JSNA Chapter - Pregnancy

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Executive summary

Introduction

The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid down in pregnancy and early childhood. The physical and mental wellbeing of the mother, foetal exposures in the womb and early childhood experience have lifelong impacts on many aspects of health and wellbeing (The Marmot Review, 2010).

Pregnancy is a particularly important period during which the physical and mental wellbeing of the mother can have lifelong impacts on the child. For example, during pregnancy, factors such as maternal stress, smoking, diet, and alcohol or drug misuse can place a child's future development at risk. A wide range of research now shows that from conception to age two is a crucial phase of human development and is the time when focused attention can reap great dividends for society (Wave Trust, 2013).

Improvements in socio-economic conditions and obstetric care have made significant contributions to reducing maternal and infant mortality such that good outcomes from pregnancy have become the expectation and the norm. However, not all population groups have the same outcomes and there remains a gap nationally between routine and manual groups and the England average in key outcomes such as infant mortality.

A number of recently-published national and local policies and strategies recognise the importance of maternity services providing safer and more personalised care which is based around an individual woman's needs. *Better Births* (NHS England, 2016) recommends that

providers and commissioners work together in a Local Maternity System (LMS) to implement changes to maternity services. The review recommended LMS be formed to provide place-based planning and leadership for transformation of maternity and neonatal services, aligning the professionals, providers and commissioners of services within a larger geographical area, co-terminus with the Integrated Care System (ICS) footprint.

To respond to the recommendations made in *Better Births* (2016), the Nottinghamshire LMS Transformation Board is developing local transformation plans. These plans are the mechanisms through which the Nottinghamshire ICS will collaboratively transform maternity services. It details where Nottinghamshire is now, where it wants to be and the shared vision to ensure that women and their babies have access to consistently high quality services from a range of providers that meets their needs as close to home as possible. The Nottinghamshire LMS Transformation Board has been identified as the most appropriate group to take forward the findings and recommendations within this JSNA chapter.

Unmet needs and gaps

Antenatal care

1) The uptake of flu vaccinations by pregnant women in Nottingham during 2017/18 was (40.6%); this is significantly lower than the England average (45.7%)

2) Bump, Birth and Baby is a universal antenatal programme for expectant families currently delivered by the Children's Public Health Service (previously known as the Health Visiting service). The reach of this offer is not consistent across all areas in Nottingham City. There is an opportunity to work in partnership with the Midwifery Service to deliver this programme and to expand the reach to clients/service-users living within Nottingham City.

3) Nottingham CityCare's Children's Public Health and Nottingham City Council Early Help services are currently in the process of aligning their services. This gives the opportunity to review and develop a consistent offer that supports pregnant women, especially those with complex social factors.

Smoking

1) In Nottingham in 2017/18, in 17.2% of women were identified as smoking at time of delivery (SATOD), which is significantly higher than the England average (10.8%) and the fifth highest rate of our statistical neighbours.

2) White British women aged 21-25 living in areas of high deprivation, are least likely to access smoking cessation services and/or successfully quit. This is consistent with the trend of greater smoking prevalence in areas of greater deprivation.
3) There has been no statistically significant reduction in the proportion of women smoking at time of delivery since 2010/11. A new approach is needed that involves all partners across the local maternity system to support women to stop smoking during pregnancy and prevent high levels of postnatal relapse.

Complex social factors

1) There has been no reduction in indirect causes of maternal mortality for 10 years. Nationally, recent evidence shows that suicide is the leading cause of maternal death. Further risk factors include the rise in maternal obesity, the high smoking prevalence and the rise in the proportion of women with medically complex pregnancies, all of which are key concerns for Nottingham.

2) Women with complex social factors (substance misuse, domestic abuse, recent migrants, asylum seekers and refugees and young women under 20 years) are far less likely to seek antenatal care early in pregnancy or to stay in contact with maternity services. Delays in accessing maternity care often results in worse outcomes for both mother and baby; this is a key concern given Nottingham's diverse population.

3) Nationally, pregnant women with complex social factors are much less likely to access maternity services early in pregnancy and local data suggests this is mirrored in Nottingham. Early access amongst these groups during 2017 ranged from 42.6% to 82.6% (all below the 90% target). Delayed access prevents women receiving the care they need.

4) Pregnant women who are recent migrants, asylum seekers or refugees, or those who have difficulty reading or speaking English are the least likely to access maternity services within recommended timescales. Challenges in gaining timely access to translation services is a key barrier to accessing maternity services. This can sometimes result in the use of an inadequately trained (or no) interpreter (family member or friends) which poses risks for both the mother and healthcare provider. When this occurs, neither the healthcare provider nor patient can be assured that accurate and effective communication is taking place. Challenges around language barriers are a particular issue in Nottingham as over one-third of births (37%) are to mothers born outside the UK.

5) In Britain, FGM among pregnant women is mostly seen in women who are recent migrants, asylum seekers or refugees and has usually taken place before they arrive in the UK. Nottingham currently has an FGM clinic and an FGM specialist midwife; however, it is unclear as to the long-term succession arrangements for the continuity of the service, which may result in a service gap for survivors of FGM.

6) It is not recommended guidance for midwifery to have a dedicated appointment alone with pregnant women to ensure that opportunities for disclosure of domestic abuse are optimised.

7) There is no safe level of alcohol consumption in pregnancy. It is estimated that more than a quarter of Nottingham women of childbearing age are binge drinkers. Given that half of pregnancies in the UK are unplanned, this potentially poses significant risks to infant outcomes including foetal alcohol spectrum disorders if women continue to drink alcohol during pregnancy.

Perinatal mental health

1) Maternal mental health is a significant issue in Nottingham with 1,885 (44%) of pregnant women estimated to have mental health issues during 2017. The current perinatal mental health pathway may not be meeting the needs of pregnant women with low-level mental health needs.

System change

1) Information technology systems require improvement across the maternity pathway. Currently the maternity systems used in hospitals and in the community are different, which prevents maternity records being accessed and updated by midwives based in the community whilst ensuring safe and effective data-sharing with other services including GPs, health visiting and IAPT services.

Recommendations for consideration by commissioners

Antenatal care

1) Explore the barriers to flu vaccination uptake in pregnant women and continue to promote widely through midwifery, health visiting and other early help and early years providers.

2) The reach of Bump, Birth and Baby is not consistent across all areas in Nottingham City. CityCare could scope opportunities to work in partnership with the Midwifery service and Small Steps Big Changes (SSBC) to deliver this programme and to expand the reach to Nottingham City residents.

Smoking

1) Continue to implement routine Carbon Monoxide (CO) testing in pregnancy at booking, 32 weeks and at delivery clinics to identify women who smoke and who can be offered support to quit.

2) The public health subgroup of the Local Maternity System should lead work with partners to develop specific interventions to reduce smoking in pregnancy and support women who want to quit smoking, including the utilisation of the NHSE grant.

3) Explore the potential for nominated midwives, maternity support workers and sonographers to be trained to the same level as specialist NHS Stop Smoking advisers to enable them to offer more intensive support.

Complex social factors

1) Conduct a Health Equity Audit of timely access to maternity services and develop strategies for increasing early access among groups of women identified as least likely to access early, specifically recent migrants, refugees, asylum seekers and those who have difficulty speaking or reading English.

2) Further develop specialist midwifery support for women with complex social needs and ensure a more equitable service is provided, as detailed in the LMS Transformation Plan 2017/18 to 2020/21.

3) Pregnant women who experience domestic abuse and pregnant women who are homeless require additional specialist care and support. It is recommended that consideration be given to increasing capacity across the Specialist Midwife for Homelessness and Domestic Abuse team.

4) Maternity services to consider seeking an opportunity for pregnant women to be seen alone during pregnancy in order to provide an opportunity for disclosure of domestic violence and abuse.

5) Explore opportunities for all maternity staff to be trained in how to respond to domestic abuse in a way that makes it easier for pregnant women and new mothers to disclose abuse.

6) Ensure adequate provision of interpreting and translation services during pregnancy and birth. Face-to-face interpreting services should be encouraged and telephone interpreting used as a minimum at each appointment when required. Family members, legal guardians or partners should not be used as an interpreter in the antenatal or postnatal period unless in an emergency.

7) Given Nottingham's diverse population, multilingual leaflets and materials should be available as standard practice and developed or sourced by midwifery services.

8) Prioritisation should be given to finding a solution for effective longer-term succession of the Nottingham FGM clinic and specialist midwives to ensure continuity of services for FGM survivors.

9) Public Health England to support work in Nottingham to develop clear consistent messages to pregnant women on alcohol usage in pregnancy based on the Chief Medical Officer Guidance and local consultation.

10) NUH to continue to ascertain alcohol usage in pregnancy through the Audit C tool and support women to stop drinking, where appropriate, with support from alcohol services.

Perinatal mental health

1) As detailed in the LMS Transformation Plan 2017/18 to 2020/21, implement an overarching perinatal mental health pathway that reflects NICE guidance and sets out a plan for the perinatal mental health pathway, to include the identification of and support for women with mental health needs and access to psychological therapy (IAPT) services via direct referral from universal services.

2) At the first contact with primary care or at the pregnancy booking visit, and at all contacts thereafter, the HV and other health care providers who have regular contact

with a woman in pregnancy and during the postnatal period (one year after) should consider asking the two Whooley depression identification questions and the GAD- 2 as part of a general discussion about her mental health using the EPDS or the PHQ-9 as part of monitoring.

System change

1) Improve information technology to ensure electronic records are accessible across the maternity pathway, as detailed in the LMS Transformation Plan 2017/18 to 2020/21.

2) Support the development and implementation of the Nottinghamshire Local Maternity System (LMS) Local Transformation Plan 2017/18 to 2020/21.

3) Feedback from extensive consultation with women, both nationally (*Better Births*) and locally, found continuity of carer to be an integral part of maternity services. Nottinghamshire LMS to consider implementing continuity of carer as detailed in the LMS Transformation Plan 2017/18 to 2020/21.

4) A healthy lifestyle during pregnancy can help to keep mother and baby healthy, including not smoking or drinking alcohol and maintaining a healthy weight. Multi-agency colleagues, including midwifery, health visiting and early years, should continue to provide advice through information and brief advice and referral into more specialist services where appropriate.