across BNSSG, as well as free swimming for pregnant women (currently only in Bristol)  
  o Work with and lobby other Local Authority (LA) departments to promote environment conducive to healthy eating & active lifestyle through e.g. town planning & legislation  
  o Current UHBristol referral for weight management support CQUIN  
  o North Somerset Council Public Health has commissioned WAHT to provide a maternal weight management service (SHINE) for women with BMI over 30 or gestational diabetes. 12 week programme aiming to support pregnant women to keep weight gain during pregnancy within recommended limits. Delivered by MCAs and in partnership with Weston children’s centres. Also looking at follow up interventions delivered in partnership with health visiting service. Explore if similar service could be provided across BNSSG |
| b. Reduce adverse outcomes and harm to women | • Safeguarding/protecting vulnerable women  
  o UHB pathway for trafficked women  
  o FGM identification and referral  
  o Information sharing with GP, social care and other services/agencies  
• Reduce postpartum haemorrhage rates  
  o Investigate which groups highest rates and see if scope to reduce  
  o Encourage participation in research trials (e.g. ImOX trial of oxytocics – it has been shown participants in studies have better care and outcome) |

## Monitoring

- Smoking at time of birth  
- FNP programme uptake  
- Under18 conceptions  
- Healthy Start uptake  
- BMI at booking  
- Referrals to, and uptake of weight management support in women with BMI ≥30  
- Periodic audit of communication between agencies  
- Rates of blood loss ≥ 1500ml
<table>
<thead>
<tr>
<th>2. REDUCE RATES OF PERINATAL AND INFANT MORTALITY AND MORBIDITY, AND REDUCE VARIATION IN OUTCOMES ACROSS THE AREA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a. Reduce stillbirth and infant mortality rates</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>- Collaborative commissioning across BNSSG CCGs and LAs</td>
</tr>
<tr>
<td>- Import key messages from infant mortality strategy including</td>
</tr>
<tr>
<td>o Smoking cessation (see below)</td>
</tr>
<tr>
<td>o Breastfeeding support (see below)</td>
</tr>
<tr>
<td>o Maternal weight optimisation (see above)</td>
</tr>
<tr>
<td>o Safe sleeping advice</td>
</tr>
<tr>
<td>o Care of the Next Infant Programme</td>
</tr>
<tr>
<td>o Participation in national and regional initiatives like the RCOG’s ‘Each baby counts’ and development of stillbirth prevention care bundle via the SWSCN, which recommends a combined approach of smoking cessation interventions, fetal movement monitoring, better interpretation of monitoring of babies’ heart rate, and improved detection of growth restricted babies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>b. Improve pre-conception care (collaborative working with GPs, pharmacies and NHS England)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>- Collaborative working with LA and GPs, pharmacies, clinics seeing women with various chronic conditions such as diabetes, schools &amp; colleges to raise awareness among women of childbearing age, particularly if in high risk groups</td>
</tr>
<tr>
<td>- Leaflet being piloted in Bristol area for pharmacies to give out to women of childbearing age</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>c. Ensure early booking</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>- Improve recording of late booking reasons and whether the woman had antenatal care elsewhere and standardise this across BNSSG (NBT books significant number of women for UHB and vice versa)</td>
</tr>
<tr>
<td>- Investigate barriers to early booking (e.g. data from NBT and UHBristol show that the proportion of women booking after the end of 12 weeks is about 16% amongst women from non-white ethnic groups, compared to about 12% amongst white women) and</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

- Ensure learning from maternal deaths is shared across the area and with all relevant services, including other clinical services, A&E, mental health and social services, and with any services which have contact with women in the preconception period, such as GPs and pharmacies |

- Maternity services and GP communication as per action plan from recent project |
- Ensure interoperability of any new electronic record systems and if possible improve interoperability of existing systems |
- Collaboration between maternity service providers, CCGs, Public Health to ensure timely data availability relevant to each organisation and reduction of duplication |
- ? Work towards one shared electronic maternity record to be accessible to women, maternity service providers and GPs (digital child health record is part of national plans) |

**Incident reports**

**Periodic audit**

**Rate of stillborn babies as percentage of all babies born at or over 24 weeks**

**Infant mortality rate**
(both by area)
<table>
<thead>
<tr>
<th>Smoking Cessation in Pregnancy 2013</th>
<th>reasons for poor attendance</th>
<th>Smoking at birth/in late pregnancy</th>
</tr>
</thead>
</table>
| d. Reduce smoking in pregnancy and after | • Collaborative working with local authorities, especially in Bristol, ensuring smoking cessation support capacity is maintained  
• Improve referral rates to smoking cessation services, e.g.  
  o North Somerset is working with the midwifery lead and CCG lead to improve the % of women who receive BI and CO monitoring at booking and are referred on and to improve data collection  
  o North Somerset also in the process of increasing the capacity of the Support to stop smoking in pregnancy service to work more collaboratively with the midwifery service to engage with those pregnant smokers who are not contactable (lost to follow up). This may translate into them offering the service at the hospital.  
  o North Somerset will also be looking at training needs for midwives  
• Proposed CQUIN next year for Bristol and North Somerset  
• Increased resource identified by Public Health to enable the provider to ensure referral response times are met and to work more collaboratively with the midwifery service in terms of linking and offering a service onsite at routine antenatal visits/scans to try and engage those women who are harder to reach and end up as lost to follow up.  
• Investigate reasons why numbers appear to be increasing (? demographics in terms of higher numbers of mums from accession states e.g. Poland where prevalence is much higher may have an impact) | CO monitoring and referral of women with CO ≥4 to smoking cessation support  
Reduced numbers of lost to follow ups |
| e. Increase breastfeeding initiation and particularly continuation (collaborative working with LA) | • Extend peer support on wards and in community  
• Access to (telephone) advice out of hours, especially in view of early discharge  
• Several maternity services elsewhere in the UK are asking women who opt to formula-feed to bring in their own and have stopped automatic provision of free formula on postnatal wards (formula still available if indicated) > investigate experiences & practicalities?  
• Education for the mothers of new mothers  
• -North Somerset Council Public Health has commissioned WAHT to provide a specialist breastfeeding clinic to address ongoing breastfeeding problems. At the moment (until June 2015) this is funded from the public health budget in North Somerset; could this become part of the standard offer across BNSSG? (Delivered by health visitors in Bristol)  
• WAHT currently admit women for breastfeeding support when required; to be reviewed soon – may be setting up a day breastfeeding support area instead / in addition  
• Establish recording of feeding method on transfer to health visitor in North Somerset | Breastfeeding initiation  
Breastfeeding on transfer to HV  
Breastfeeding at 6-8 weeks rates  
(exclusive bf, partial bf and not bf) |
and South Gloucestershire and ensure consistent recording across the BNSSG area
- Proposed CQUIN next year for South Gloucestershire

| f. Reduce term admissions to neonatal unit (taking into account that the two consultant-led units receive many referrals from outside the area) | • Staff training in recognition of risk factors for, and signs of fetal problems is in place  
• Ensure adequate staffing levels & skill mix; monitor effect of recent increases in staffing at NBT and UHBristol | Admissions of babies born at 37 weeks or over for special, high dependency and intensive neonatal care – indicator TBC (by area not provider) |
|---|---|---|
| g. Reduce rate of preterm labour | • A cervical surveillance clinic has been established in order to help prediction and prevention of preterm labour due to cervical insufficiency in high risk groups  
• Other causes of preterm labour can be reduced with smoking cessation strategies and optimising care of women with medical conditions | Preterm birth rate (by area not provider) |
| h. Reduce rate of low birth weight at term | • See risk tasking behaviour 1.a and smoking cessation 2.d above  
• See early booking 2.c above and follow up of women with poor antenatal care attendance  
• Identification & management of hypertensive disorders  
• Ensure adequate nutrition & iron status | Low birth weight at term (by area not provider) |
| i. Improve screening and immunisation uptake for pregnant women | • Investigate and pilot alternative models for flu and pertussis vaccination delivery to pregnant women in collaboration with CCGs and NHS England, taking into account logistics, capacity, recordkeeping etc.  
• Midwives’ recommendation is strongest factor in uptake so training for midwives re. importance of vaccination and screening  
• Raise awareness of vaccinations among pregnant women, including via pharmacies  
• Ensure women access all the screening tests available if they wish to do so | TBC |
| j. Child protection (including protection from FGM) | • Documentation of newborns at risk  
• Information sharing, particularly between GPs and maternity services | Periodic audit |
3. IMPROVE EMOTIONAL/MENTAL HEALTH & WELLBEING OF PREGNANT WOMEN AND NEW MOTHERS

Aligns with Policy and/or Outcomes Framework

NHS OF 3, 4
Public Health OF 2, 4

Key evidence

- NSPCC report ‘Prevention in Mind’
- RCM Maternal Mental Health report
- ALSPAC papers
- LSE report ‘Costs of perinatal mental health problems’

a. Address gaps in local perinatal mental health services with regard to:
   - Pre-conception care
   - Screening, diagnosis and referral
   - Support for particular groups, such as young mothers (South Gloucestershire focus) and bereaved parents

   A Health Integration Team (HIT) has been established to seek improvements to perinatal mental health services and the recommendations of the HIT will be incorporated into this strategy

   Likewise recommendations from perinatal mental health group of the South west Strategic Clinical Network

   Development and implementation of agreed SW-wide service standards in collaboration with SWSCN perinatal mental health working group

   Explore provision of mental health specialist midwives

   Bereavement support for those with adverse perinatal events including perinatal death

   Prompt application to practice of evidence from regional multicentre research (e.g. InSight study of bereavement care)

   Pre-conception care plan for women with serious mental health issues, including plan for medication

   Role of GPs and pharmacies in raising awareness and pre-conception counselling of women on e.g. anti-depressants

   Improved screening and identification for mental health problems not just by midwives but also health visitors

   Raise women’s awareness of services available

   Use of IAPT (Improving Access to Psychological Therapies) or improved resourcing for Supervisors of Midwives to address anxieties about labour

   Birth afterthoughts-type service across BNSSG (probably delivered locally) to discuss and understand labour events

   Identify the mental health needs of young mothers and service development to meet these needs, e.g. via FNP and teenage pregnancy midwives, and local voluntary organisations

Dependent on standards to be developed

4. IMPROVE WOMEN AND FAMILIES’ EXPERIENCE OF MATERNITY CARE

Aligns with Policy and/or Outcomes Framework

NHS OF 4
Public Health OF 2, 4

a. Improve antenatal continuity

Focus at North Somerset: explore feasibility of integrated team of midwives to provide ante-natal and postnatal care, through one-to-one midwife care to improve continuity of

Implement action plans formulated by UHBristol, NBT and WAHT in response to the 2013 BNSSG antenatal continuity audit, e.g. buddying and other rostering changes and evaluate effectiveness of measures taken

Discuss women’s priorities and how to maximise continuity

Aim to provide maximum continuity especially for first time mothers and vulnerable women

Apply lessons from research for bereaved parents

Explore NHS-funded midwifery group practices

UHBristol does this to some extent (used to be more extensive with Granby team but midwife burn-out); NBT looking into it as well but may not be possible at WAHT due to small midwife numbers

Re-audit antenatal continuity
Postnatal surveys
FFT for general satisfaction with antenatal care
### Key evidence
- CQC Maternity Survey
- National Audit Office report
- Maternity Matters
- Bristol Maternity Services Review
- Birthplace in England study
- BNSSG Antenatal Continuity Audit
- NICE guidelines for care in labour

**Care (taking into account existing evidence and local experience with different models of care)**

| b. Ensure choice for place of birth and encourage birth in midwife-led environments for low-risk women to avoid unnecessary intervention and improve experience this includes local North Somerset focus to operate an effective and efficient birth centre in the North Somerset area for ‘low risk’ women; consider viability of WAHT as a provider trust to continue to provide maternity services for the population of NS alongside the most optimum location of a birth centre to serve the whole population of NS | • Triage low risk women to midwife-led unit on admission in labour  
• Avoid unnecessary admissions, and ensure women are seen and give birth in most appropriate environment, e.g. through exploring the possibility of midwife telephone triage in collaboration with the ambulance service  
• Investigate current usage of different birth environments  
• Improved conversations with parents about the review in late pregnancy about choice for place of birth  
• Ensure continued homebirth provision  
• Ensure that regardless of location of NS birth centre, women in Weston area retain birthplace choices and access to services like breastfeeding support | Postnatal surveys  
CQC surveys (next 2016)  
Feedback via Maternity Voices  
Birth rates in each setting (as well as transfer rates as together gives better idea of usage) |
| c. Increase satisfaction with birth and place of birth | • Keeping normality at the heart of complexity project NBT  
• Ensure women are informed of what is and is not available in different settings  
• Investigate the factors associated with the high induction rates at UH Bristol and NBT, and the different patterns in elective and emergency caesarean sections, and share good practice. Explore offering outpatient induction to women at low risk of complications | Friends & Family Test  
Postnatal surveys  
CQC surveys (next 2016) |
| d. Improve satisfaction with postnatal care, including infant feeding support | • Option for partners to stay overnight where possible  
• Explore peer support for feeding and general postnatal support in hospital and community  
• Possible inclusion of feasible service improvement CQUINs relating to ante-natal /postnatal period, to be agreed across BNSSG (NBT currently has postnatal care CQUIN to increase Friends & Family Test score; parent education provision considered by North Somerset as possible CQUIN)  
• Review staffing and bed capacity, including skill mix | Postnatal surveys  
CQC surveys (next 2016)  
Feedback via Maternity Voices  
Friends & Family Test |
| e. Engage users and voluntary sector through Maternity Voices (Maternity Service Liaison Committee) | • Recruitment drive through posters, website, approaching underrepresented groups  
• Maternity Voices website and Facebook feedback  
• Liaise with other MSLCs re. engagement strategies  
• Walkabouts | Meeting minutes  
Membership of MV |
Relevant documents

National guidance, reports, standards, research
1. NHS Outcomes Framework 2013/14 and 2014/15
2. Public Health Outcomes Framework 2013-16
3. NHS Forward View 2014
5. Safer Childbirth, RCOG RCM, RCA, RCPCH 2007
6. NICE Maternity Care Guidelines
7. NICE Intrapartum Care Guideline 2014
8. Standards for Maternity Care, RCM, RCOG, RCA, RCPCH 2008
16. CQC Maternity Survey 2013
17. NPEU (2011) Birthplace in England research programme
18. ALSPAC (Children of the 90’s) research programme
19. NSPCC Prevention in Mind 2013
20. RCM Maternal Mental Health Report 2014
21. LSE & Centre for Mental Health The costs of perinatal mental health problems
22. Smoking Cessation in Pregnancy 2013
23. InSight study abstract - improving maternity bereavement care for stillbirth

Local information and reports
27. Bristol City Council Health & Wellbeing Strategy 2013
29. South Gloucestershire Council Health & Wellbeing Strategy 2013-16
30. North Somerset Joint Strategic Needs Assessment and population section
31. BNSSG Antenatal Continuity Audit 2013/14
32. BNSSG Maternity Report Q3 2014/15
33. Local Supervising Authority report for the South of England 2013
34. 2014 CQC inspection report UH Bristol – St Michael’s
35. 2014 CQC inspection report NBT – Southmead
36. 2014 CQC inspection report NBT - Cossham

Additional data
37. Public Health England interactive data and mapping tools
38. Parents’ country of birth, ONS (2013)

Maternity pathway tariff
Appendix 1: Birth projections across the BNSSG area

These projections, produced by the Bristol Public Health Intelligence Unit, are linear forecasts based on actual live births for 2009 – 2013 (ONS figures) and assume that trends for 2009-2013 continue in the future. They are estimates and need to be treated with caution as they are simply projecting historical birth trends and do not take into account any other factors. In 2013 all areas in Bristol experienced a drop in birth numbers, and if this pattern should continue into the future the projections below will overestimate increases in birth numbers. Local figures for 2014 also suggest that any increases in births may be smaller than projected in the tables and figures below. These local data were not fine-grained enough to use for these projections, but the forecasts will be updated when 2014 ONS figures are published in summer 2015.

Source for all tables and figures below: Bristol Public Health Intelligence Unit (using Public Health Birth File, ONS)

BNSSG overall

Live birth projections – BNSSG CCGs

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Somerset</td>
<td>2,246</td>
<td>2,217</td>
<td>2,188</td>
<td>2,160</td>
<td>2,131</td>
</tr>
<tr>
<td>South Gloucestershire</td>
<td>3,138</td>
<td>3,154</td>
<td>3,170</td>
<td>3,186</td>
<td>3,203</td>
</tr>
<tr>
<td>Bristol</td>
<td>6,815</td>
<td>6,907</td>
<td>6,998</td>
<td>7,090</td>
<td>7,181</td>
</tr>
</tbody>
</table>

Live birth projections – BNSSG CCGs

![Graph showing birth projections over time for different localities.]

Bristol

For the purpose of these projections, Bristol has been split into five sub-localities, based on the three NHS localities of Bristol North and West, Inner City and East and Bristol South, with Bristol North & West further divided into North and West and Inner City & East further divided into Bristol Central and Bristol East. These subdivisions were used as socio-demographically Bristol North & West and Inner City & East are each made up of two distinct areas with very different characteristics. This can be seen by the difference in birth trends between Bristol North (increasing) and Bristol West (decreasing).
### Live birth projections – Bristol sub-localities

<table>
<thead>
<tr>
<th>Sub-locality</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bristol Central</td>
<td>1,175</td>
<td>1,189</td>
<td>1,203</td>
<td>1,217</td>
<td>1,232</td>
</tr>
<tr>
<td>Bristol North</td>
<td>1,268</td>
<td>1,306</td>
<td>1,343</td>
<td>1,381</td>
<td>1,418</td>
</tr>
<tr>
<td>Bristol South</td>
<td>2,365</td>
<td>2,403</td>
<td>2,441</td>
<td>2,479</td>
<td>2,517</td>
</tr>
<tr>
<td>Bristol West</td>
<td>938</td>
<td>921</td>
<td>905</td>
<td>889</td>
<td>872</td>
</tr>
<tr>
<td>Bristol East</td>
<td>1,069</td>
<td>1,088</td>
<td>1,106</td>
<td>1,124</td>
<td>1,143</td>
</tr>
<tr>
<td>BRISTOL</td>
<td>6,815</td>
<td>6,907</td>
<td>6,998</td>
<td>7,090</td>
<td>7,182</td>
</tr>
</tbody>
</table>

### South Gloucestershire

### Live birth projections – South Gloucestershire – Official localities

<table>
<thead>
<tr>
<th>Sub-locality</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severnvale</td>
<td>1,070</td>
<td>1,064</td>
<td>1,058</td>
<td>1,053</td>
<td>1,047</td>
</tr>
<tr>
<td>Yate</td>
<td>737</td>
<td>745</td>
<td>752</td>
<td>760</td>
<td>767</td>
</tr>
<tr>
<td>Kingswood</td>
<td>1,319</td>
<td>1,330</td>
<td>1,342</td>
<td>1,353</td>
<td>1,365</td>
</tr>
<tr>
<td>South Glos Total</td>
<td>3,138</td>
<td>3,154</td>
<td>3,170</td>
<td>3,186</td>
<td>3,203</td>
</tr>
</tbody>
</table>
Live birth projections – South Gloucestershire – Alternative localities

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>West</td>
<td>941</td>
<td>938</td>
<td>935</td>
<td>931</td>
<td>928</td>
</tr>
<tr>
<td>South</td>
<td>1,410</td>
<td>1,417</td>
<td>1,425</td>
<td>1,432</td>
<td>1,440</td>
</tr>
<tr>
<td>North</td>
<td>774</td>
<td>783</td>
<td>792</td>
<td>802</td>
<td>811</td>
</tr>
<tr>
<td>South Glos Total</td>
<td>3,138</td>
<td>3,154</td>
<td>3,170</td>
<td>3,186</td>
<td>3,203</td>
</tr>
</tbody>
</table>

North Somerset

Live birth projections - North Somerset – Official localities

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worle</td>
<td>391</td>
<td>374</td>
<td>358</td>
<td>342</td>
<td>325</td>
</tr>
<tr>
<td>Nailsea / Rurals</td>
<td>579</td>
<td>568</td>
<td>558</td>
<td>547</td>
<td>537</td>
</tr>
<tr>
<td>Weston Town</td>
<td>627</td>
<td>618</td>
<td>609</td>
<td>601</td>
<td>592</td>
</tr>
<tr>
<td>Clevedon / Portishead</td>
<td>619</td>
<td>618</td>
<td>618</td>
<td>617</td>
<td>617</td>
</tr>
<tr>
<td>North Somerset Total</td>
<td>2,246</td>
<td>2,217</td>
<td>2,188</td>
<td>2,160</td>
<td>2,131</td>
</tr>
</tbody>
</table>
Live birth projections - North Somerset – Alternative localities

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>South</td>
<td>1,310</td>
<td>1,269</td>
<td>1,228</td>
<td>1,187</td>
<td>1,146</td>
</tr>
<tr>
<td>North</td>
<td>905</td>
<td>910</td>
<td>915</td>
<td>920</td>
<td>925</td>
</tr>
<tr>
<td>North Somerset Total</td>
<td>2,246</td>
<td>2,217</td>
<td>2,188</td>
<td>2,160</td>
<td>2,131</td>
</tr>
</tbody>
</table>

Locality Maps

Bristol’s five sub-localities (for the purpose of these projections)
Official localities

Alternative localities
Maternity Voices
Bristol, North Somerset and South Gloucestershire
Maternity Services Liaison Committee

Maternity services activity and performance
2015/2016 quarter 1 and trends

Contents

Bookings and birth episodes 2
Place of birth 3
Mode of birth 5
Maternal events and outcomes 6
Neonatal events and outcomes 6
Public health 8
Pathway and finance summary 12
Quality and governance summary 13

Abbreviations

NBT = North Bristol NHS Trust (Southmead Hospital, Mendip Birth Centre (at Southmead), Cossham Birth Centre and community services)
UHB/UHBristol = University Hospitals Bristol NHS Foundation Trust (St Michael’s Hospital and Midwife-led unit and community services)
WAHT = Weston Area Health NHS Trust (Ashcombe Birth Centre and community services)
CCG = Clinical Commissioning Group
BNSSG = Bristol, North Somerset and South Gloucestershire
CLU = consultant-led unit
MLU = midwife-led unit
AMU = alongside midwife-led unit (St Michael’s Midwife-led unit and Mendip Birth Centre)
FMU = freestanding midwife-led unit (Cossham Birth Centre and Ashcombe Birth Centre)
CS = caesarean section
Q = quarter

All data in this report are as provided by the maternity services. Previously provided figures are sometimes adjusted by the Trusts when supplying data for the new quarter so this report supersedes any previous reports. Where data are unavailable or where definitions have changed, this will be indicated.
Quarter 1 2015/16 and annual trends by maternity care provider: Following an increase in the previous quarter, bookings for antenatal care at NBT have remained at this level during Q1 15/16. Bookings at UHB increased by 4% from last quarter but decreased by 5% at WAHT. Birth episodes (women giving birth) increased by 8% at UHB and 5% at WAHT from the previous quarter and remained the same at NBT.

Year on year, bookings at WAHT have remained stable while bookings at NBT appear to have increased slightly over the last 4 years*. Birth episodes at UHB and WAHT have decreased slightly over the last 4 years while those at NBT have stayed about the same.

Annual bookings and birth episodes by provider

*) From quarter 2 2013-14, bookings are explicitly reported as bookings for antenatal care, i.e. where the Trust was the antenatal lead provider. This ensures consistency and avoids double-counting, as women who receive antenatal care from one Trust but give birth in another are booked by the second trust as well.

NB: Booking figures for UH Bristol for 2012-13 in the second graph above and for Bristol in particular in the third graph below are likely lower, and for 2013-14 possibly slightly higher than actual figures, due to a recording backlog during implementation of a new record system.

Bookings and birth episodes

Quarterly bookings and birth episodes by provider

<table>
<thead>
<tr>
<th></th>
<th>2013-14</th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>NBT bookings</td>
<td>1886</td>
<td>1873</td>
<td>1937</td>
</tr>
<tr>
<td>NBT birth episodes</td>
<td>1556</td>
<td>1586</td>
<td>1503</td>
</tr>
<tr>
<td>UHB bookings</td>
<td>1049</td>
<td>1168</td>
<td>1149</td>
</tr>
<tr>
<td>UHB birth episodes</td>
<td>1333</td>
<td>1453</td>
<td>1326</td>
</tr>
<tr>
<td>WAHT bookings</td>
<td>367</td>
<td>389</td>
<td>376</td>
</tr>
<tr>
<td>WAHT birth episodes</td>
<td>64</td>
<td>68</td>
<td>52</td>
</tr>
</tbody>
</table>

Annual bookings and birth episodes by provider

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>UHB bookings</td>
<td>494</td>
<td>3480</td>
<td>4622</td>
<td>4313</td>
</tr>
<tr>
<td>NBT bookings</td>
<td>7190</td>
<td>7236</td>
<td>7634</td>
<td>7411</td>
</tr>
<tr>
<td>WAHT bookings</td>
<td>1484</td>
<td>1545</td>
<td>1499</td>
<td>1520</td>
</tr>
<tr>
<td>UHB birth episodes</td>
<td>5774</td>
<td>5680</td>
<td>5452</td>
<td>5248</td>
</tr>
<tr>
<td>NBT birth episodes</td>
<td>6304</td>
<td>6231</td>
<td>6110</td>
<td>6318</td>
</tr>
<tr>
<td>WAHT birth episodes</td>
<td>299</td>
<td>274</td>
<td>238</td>
<td>233</td>
</tr>
</tbody>
</table>
Annual trends by CCG: Overall birth episodes in the area have remained unchanged from last year (Bristol -1%, North Somerset and South Gloucestershire each +1%). Some booking data by CCG for 2014/15 Q4 and Q1 2015/16 are still pending so a complete annual figure cannot yet be provided.

Place of birth

Nationally around 15% of births take place in midwife-led environments (at home and in midwife-led units), and across the South West about 17%. While the current proportion in BNSSG is nearly 19%, this has gradually decreased during the past year from a peak of nearly 23% in Q4 2013/14. A collaborative evaluation of place of birth across BNSSG is underway.
**WAHT does not have a consultant-led unit, so the proportion of births at home and in the midwife-led unit is much higher than at the other two Trusts. Given the close link between UHB and WAHT, the proportions with the two Trusts combined are show as well.**

Transfer rates from homebirths and midwife-led units to consultant-led units during or immediately after labour are shown below as a proportion of the number of women who laboured in this location, insofar as data were available. It remains difficult to capture complete and consistent transfer data from the maternity systems. Generally, the transfer rate for women expecting their first baby is much higher than for those who have had a baby before. The most common reasons for transfer were slow progress in labour (particularly in first time mothers) and concerns about the baby’s heart rate or meconium. Other reasons included maternal request (including for an epidural) and heavy bleeding after the birth.
Local normal birth rates (defined as spontaneous vaginal births, i.e. not with instruments or by caesarean section) decreased compared to last year both at UHB and NBT. The average normal birth rate for the large maternity units in the South West (>4500 births per year) is similar to the national rate at 61%, while their average caesarean birth rate is lower than the national rate at 22%.

The normal birth rate in quarter 1 2015/16 was 63.6% at UHB and 59.7% at NBT, with caesarean birth rates of 22.3% at UHB and 27.8% at NBT.

The normal birth rate at WAHT is 100% per definition, as women needing assistance are transferred to a consultant-led unit.
Maternal events and outcomes

Since the introduction of the South West Strategic Clinical Network regional maternity data collection, a number of maternal events and outcomes can be reported. The different character of the maternity units across the South West has to be borne in mind, as well as the relatively small numbers for most of the outcomes below. Any differences in the rates of postpartum haemorrhage and 3\(^{rd}\) and 4\(^{th}\) degree tears could be due to this, and in some part to diagnosis and measurement, but they do merit monitoring over a longer period. The average labour induction rate of the largest maternity units in the South West is similar to the 25% national average, but is higher than this at NBT and UHB.

Neonatal events and outcomes

The rates of preterm births (born before 37 weeks) and low birth weight babies at 37 weeks or over were similar in 2014-15 and 2013-14 and similar to the national rate of 7.3% for women from the BNSSG area, but the proportion of preterm births in out of area women is increasing and this quarter the overall BNSSG preterm birth rate is slightly higher at 8.9%. Many women from outside the CCG area give birth at NBT or UHB because of their level 3 neonatal units, so the same outcomes are shown by CCG area of the woman’s GP. The low birth weight rate in term babies for Bristol is in line with the England average of 2.8% and lower than the English core city average of 3.2%.

The stillbirth rate in 2013-14 was similar to the national England and Wales rate, which was 0.46%, and decreased at both UHBristol and NBT during 2014-15. There were no stillbirths at WAHT, but the intra-uterine death of a baby prior to labour (which is much more common than during labour) would be recorded as a stillbirth by the Trust where a woman undergoes induction of labour and gives birth following the diagnosis of an intra-uterine death, which would not be at WAHT per definition.

Low Apgar rate at 5 minutes in babies born at 37 weeks or over (a measure of the baby’s condition shortly after birth) has been added for the first time this quarter. Bearing in mind the small numbers, all three Trusts have a low rate of low Apgar compared to the South West average of 1.3% (1.1% in the largest maternity units).
The denominator used for the stillbirth rate and preterm birth rate (born before 37 weeks) is all babies born at the Trust. This includes babies born at the Trust following transfer from elsewhere for specialist neonatal care. The denominator used for the term babies with low birth weight rate (LBW; birth weight under 2500 g) and low Apgar (an Apgar score of less than 7 at 5 minutes in term babies) is all babies born at 37 weeks and over ('term' strictly speaking refers to 37-42 weeks gestation, but the number of births beyond 42 weeks is very small and they are included in the denominators for low Apgar and low birth weight at term as the point here is just to exclude preterm babies)

The denominator used for the stillbirth rate and preterm birth rate (born before 37 weeks) is all babies born at the Trust. This includes babies born at the Trust following transfer from elsewhere for specialist neonatal care. The denominator used for the term babies with low birth weight rate (LBW; birth weight under 2500 g) and low Apgar (an Apgar score of less than 7 at 5 minutes in term babies) is all babies born at 37 weeks and over ('term' strictly speaking refers to 37-42 weeks gestation, but the number of births beyond 42 weeks is very small and they are included in the denominators for low Apgar and low birth weight at term as the point here is just to exclude preterm babies)
Public health

Obesity

Nearly half of pregnant women in the BNSSG area have a body mass index (BMI) of 25 or over at booking, with around 20% being obese (BMI of 30 or over). This is in line with the average level of obesity in women of childbearing age in England and compares to around 40% of women having a normal weight (BMI between 18.5 and 25) and 25% being obese in the general population in England (this includes women beyond childbearing age). Women with a BMI over 30 are offered weight management support but uptake is low during pregnancy. Q1 2015/16 figures are similar to the previous year.

Births in women aged 40 or over and women under 18

Births in women under 18 have been reducing across the UK, and more rapidly in Bristol than nationally. Births in women aged 40 and over have been increasing in recent years.

Female genital mutilation

4.3% of Bristol women who gave birth in Q1 2015/16 and 1.4% of out of area women had had FGM (representing 4.3% of women who gave birth at UHB and 1% of women who gave birth at NBT).
Smoking in pregnancy

The national average percentage of women smoking at the time of birth was 12% in 2013-14 and has been declining year on year. The rate across the South West is similar. The England core city average is 14.2%. Annual rates in South Gloucestershire have declined over the past 5 years and have been under 10% for 3 years now, but rates in Bristol and North Somerset have not.

Variation in the charts below looks exaggerated for out of area and WAHT women, due to small numbers.
Early booking

This is the proportion of women who booked for maternity care by the end of 12 weeks of pregnancy using bookings of those who lived in/were registered with a GP in the area at this point as denominator. The national early booking indicator uses birth episodes as denominator but this often leads to heavily skewed figures where there is a lot of movement of women between areas or providers during pregnancy.

However, the figures below also need to be treated with caution, as ‘in area’ is not very clearly defined. The SWSCN is working on a definition which can be implemented consistently across the South West.

The rates by provider before quarter 2 2013/14 include out of area women, which lowers the rate of early bookings. The 90% target was exceeded by UHBristol for the last year as previously not all women not in the area by the end of 12 weeks were excluded. Out of area women are excluded for the chart by CCG area. Data by CCG for quarters 3 and 4 2014/15 and Q1 2015/16 cannot yet be provided.
Breastfeeding initiation

The breastfeeding initiation rates (the proportion of liveborn babies receiving any breastmilk in the first 48 hours after birth) for Q1 2015/16 have decreased slightly and in the case of Bristol dropped below 80% for the first time in over two years. The rates in the BNSSG area have been higher than the average rate for England of 74% in 2013-14 and the average English core city rate of 69%. North Somerset also usually exceeds the 80% target and this has to be kept in mind when looking at the rates by provider, as for WAHT this only includes the small number of women who gave birth here, not the much larger number who received antenatal and postnatal care from WAHT. South Gloucestershire increased over the past year but dropped this quarter.

There is a considerable drop-off in breastfeeding continuation in all areas: the rates of babies totally or partially breastfed at 6-8 weeks in 2013-14 were 58.5% in Bristol, 47.9% in South Gloucestershire and 47% in North Somerset, compared to an English core city average of 48% (2013-14), and an England average of 47% (2012).
A new payment system for maternity care was implemented nationally from April 2013, introducing set payments for the antenatal, intrapartum and postnatal periods according to the level of care a woman is anticipated to require for her ante- and postnatal care or has required for her care during labour and birth (intrapartum care). The ante-and postnatal pathway categories are ‘standard’, ‘intermediate’ and ‘intensive’, and the intrapartum pathway categories are ‘without complications or comorbidities’ (other medical or pregnancy problems) and ‘with complications or comorbidities’.

Over the past 2 years, local proportions of women on the different antenatal pathways have been roughly in line with the projections from the Department of Health (DoH).

More women than projected by the DoH had intrapartum complications or comorbidities, particularly at UH Bristol in 2014-15. At NBT, more than half of the women who fell in the ‘with complications or comorbidities’ payment category had a blood loss of 500 ml or more as a factor. Data for UHB are still incomplete but here the most common factor appears to be ‘diabetes/endocrine’ (around 27%).

Postnatally, both NBT and UHB tend to have more women on the standard pathway than projected by the DoH.

At NBT, the most common reasons why women were not on the standard pathway were ‘complex social factors’ and ‘BMI over 35’, with ‘mental health’ antenatally, and ‘diabetes/other endocrine’ postnatally as another common reason. Complete WAHT pathway data are not currently available.
Quality and governance summary

Friends & Family Test (FFT) scores September 2014 to June 2015
Percentage of women who would recommend the service

Rates for Cossham Birth Centre were not reported by NHS England for months where there were too few responses

This single question survey was introduced nationally to provide a consistent measure of satisfaction with healthcare services. For maternity care, it asks women how likely it would be that they would recommend the service to their friends and family if they needed similar care, at 4 points (care during pregnancy, care during birth, care on the postnatal ward and postnatal community care). Only percentages who would recommend the service are shown here. For comparison, overall England percentages are shown in black. For birth care scores, alongside midwife-led units are reported jointly with consultant-led units.

NHS England stresses that the Friends and Family Test is not intended to directly compare Trusts, but to track progress over time. Response rates are low nationally (around 22% for birth care) and declined at all three trusts this quarter to 33% at WAHT, 22% at UHB and 10% at NBT, so the figures need to be treated with caution.

The ratings of postnatal care whilst in hospital were less positive in the large Trusts as well as nationally but show an improving trend at NBT. Community care ratings (ante- and postnatally) and birth care ratings appear quite high and stable, with postnatal care in the community viewed particularly positively across the area.
**Trust updates**

*(Further details are available in the Trust highlight reports which are circulated to Maternity Voices and Joint Maternity Commissioning Group members)*

**NBT** – Staffing was raised as an area for improvement at the Care Quality Commission (CQC) inspection in autumn; funding for extra midwives was secured and recruitment is ongoing.

The maternity unit celebrated 10 years of Baby Friendly status and the birth of the 1000th baby in Cossham Birth Centre in May.

**UH Bristol** – Staffing is up to full establishment although not all new staff have started yet.

The maternity unit has received £20,000 of capital funding to improve the layout of the antenatal/postnatal ward, as wards 71 and 74 have now been made into one ward area.

**WAHT** – Staff sickness rates and early booking rates have improved. The maternity unit is awaiting results of their CQC inspection.

The process of the possible acquisition by Taunton and Somerset NHS Foundation Trust is still ongoing and it will not be certain until about December if the Trust will be acquiring WAHT, and what impact this would have on the maternity services.

<table>
<thead>
<tr>
<th>2014/15 Q2 to 2015/16 Q1</th>
<th>UHB</th>
<th>NBT</th>
<th>WAHT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td>Midwife to births ratio</td>
<td>Funded 1:32, in post:</td>
<td>1:34</td>
<td>1:36</td>
</tr>
<tr>
<td>(at WAHT this ratio is influenced by the large difference in number of women cared for during pregnancy and number cared for during birth)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of women in established labour receiving 1 to 1 care from a midwife</td>
<td>100 %</td>
<td>100 %</td>
<td>100 %</td>
</tr>
<tr>
<td>Consultant cover (hours per week) (if consultant-led unit)</td>
<td>80</td>
<td>80</td>
<td>80</td>
</tr>
<tr>
<td>Number of maternity unit closures (+ attempted closures)</td>
<td>5 (+3)</td>
<td>4 (+2)</td>
<td>2</td>
</tr>
<tr>
<td>Number of positive comments received this quarter</td>
<td>‘do not collect’ Feedback is monitored through a monthly postal survey</td>
<td>55</td>
<td>30</td>
</tr>
<tr>
<td>Number of complaints this quarter</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>Number of serious untoward incidents this quarter</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Care Quality Commission alerts or other issues</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>