Review of the relationship between Public Health and Maternity Services with respect to the delivery of the antenatal and postnatal elements of the Healthy Child Programme

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Author: Helen Buttivant, Public Health Specialty Registrar, Kent Public Health Team

Contact details: 03000 415912
helen.buttivant@kent.gov.uk

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Contents

Glossary

- BME – Black or Minority Ethnic Group
- BMI – Body Mass Index
- CAF – Common Assessment Framework
- CC – Children's Centre
- CCG – Clinical Commissioning Group
- CQC - Care Quality Commission
- DVH – Darent Valley Hospital
- EKHUFT – East Kent Hospitals University NHS Foundation Trust
- FNP – Family Nurse Partnership
- FTE – Full Time Equivalent
- GFR – General Fertility Rate
- HCP – Healthy Child Programme
- HepB – Hepatitis B
- HoM – Head of Midwifery
- HV – Health Visitor
- JHWBS – Joint Health and Wellbeing Strategy
- JSNA – Joint Strategic Needs Assessment
- KCC – Kent County Council
- KCHT – Kent Community Health NHS Trust
- K&M SIT - Kent & Medway Screening & Immunisations Team
- KMCS – Kent Commissioning Support Service
- KMPHO – Kent and Medway Public Health Observatory
- KPHT – Kent Public Health Team
- LD – Learning Disability
- MECC – Making Every Contact Count
- MH – Mental health
- MIMHS – Mother and Infant Mental Health Service
- MMHA – Maternal Mental Health Alliance
- MMR – Measles, Mumps and Rubella
- MSLC - Maternity Service Liaison Committee
- MTW - Maidstone and Tunbridge Wells NHS Trust
- NHS FFT – NHS Friends and Family Test
- NICE – National Institute for Health and Care Excellence
- PCT – Primary Care Trust
- PH – Public Health
- PWLD – People with Learning Disabilities
- QEQM – Queen Elizabeth the Queen Mother Hospital Margate
- SECMCYPCN – South East Coast Maternity, Children and Young People Clinical Network
- TB – Tuberculosis

Executive Summary

Introduction

Rationale

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 well-being– from obesity, heart disease and mental health, to educational achievement and economic status.

Evidence suggests that parents are more receptive to offers of advice and support during pregnancy and the early days after birth. This offers a unique window of opportunity for health and care professionals to support families to improve their own health and wellbeing and give their child the best start in life.

The economic case for intervention during this period is compelling with studies in both the UK and US demonstrating significant returns of investment on well-designed early years interventions with savings far exceeding the costs. Evaluations also highlight the financial implications of failing to intervene in terms of the direct and indirect costs of later anti-social behaviour or mental or physical ill health and the potential for perpetuating the cycle of harm through later generations.

Context

Although considerable improvements have been made in the health and wellbeing of mothers and infants, both locally and nationally, there remains room for improvement and the opportunity to achieve significant population health gains, for instance:

- 11.5% of women in England report smoking at the time of delivery. The figures for Kent vary considerably ranging from 8.1% in Canterbury and Coastal CCG to 18.8% in Thanet CCG.
- In 2013/14 73.9% of babies in England were breastfeed at birth compared to 72.1% in Kent. In 2012/13 47.2% of babies in England continued to be breastfeed at 6-8 weeks of age compared to 40.1% in Kent.
- There are strong links between maternal and infant health and socioeconomic status. Children of disadvantaged mothers are more likely to be born with a low birth weight, less likely to be breastfed, more likely to be exposed to tobacco smoke and less likely to be immunised.

Improving health in pregnancy and early childhood now forms a central pillar of national and local health improvement policy reflected in strategies which aim to give every child the best start in life. The Chief Medical Officer for England recently emphasised that in order to achieve this strategic objective, policy makers need to focus on identifying and prioritising interventions that reduce adverse outcomes of pregnancy.

The national Healthy Child Programme describes a package of public health interventions which local health services are expected to deliver in partnership from conception to age 19 with the overall aim of improving child health and wellbeing and reducing inequalities in child outcomes. The programme combines universal services available to all families with targeted services available according to assessed need. The -9months to 1 week postnatal section of the programme involves the delivery of a series of antenatal health reviews, screening and immunisations, supplemented with advice around health, wellbeing and parenting. In this period programme delivery is led by Midwives in collaboration with Health Visitors, GPs and other health and care professionals.

Project Aim

The review was undertaken on behalf of the Kent Children's Health and Wellbeing Board, a sub-group of Kent Health & Wellbeing Board. It forms part of a wider piece of work to map the multi-disciplinary pathways for health and social care services for children and families in Kent from pre-conception to age 2 ½ .

The key aim of this review was to assess the contribution that maternity services make to the achievement of positive public health outcomes for mother, baby and family by reviewing the delivery of the antenatal and postnatal elements of the Healthy Child Programme in Kent.

Methodology

The project scope included the commissioners and providers of maternity care for Kent residents and also the interfaces and interdependencies between other services on the antenatal and postnatal care pathway e.g. GPs, Health Visitors, Children's Centres and Social Care.

The review consisted of stakeholder interviews, engagement with the Maternity Service Liaison Committees for each provider Trust, a survey of Early Help Group Managers and desk-based research and analysis.

The review did not seek to assess the clinical aspects of maternity care including intrapartum care (care of mother and baby during labour and delivery) or analyse clinical outcomes for maternity services. It did not explore in detail the delivering of the antenatal and new born screening programmes as they are already subject to a robust programme of quality assurance through the UK National Screening Committee Regional Quality Assurance Team.

It focussed on the delivery of public health prevention and health promotion interventions delivered as part of the Healthy Child Programme.

- **Strategic context**

National

The birth rate in England has risen by over 22% over the last decade and although the rate of increase has slowed it still continues to rise by approximately 2% per year.

Over 700,000 women per year access maternity services in England. (11)

A report by NHS England in 2012 identified 5 key challenges currently facing maternity service commissioning and provision: (11)

- Patchy pre-conception care leading to a lack of opportunity for early engagement with women in pre-conception or early pregnancy planning.
- Variation in the provision of specialist mental health services for pregnant women or training to address mental health issues. Patchy provision of support for pregnant women with chronic, low-level mental health problems with confused responsibility between primary care, mental health and maternity services.
- Rising birth rates creating challenges for organisations to maintain safe services in terms of both staffing levels and physical capacity.
- Increasing complexities of pregnancy and birth driven primarily by increases in the number of older mothers, those with a high BMI or pre-existing medical conditions.
- Lack of integration between Midwives, GPs and Health Visitors on a streamlined maternity and early years care pathway.

The national policy agenda relating to pregnancy and the early years has been through a period of intense development over the last decade with the publication of multiple reports and strategies all of which have implications for the delivery of maternity services and the Healthy Child Programme.

Alongside the development of the strategic policy agenda for pregnancy and the early years, a number of high profile reports have been published examining the organisation and delivery of maternity and early years services in England. Many of these reports have made recommendations that have been reflected in child and maternal health policy or are likely to influence future policy direction.

Local

There were just under 18,000 births in Kent in 2012.

The general fertility rate (GFR) is the measure the number of births per 1,000 women aged between 15 and 44 in a population. Analysis of trends in GFR over the last 6 years shows no distinguishable trend in Kent as a whole and rates in most CCGs have fluctuated over this period. Only Dartford, Gravesham and Swanley and West Kent CCGs have seen a consistent upward trend in their GFRs over the last 6 years.

The Kent Health & Wellbeing Strategy identifies that giving every child in Kent the best start in life is a key priority. The strategy recommends that constituent agencies in the health economy, including CCGs, develop a common vision and complementary strategies to support the achievement of this aim. A review of CCG 5 Year Strategic Commissioning Plans revealed that only 4 of the 7 CCGs identified aims or objectives that specifically related to services or outcomes in the antenatal or postnatal period.

Kent maternity services and organisations with interdependencies with these services have recently been subject to a number of independent inspections by both the Care Quality Commission and OFSTED. The findings and recommendations of these inspections are summarised in this report.

- **Findings**

An overview of current maternity service commissioning and provision across Kent is provided alongside a detailed analysis of the current delivery of the universal and progressive elements of the Healthy Child Programme by each maternity service provider.

The service interdependencies and professional interfaces between maternity services and other professionals involved in the maternity care pathway is also explored.

Key findings included:

- A lack of a Kent-wide Maternity Service Specification and inadequate systems for performance and quality monitoring of Kent maternity services.
- A distinct variation in the provision of specialist midwives across Kent.
- Wide variation in the delivery of specific elements of the Healthy Child Programme by maternity services with areas of excellent practice and areas where significant development is required.
- Significant variation in the methods and quality of communication between midwives and other professionals involved in the delivery of the maternal care pathway with many opportunities for clarification and the improvement of information sharing.
- A lack of a robust and comprehensive perinatal mental health pathway across Kent with a lack of awareness of access to NHS Talking Therapies, significant disparities in the provision of Mother and Infant Mental Health Services and a lack of a specialist Mother and Baby Unit within Kent.

- Wide variation in the level of collaboration between Midwives and Children's Centres, an issue which has also recently been highlighted in an OFSTED inspection of local Children's Centres.
- A lack of capacity in dietetics services to provide support to all pregnant women with a BMI >30 in line with current NICE guidelines
- Analysis of national reports which suggest that the issues identified in this review are not unique but common amongst other services locally and nationally. There is significant opportunity for local, regional and national collaboration to share knowledge, expertise and ideas as to how to address the issues identified.

Conclusion

This review revealed distinct variation between providers in their delivery of the Healthy Child Programme and their interfaces with other professionals on the maternity care pathway.

It also highlighted the lack of robust performance and quality monitoring of maternity services by commissioners and the urgent need for a Kent-wide maternity service specification that requires comprehensive and universal delivery of the full -9months to 1week element of the HCP by all providers.

Recommendations

A series of recommendations have been made to address the key issues identified by this review.

Key recommendations:

Maternity Service Specification
For stakeholders to develop a Kent-wide Maternity Service Specification to include comprehensive and universal delivery of the full conception to 1week element of the HCP and reflect all relevant NICE Guidelines for maternity care. A robust process of performance monitoring and challenge should also be agreed to ensure adherence to the specification and encourage continuous service improvement.

Maternity Service Information Dashboard
For Kent Public Health and the Maternity, Children and Young Peoples Team in Kent & Medway Commissioning Support Service (KMCS) to work together to establish a Kent-wide and CCG specific Maternity Services Information Dashboard. This should incorporate both clinical and public health activity and outcomes data, making use of data available from the new national maternity services dataset which is due to become available in late 2014/early 2015. The local dashboard should also align with the South East Regional Maternity Dashboard currently being developed by the South East Coast Maternity, Children and Young Peoples Clinical Network.

Maternity Health Needs Assessment and Health Equity Audit
For Kent Public Health Team to work in collaboration with KMCS and Maternity Services to undertake a Health Equity Audit of provision and access to specialist midwifery services such as mental health, domestic violence and healthy weight. This should be undertaken as part of a comprehensive epidemiological Maternity Health Needs Assessment for Kent which also incorporates the findings of this Service Review.

Analysis of mothers engaging late with midwives
For providers to analyse the demographics of women who present late for booking to identify those groups most likely to present late. To implement evidence-based interventions for these groups to facilitate early access and encourage continuous engagement with maternity care throughout pregnancy.

Audit of multi-disciplinary communication
For each provider, in collaboration with GPs and Health Visitors, to undertake an audit into multi-disciplinary communication and information sharing during the antenatal and postnatal periods using the audit tool developed by EKHUFT & KCHT as a template.

Improved collaboration between maternity services and Children's Centres
For the Heads of Midwifery and Head of Kent Integrated Family Support Services to encourage Early Help Managers & Community Midwives to collaborate to explore opportunities to improve communication and increase the delivery of maternity services within Children's Centres where appropriate.

Perinatal Mental Health Pathway
For commissioners and providers to collaborate to produce a Kent-wide perinatal mental health pathway with equitable access to perinatal mental health support at all levels of need, including prevention services, for pregnant women across Kent.

Support for obese pregnant women
For Heads of Midwifery to liaise with Dieticians and Service Commissioners to ensure that there is sufficient capacity to refer all women with a BMI >30 for dietetic support as per the NICE Guideline PH27.

Referral pathway for early help
For Maternity Care, Early Help and Children's Service providers to review the referral pathway for mothers requiring early help and support antenatally. To identify the potential causes of existing delays in the acceptance of antenatal referrals to Children's Services and to develop an action plan to address these issues.

Forum to oversee implementation of the recommendations
For the Kent Child Health & Wellbeing Board to identify an appropriate forum to take on responsibility for monitoring and reporting on the implementation of the recommendations of this review. Options include:

I. The new Kent-wide project group for Collaborative Commissioning for Children's and Maternity Services
II. The new Local Maternity Service Quality Groups (currently proposed by South East Commissioning Support Unit) whose terms of reference could include monitoring and reporting on the implementation of the recommendations of this report.
III. Expanding the existing KCC led Early Help and Healthy Child Programme Task and Finish Group to become a more permanent Kent-wide multidisciplinary forum for Primary Care, Maternity Services, Early Help and Social Care providers to discuss issues relating to the delivery of the HCP in the early years and monitor the implementation of the recommendations of this review.

Introduction

Rationale for undertaking the project

The review was undertaken on behalf of the Kent Children's Health and Wellbeing Board, a sub-group of Kent Health & Wellbeing Board. It forms part of a wider piece of work to map the multi-disciplinary pathways for health and social care services for children and families in Kent from pre-conception to age 2 ½ .

Background

I. Importance of preconception and pregnancy health

It is now widely accepted that 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 well-being– from obesity, heart disease and mental health, to educational achievement and economic status. (1) (2)
Unfortunately it isn't possible to control exposure to all risk factors during pregnancy however many are amenable to change and are known as modifiable risk factors. These include smoking, obesity, alcohol consumption, substance misuse and nutrition. (3) A list of the main modifiable risk factors and their potential health impacts can be found in Appendix 1.

A recent review of evidence has identified the conditions under which positive foetal development is likely to be optimal. (2) This occurs when mothers are:

- not in poor physical, mental or emotional health
- enjoying a well-balanced diet
- not smoking, consuming alcohol or misusing illegal substances
- not experiencing stress or anxiety
- in a supportive relationship and not experiencing domestic violence
- not socio-economically disadvantaged
- at least 20 years old
- have a supportive birthing assistant at the birth itself.

During pregnancy most women want to do the best for their growing baby and this prompts them to reflect on their own health and lifestyle. This can provide a unique window of opportunity for health professionals, family and friends to support women to alter their exposure to some of these modifiable risk factors by improving their health and wellbeing, tackling unhealthy habits and making healthy lifestyle choices. (3) Evidence also suggests parents are more receptive the offers of advice and support during pregnancy and the early days after birth. (4)

There is also an economic case for intervention with studies in both the UK and US demonstrating significant returns of investment on well-designed early years interventions with savings far exceeding the costs. Evaluations also highlight the costs of failing to intervene in terms of the direct and indirect costs of later anti-social behaviour or mental or physical ill health and the potential for perpetuating the cycle of harm through later generations. (2)

Although there is still a lot to learn about the mechanisms of foetal programming and brain development, improving health in pregnancy and early childhood now forms a central pillar of national and local health improvement policy. At a national level, the consensus of agreement on the critical importance of this period has facilitated the production of a cross-party manifesto calling for a refocusing of parliamentary support to improve prevention and early intervention services during pregnancy and the early years. (4)
This and other key national and local drivers are explored further in the "*National Context*" section.

II. Key indicators of preconception and pregnancy health

Although considerable improvements have been made in reducing exposure to modifiable risk factors in pregnancy and the early years, both locally and nationally, there remains room for improvement and the opportunity to achieve significant population health gains:

- In 2010 in the UK, 37% of women reported taking folic acid before they were pregnant and 79% reported taking it during the first three months of pregnancy. (3)
- Around 6% of women in the UK have a body mass index of 35 (obese) or over during pregnancy. (3)
- In 2010, about 40% of women drank alcohol during pregnancy. Alcohol consumption is more likely in mothers aged 35 or over (52%) and in mothers from managerial and professional occupations (51%). (3)
- The latest statistics show that 11.5% of women in England report smoking at the time of delivery. The proportion of women smoking during pregnancy in Kent varies considerably between CCG areas ranging from 8.1% in Canterbury and Coastal CCG to 18.8% in Thanet. (5)
- In 2013/14 73.9% of babies in England were breastfeed at birth compared to 72.1% in Kent. In 2012/13 47.2% of babies in England continued to be breastfeed at 6-8 weeks of age compared to 40.1% in Kent. (6)

A recent NSPCC report estimated that in the UK: (7)

- 19,500 babies under 1 year old are living with a parent who has used Class A drugs in the last year
- 39,000 babies live in households affected by domestic violence in the last year
- 93,500 babies live with a parent who is alcohol dependent.
- 144,000 babies live with a parent who has a common mental health problem

There are strong links between maternal and infant health and socioeconomic status and children of disadvantaged mothers are more likely to be born with a low birth weight, less likely to be breastfed, more likely to be exposed to tobacco smoke and less likely to be immunised. (2)
Inequalities in early learning and achievement begin to become apparent in early childhood, with a gap opening up between the abilities of poor and prosperous children at as early as two or three years of age. Children who come from families with multiple risk factors (e.g. mental illness, substance misuse, debt, poor housing and domestic violence) are more likely to experience a range of poor health and social outcomes. These might include developmental and behavioural problems, mental illness, substance misuse, teenage parenthood, low educational attainment and offending behaviour. (8)

III. Role of Healthy Child Programme & Maternity Services.

The Healthy Child Programme (HCP) provides a comprehensive framework of evidence-based preventative public health interventions to be delivered from early pregnancy to age 19 with the overall aim of improving child health and wellbeing and reducing inequalities in outcomes. The programme combines universal services available to all with targeted services available according to assessed need. The programme was formally established as part of the National Service Framework for Children, Young People and Maternity Services in 2004 and updated in 2009. (8)

The programme is led by Health Visitors with the support of other key health service providers including; midwives, GPs and community nurses and in collaboration with colleagues from children's services and the wider children's workforce. The interventions should be offered in a range of settings including the home.
The objectives of the programme are to:

- Help parents develop a strong bond with children.
- Encourage care that keeps children healthy and safe.
- Protect children from serious diseases, through screening and immunisation.
- Reduce childhood obesity by promoting healthy eating and physical activity.
- Encourage mothers to breastfeed.
- Identify problems in children's health and development and safety so that they can get help with their problems as early as possible.
- Make sure children are prepared for school.
- Identify and help children with problems that might affect their chances later in life.

The programme is split into 2 phases; pregnancy & the first 5 years of life and school age 5-19.
The HCP for 0-5 focuses on providing a programme of screening, immunisations, health and developmental reviews, supplemented with advice around health, wellbeing and parenting.

This review will focus on the delivery of the HCP from early pregnancy to 1 week post-partum which is led by midwives in collaboration with GPs and Health Visitors.
The full HCP schedule for early pregnancy to 1 week post-partum and the Maternity Care Pathway for England can be found in Appendices 2 and 3.

The Chief Medical Officer recently emphasised that in order to achieve the strategic objective of giving "every child the best start in life" policy makers need to focus on identifying and prioritising interventions that reduce adverse outcomes of pregnancy. Services for pregnancy and the early years should be expanded and the quality of both universal and targeted services should be improved. She also acknowledged the fundamental role that midwives play in facilitating a healthy pregnancy and birth, recommending that they should prioritise the implementation of pre and postnatal interventions that reduce adverse outcomes of pregnancy and infancy. (3)

Evidence indicates that early intervention by midwives can lead to a direct reduction in the risk of poor outcomes for young children including; (2)

- Reduced risk of low birth weight and foetal injury
- Improved uptake of preventative care
- Lower risk of poor parent-infant bonding
- Reduced child neglect and abuse

Maximising the impact of nursing and midwifery on improving and protecting the public's health is one of six key areas for action highlighted in the National Nursing, Midwifery and Care Strategy launched in December 2012. (9)

The Department of Health and Public Health England also recently outlined the key actions midwives can take to maximise their contribution to improving population health and wellbeing. These largely reflect some of the core elements of the HCP for early pregnancy to 1 week post-partum HCP. A list of these actions is included in Appendix 4 for information.

o Aims & Objectives

The key aim of the review was to:

Review the contribution that maternity services make to the achievement of public health outcomes for mother, baby and family during the antenatal and perinatal periods.

The objectives were:

- To review the delivery of public health advice, information and interventions by maternity services in comparison to national and local guidelines.
- To identify the care pathways for public health related support during the antenatal and perinatal period.
- To review the interfaces between maternity services and other partners such as Community Midwifery, Obstetricians, Perinatal Mental Health Teams, Health Visiting, Family Nurse Partnership, GPs, Children's Centres & Social Workers.
- To identify gaps or barriers to the provision of best practice in relation to public health support with particular reference to the delivery of the -9monts to 1 week elements of the Healthy Child Programme.
- To identify opportunities for Kent Public Health Team to provide further support to maternity services to develop their public health role.
- To explore ways in which a whole systems approach to children and young people's intelligence could support and enhance the commissioning of maternity services.
- To provide recommendations for commissioners to inform their maternity services commissioning strategies.
- To identify and share examples of good practice.

These locally identified objectives also reflect many of the key areas of enquiry recommended by the Royal College of Midwives, Royal College of Obstetricians and Gynaecologists and the National Childbirth Trust to assist CCGs to assess local maternity services in 2011. (10) See "*National Context*" section for further details.

o Methodology

The review was undertaken by Helen Buttivant, Public Health Specialty Registrar, Kent County Council Public Health Team, from April – September 2014

The review consisted of:

- Structured interviews with Heads of Midwifery for MTW and DVH and the Consultant Midwife for Public Health for EKHUFT (in the absence of their HoM). The interview framework was based on a previous model developed by Michael Edelstein , Public Health Specialty Registrar in Haringey. The framework is outlined in the tables included in the results section titled; "Mapping delivery of HCP elements".
  The original framework, which was based on the Healthy Child Programme, was updated by the report author to include appropriate elements of NICE and other guidance relating to maternity service delivery published since the Healthy Child Programme in 2009 (see Appendix 5 for a list of NICE Guidelines).
- Semi-structured interviews with CCG Clinical Advisers for Children and Maternity, Head of Kent Integrated Family Support Services, Mother & Infant Mental Health Service Manager, Kent & Medway Screening & Immunisation Lead, Head of Health Visiting and Family Nurse Partnership and Senior Children Public Health Specialists.
- A survey of Early Help Group Managers.
- Attendance at the Maternity Service Liaison Committee meeting for each provider Trust.
- Desk research using national and local reports and other documents.
- Analysis of the latest statistics on indicators of maternal and infant health including the Public Health Outcomes Framework (undertaken by the Kent & Medway Public Health Observatory).

See Appendix 6 for a full list of interviewees & Appendix 7 for details of the survey of Early Help Group Managers.

o Scope

- Inclusions

The 7 commissioners of maternity care for Kent residents:

- Ashford CCG
- Canterbury & Coastal CCG
- Dartford Gravesham & Swanley CCG
- South Kent Coast CCG
- Swale CCG
- Thanet CCG
- West Kent CCG

The 3 main providers of maternity care for Kent residents;

- Dartford & Gravesham NHS Trust
- East Kent Hospitals University Foundation Trust
- Maidstone and Tunbridge Wells NHS Trust

A significant number of Kent residents (particularly from Swale and areas north of Maidstone) also access the maternity services provided by Medway NHS Foundation Trust at Medway Hospital. This Trust, in collaboration with Medway CCG, have recently completed their own review of maternity services provision. It was therefore

agreed, in collaboration with the Public Health Team in Medway, that a further formal review wasn't necessary at this stage and this maternity service provider was not formally included in the review.

A review of the key findings & recommendations from their report that have relevance to the delivery of public health aspects of maternal care are summarised in the section "*Mapping delivery of the Healthy Child Programme in Maternity Services".*

Maternity services do not deliver the antenatal and postnatal elements of the Healthy Child Programme in isolation. The report also briefly explores the interfaces and interdependencies between other services on the antenatal and postnatal care pathway including:

- GPs
- Health Visitors / FNP Practitioners
- Children's Centres
- Social Workers
- Mother & Infant Mental Health Services

    - Exclusions
- This review did not seek to assess the clinical aspects of care including intrapartum care (care of mother and baby during labour and delivery).

- The review did not focus on the delivery of the antenatal and new born screening programmes. Although this is included in the Healthy Child Programme they are already subject to a robust programme of quality assurance through the UK National Screening Committee Regional Quality Assurance Team. However the interfaces between maternity services and the Immunisation, Antenatal and Newborn Screening Services commissioned by NHS England were explored through interviews with midwives and with the Screening and Immunisation Lead for Kent & Medway.

o Acknowledgements

The author would like to express her thanks and appreciation to everyone who has contributed to the development of this report.

In particular to:

- Members of the *Kent & Medway Commissioning Support Service Children, Young People and Maternity Team* who provided valuable support, insight and information.
- All those who participated in individual interviews (see Appendix 1 for a list) who generously shared their time and expertise.
- The Chairs and members of the 3 Local Maternity Service Liaison Committees in Kent for welcoming me to join their meetings and providing a valuable user perspective.
- All those who reviewed and commented on the draft report.

Strategic Context

National Context

Demographics

The birth rate in England has risen by over 22% over the last decade and although the rate of increase has slowed it still continues to rise by approximately 2% per year. Over 700,000 women per year access maternity services in England. (11)

A report by NHS England in 2012 identified 5 key challenges currently facing maternity service commissioning and provision: (11)

- Patchy pre-conception care leading to a lack of opportunity for early engagement with women in pre-conception or early pregnancy planning.
- Variation in the provision of specialist mental health services for pregnant women or training to address mental health issues. Patchy provision of support for pregnant women with chronic, low-level mental health problems with confused responsibility between primary care, mental health and maternity services.
- Rising birth rates creating challenges for organisations to maintain safe services in terms of both staffing levels and physical capacity.
- Increasing complexities of pregnancy and birth driven primarily by increases in the number of older mothers, those with a high BMI or pre-existing medical conditions.
- Lack of integration between Midwives, GPs and Health Visitors on a streamlined maternity and early years care pathway.

Policy & Strategy

The national policy agenda relating to pregnancy and the early years has been through a period of intense development over the last decade with the publication of multiple reports and strategies all of which have implications for the delivery of maternity services and the Healthy Child Programme.

A number of these key national strategies and their relevance to maternity services and the HCP are summarised below:

- *Maternity Matters 2007* (12)

This strategy set a vision for the future of maternity services with improvements in the quality of maternity services including safety and patient experience. There was also a focus on tackling inequalities in access to maternity services and outcomes for mother and child.

It described a detailed programme of action for improving choice, access and continuity of care & the delivery of the “Choice Guarantee” by 2009. This guaranteed that women would have the following 4 choices regarding antenatal, intrapartum and postnatal care:

- Choice of how to access maternity care
- Choice of type of antenatal care
- Choice of place of birth
    - a home birth
    - birth in a local facility, under the care of a midwife
    - birth in a hospital supported by a local maternity care team including midwives, anaesthetists and consultant obstetricians.
- Choice of place of postnatal care

Provision was also made for a woman to choose to access maternity services outside her area with a provider that has available capacity.

- *Healthy Child Programme: Pregnancy and the first five years of life, 2009* (8)

The Healthy Child Programme (HCP) provides a comprehensive framework of evidence-based preventative public health interventions to be delivered from early pregnancy to age 19 with the overall aim of improving child health and wellbeing and reducing inequalities in outcomes. It has previously been described in detail in the "Background" section

- *Healthy Lives Brighter Futures: The Strategy of Children and Young People's Health, 2009* (13)

This strategy presented the Government's vision for children and young people's health and wellbeing and how it intended to achieve the ambition of making England the best place for children to grow up by 2020.

It consolidated policy recommendations made in previous strategies including the National Service Framework for Children, Young People and Maternity Services and the Every Child Matters Programme.
Specific commitments for improvements in maternity and postnatal services were made including:

- More health visitors to improve delivery of the HCP
- A strengthened role for Children's Centres to deliver health-improvement programmes such as smoking cessation and healthy weight.
- Further expansion of the Family Nurse Partnership
- The development of a new Antenatal and Preparation for Parenthood Programme for mothers and fathers.

- *Healthy Lives, Healthy People, 2010* (14)

This document presented the new Government's strategy for public health and outlined its plans to reform the public health system by:

- Moving public health services out of the NHS and back into Local Authorities and devolving more public health decision making to local areas.
- Providing a ring-fenced budget for public health services.
- Establishing Public Health England, a new organisation with responsibility for national public health.

The strategy also confirmed the Government's ongoing commitment to provide every child in every community the best start in life and made a number of pledges for service improvements to support this ambition which included:

- Further investment in the health visitor service to significantly increase the numbers of health visitors by 2015
- Doubling the number of families reached through the Family Nurse Partnership Programme.
- Refocusing Children's Centres towards the communities and individuals who need them most.

- *Healthy Lives, Healthy People: Update and way forward, 2011* (15)

This follow up to the 2010 strategy provided further clarification around commissioning responsibilities for public health following the implementation of the Health and Social Care Bill.
It confirmed that the commissioning of the delivery of the Healthy Child Programme would initially be split between NHS England and Local Authorities.
NHS England would commission services to deliver the HCP from 0-5 i.e. health visiting and Family Nurse Partnership teams to ensure continuity in the delivery of the national targets for HV service transformation.
Local authorities would commission services to deliver the HCP from 5-19 i.e. school nursing teams. The ambition was that local authorities would commission services to deliver all elements of the HCP once the HV service transformation was completed in 2015.

- *Supporting Families in the Foundation Years, 2011* (16)

This report provided additional information about how the ambitions outlined in "Healthy Lives, Brighter Futures" children and young people's strategy will be achieved through further development of maternity, early years and early help services. The document includes the following pledges:

- To ensure the HV workforce has the capacity to fully and consistently deliver the Healthy Child Programme to meet families' needs.
- Encouraging stronger partnerships between health and early years services, leading to stronger integrated working and clarifying how information-sharing in the foundation years can work better.
- Helping professionals to use all interactions with families as opportunities to identify any additional needs of both parents and other key family members and offer further help.
- Supporting the provision of online and phone-based family-support services accessible to fathers and mothers;
- To retain a national network of Children's Centres and set out a new core purpose for them with early intervention at its heart.
- Working with sector partners to increase take-up of parenting and relationship programmes

- *Giving all children a healthy start in life, 2013* (17)

This joint policy statement from the Department of Health and Department for Education updated and outlined additional commitments from the government to help give every child the best start in life. It included the following pledges:

- To improve maternity care by:
  - Giving women a single, named midwife who will oversee their care during pregnancy and after they have their baby.
  - Making sure every woman has 1to1 midwife care during labour and birth.
  - Giving people expecting a baby a choice about where and how they give birth.
  - Making sure that women who have postnatal depression or have suffered a miscarriage, stillbirth or death of a baby get more support from the NHS.
- To increase access to information and advice for people expecting a baby by:
  - Giving parents information and advice through regular emails, text messages and short videos on the NHS Information Service for Parents website.
- To improve support for mothers and children with mental health problems by:
  - Investing £400 million on giving more people, including pregnant women and children and young people, access to talking therapies.
  - Making sure that health visitors have training to spot the signs of postnatal depression in patients and get them the help they need as soon as possible.
- To improve chances for children with vulnerable mothers by:
  - Doubling the number of places on the Family Nurse Partnership programme between 2010-2015

- *The 1001 Critical Days; The importance of the Conception to Age 2 period. A Cross Party Manifesto, 2014* (4)

This cross-party manifesto calls for parliament to refocus on improving prevention and early intervention services during pregnancy and the early years. It advocates for a holistic approach to antenatal and postnatal services with seamless access for all families and recommends that:

- All parents should be able to access antenatal classes which address both the physical and emotional aspects of parenthood and infant well-being.
- Birth registration should be offered by local registrars in Children's Centres to encourage engagement with families.
- All professionals and organisations involved in the HCP care pathway should share vital information to ensure those who need it receive timely and culturally sensitive support.
- The health and early years workforce should receive high quality training in infant mental health and attachment.
- At-risk families should be able to access evidence-based services which promote parent-infant interaction and parent-infant psychotherapy, delivered by qualified professionals.
- A range of services should be available in every local area to ensure women at risk or suffering from mental health problems are given appropriate support at the earliest opportunity. This includes specialist parent and infant mental health midwives and health visitors with appropriate training, to improve identification and support for families.

- The NICE Guidelines recommending that every woman with a history of past or present serious mental illness should have access to a Consultant Perinatal Psychiatrist and specialist perinatal psychological care for mother and baby must be followed.
- Local commissioning and decision making boards should consider the social and emotional health needs of babies and include this information in their Joint Strategic Needs Assessment and Local Health & Wellbeing Strategy.

Better health outcomes for children and young people: Our Pledge, 2013 (18)

This pledge was launched by Department of Health in 2013 in response to recommendations made by the Children and Young People's Health Outcomes Forum.
The pledge commits signatories to put children, young people and families at the heart of decision making and improve every aspect of health services - from pregnancy through to adolescence and beyond.

Outline of the pledge:
"We are committed to improving the health outcomes of our children and young people so that they become amongst the best in the world. We pledge to work in partnership, both locally and nationally, with children, young people and their families.

Our shared ambitions are that:
- *Children, young people and their families will be at the heart of decision-making, with the health outcomes that matter most to them taking priority.*
- *Services, from pregnancy through to adolescence and beyond, will be high quality, evidence based and safe, delivered at the right time, in the right place, by a properly planned, educated and trained workforce.*
- *Good mental and physical health and early interventions, including for children and young people with long term conditions, will be of equal importance to caring for those who become acutely unwell.*
- *Services will be integrated and care will be coordinated around the individual, with an optimal experience of transition to adult services for those young people who require ongoing health and care in adult life.*
- *There will be clear leadership, accountability and assurance and organisations will work in partnership for the benefit of children and young people.*

All organisations that have the power to take action to improve outcomes for children and young people have been invited to sign up and current signatories include:
- Public Health England
- Faculty of Public Health
- Royal College of GPs & Royal College of Nurses
- Local Government Association
- Association of Directors of Children's Services (ADCS)
- NHS England
- NICE

- Reports

Alongside the development of the strategic policy agenda for pregnancy and the early years, a number of high profile reports have been published examining the organisation and delivery of maternity and early years services in England. Many of these reports have made recommendations that have been reflected in child and maternal health policy or are likely to influence future policy direction.
Some of these key reports are highlighted and summarised below:

- *Maternity Services in England. House of Commons Committee of Public Accounts: Fortieth Report of Session 2013–14, 2014* (19)

This report highlighted the increasing pressures on maternity services caused by rising birth rates and the increasing proportion of complex births.

It revealed that England has relatively poor outcomes for infants, particularly still birth rates and death in the first 7 days, compared to other UK nations and some European countries. It also highlighted the cost of poor quality maternity care indicating that approximately 1/5 of the £2.6 billion maternity care budget is currently spent on clinical negligence cover.
The report suggested the Department of Health has a lack of oversight of the quality of maternity services and lacks assurance about performance. It also implied that the NHS has failed to address persistent inequalities in access to maternity care and that local commissioners were failing to adequately hold trusts to account for their maternity services with over a quarter of trusts currently lacking a written service specification.

- *Maternity Services in England: Report by the Comptroller and Auditor General, 2013* (20)

This report highlighted a number of concerns regarding maternity service provision.
It echoed the findings of the Public Accounts Committee report regarding the lack of written service specifications for maternity services and the subsequent lack of performance monitoring.
It also highlighted significant variation between trusts in the costs of maternity care provision despite the introduction of the new pathway tariff payment system for maternity services.
Finally the report highlighted the ongoing need to improve diagnosis and support services for women with pregnancy-related mental health problems.

- *State of Maternity Services Report, 2013* (21)

This is the 3rd in a series of annual reports on the state of maternity services by the Royal College of Midwives. It analyses trends in both birth rates and in the size of the midwifery workforce. The analysis indicates that birth rates may have slowed. However it also states that midwives are still dealing with increasingly complex cases due to multiple births, older mothers, those with existing health conditions or underlying health issues such as obesity or smoking.
It highlights the ongoing shortage in trained midwives suggesting that there was a shortfall of 4800 in 2012 compared to the number required to safely deliver the amount of babies born in that period. It acknowledges that although the shortfall in the midwifery workforce continues to decrease and despite the indication that the birth rate is slowing, there is still an urgent need for more trained midwives to address the gap in service provision and ensure women with complex needs are provided with safe and effective care.

- *Conception to Age Two: The age of opportunity, 2013* (2)

This report was produced by a Special Interest Group established by the Departments of Health and Education to explore how the principles set out in "Supporting Families in the Foundation Years" (summarised above) could be effectively promoted and implemented. The report focuses specifically on services to support children, parents and families in the period from conception to the child's second birthday, commonly referred to as the "1001 critical days"
The report recommends that commissioners and providers of services for pregnancy and very early childhood should:

- Ensure health professionals are well equipped to detect stress, anxiety and depression during pregnancy and carry out a mental health risk assessment as early in pregnancy as possible.
- Provide referral to appropriate psychological or other interventions for antenatal anxiety and depression and ensure there are enough trained professionals to provide this help.
- Target maternal stress during pregnancy, focusing on reducing domestic violence and supporting the quality of relationships.
- Make it a priority for midwives, GPs and other health professionals to identify and provide family support where domestic violence is identified as a risk.
- Consider whether antenatal education classes should include a discussion on the emotional impact of becoming a parent.
- Promote awareness of the importance of the parent/baby relationship and how this will influence the baby's brain development and enquire about the mother's bonding with the foetus.
- Develop a care pathway for women identified as being at risk which includes:
    - Early referral by a midwife to the local health visiting team.
    - A minimum of 2 Health Visitor visits in the antenatal period.

- *Report of the Children & Young People's Health Outcomes Forum, 2012* (22)

This is the first report of the national independent Children and Young People's Health Outcomes Forum. The forum was established by the Secretary of State for Health in 2012 to develop a Children and Young People's Health Outcomes Strategy to identify and address the key obstacles that are currently impeding improvements to children and young people's health. Amongst its many tasks the forum was asked to describe the contribution that each part of the new health system needs to make in order to achieve improvements in the most important child health outcomes.

The forum made a series of recommendations for local stakeholders including:

- All organisations in the new health system should take a life-course approach, coherently addressing the different stages in life and the key transitions instead of tackling individual risk factors in isolation.
- Directors of Public Health and their local clinical commissioning groups (CCGs) should work together with maternity and child health services to identify and meet the needs of their local population.
- Directors of Public Health, through their health and wellbeing board, should ensure that they include comprehensive data for all children and young people within their Joint Strategic Needs Assessment.
- CCGs need to develop local networks and partnerships with providers to address and deliver the sustainable provision of local acute, surgical, mental health and community children's services and to ensure both care closer to home and no gaps in provision.
- All organisations leading the new system – including local authorities and CCGs – should clearly set out their responsibilities for children, young people and their families and how accountability will be exercised at every level in the system, and should be transparent about the funds they spend on child health.
- Local commissioners, including CCGs and local authorities, should identify a senior clinical lead for children and young people.

In addition to this main report the Forum also produced reports on specific themes:

- Report of mental health subgroup - http://www.dh.gov.uk/health/files/2012/07/CYP-Mental-Health.pdf
- Report of public health and prevention subgroup http://www.dh.gov.uk/health/files/2012/07/CYP-Public-Health.pdf
- Report of acutely ill children subgroup http://www.dh.gov.uk/health/files/2012/07/CYP-Acutely-Ill.pdf
- Report of long-term conditions, disability and palliative care subgroup http://www.dh.gov.uk/health/files/2012/07/CYP-Long-Term-Conditions.pdf
- Inequalities in health outcomes and how they might be addressed http://www.dh.gov.uk/health/files/2012/07/CYP-Inequalities-in-Health.pdf

- *Improving Children and Young People's Health Outcomes: a system wide response to the report of the Children and Young People's Health Outcomes Forum, 2013* (23)

This report outlined the Government's response to the recommendations of the first report of the Children and Young People's Health Outcomes Forum. It confirmed the Government's aim to improve health outcomes for children and young people to a level comparable to the best countries in the world.

Commitments at a national level included:

- The establishment of a Children and Young People's Health Outcomes Board led by the Chief Medical Officer. The Children and Young People's Health Outcomes Forum was also formally established to provide expert advice and challenge to maintain progress towards improvements in outcomes.
- Department of Health plans to redevelop the Start4Life social marketing programme to focus on key behaviours in pregnancy and for parents of children up to age 5.
- Plans for a national maternity and children's dataset linking information from maternity records and Child Health Information Systems.
- Development of NICE Quality Standards for antenatal and postnatal care (both of which have subsequently been published).

Recommendations were also made for local action:

- Commissioners were asked to improve the provision of integrated care for children and young people in order to improve quality and reduce health inequalities.
- The Lead Member for Children's Services (LMCS) and the Director of Children's Services (DCS) were requested to play a key role in championing a shift towards prevention and early intervention.

- *Report of the Children & Young People's Health Outcomes Forum, 2013/14* (24)

In this 2nd annual report of the Children and Young People's Health Outcomes Forum the group reviewed progress against its original recommendations and identified future challenges and areas for action.

It echoed the stance of Public Health England in recognizing the crucial contribution that midwives can make to population public health through improving the health outcomes of babies. The forum acknowledged the opportunity midwives have to engage with women at the earliest opportunity via early antenatal booking and working in partnership with health visitors to establish appropriate pathways for care of pregnant women and mothers.

The report also highlighted the risk posed by the current commissioning arrangements for child health services which splits responsibility between NHS England, Local Authorities and CCGs and the work that local authorities, primary care and secondary care need to undertake to ensure that gaps in service provision are addressed and not exacerbated by this lack of integration.

The report also highlighted ongoing issues in access to perinatal mental health services, urging Local Authorities and Clinical Commissioning Groups to continue to invest in early help for pregnant women, mothers and fathers with mental health issues and identify and support mental health problems during infancy.

The forum recommended that the development of the payment by results system for maternity services needs to improve, particularly in relation to the current system where providers of care need to recoup costs for women who give birth outside the local provider.

- *Commissioning Maternity Services - A Resource Pack to support Clinical Commissioning Groups, 2012* (11)

This resource pack was developed by NHS England to support CCGs with the commissioning of maternity services from acute trusts. It was intended to assist new clinical commissioners to:

- Review local arrangements for the commissioning of maternity services and identify priorities for service improvement.
- Support and enhance an integrated approach to maternity care provision which is part of a wider early years health and social care service that spans primary, acute, community and social care.

The report recommends that clinical commissioners should contribute to:

- The redesign of the whole -9 months to 5 years pathway.
- Challenge existing provider behaviour where there is unacceptable variation in maternity service outcomes
- Develop new primary care led maternity services such as preconception care and perinatal mental health services.

It proposes a set of principles which CCGs could use to guide local maternity service delivery which include:

- Outreaching to frequently excluded groups, encouraging them to engage with services.
- Establishing a community based multi-professional partnership approach to care that ensures seamless links between primary, secondary and community services.
- Improving accessibility of maternity services to encourage early booking and ensures women stay in regular contact with midwifery services throughout pregnancy and the postpartum period.
- Promoting continuity of care especially for disadvantaged women or those with special needs.
- Providing a seamless service to women who require additional care including medical/ obstetric/ psychological support during their pregnancy.

- Promoting family based care and locally available access to other services such as parenting skills, family planning, benefits agencies and baby clinics.
- Safeguarding and promoting the welfare of children through appropriate and timely therapeutic and preventative interventions.

Further information and recommendations from this resource pack have been referred to and summarised throughout this report.

- *Making sense of commissioning Maternity Services in England – Some Issues for Clinical Commissioning Groups to Consider, 2011* (10)

This joint briefing paper provides an overview of some of the challenges facing CCGs as the new commissioners of maternity services.
It recommends 13 key lines of enquiry that local commissioners should consider in reviewing the quality and performance of existing providers of maternity services:

1. Are women accessing maternity services early?
2. What percentage of women are socially vulnerable and what arrangements are in place to care for them?
3. What arrangements are there for women who are unwell, apprehensive or whose pregnancies begin to deviate from the norm?
4. How do you make sure women have choices about the place and manner of their birth?
5. What is the normal birth rate?
6. How many hours are consultants present on the labour ward?
7. How many women receive 1:1 care in labour?
8. What are your breastfeeding rates?
9. Do you have special arrangements for women with risk factors, for example high BMI?
10. How are women with antenatal and postnatal mental health problems supported
11. What collaborative arrangements are in place for midwives and health visitors to work together?
12. How can you be assured of the safety of the service?
13. Are all areas of the maternity pathway adequately resourced?

The briefing paper provides a rationale for each line of enquiry along with details of what assurance commissioners should be looking for and suggestions as to how any inadequacies or insufficiencies in current provision could be collaboratively addressed.

Many of these suggested lines of enquiry have been explored during the course of this review and are discussed throughout this report.

- *Saving Mothers' Lives: 8th Report into the Confidential Enquiry into Maternal Deaths in the UK, 2011* (25)

This report highlighted the continuing decrease in maternal death rates in the UK and provided evidence that the inequalities gap in maternal death rates between women of different socio-economic status had narrowed for the first time.

The report provided a series of recommendations for policy-makers, commissioners and providers of maternity services, these included

- Pre-pregnancy counselling services, starting for women with pre-existing medical conditions, but ideally for all women planning a pregnancy, are a key part of maternity services and should be routinely commissioned.
- Professional interpretation services should be available in both primary-care and secondary-care settings for all pregnant women who do not speak English.
- Referrals to specialist services in pregnancy should be prioritised as urgent. Good communication among professionals is essential and referral between specialties should be at a senior level.

- Providers and commissioners should consider developing protocols to specify which pre-existing medical conditions mandate at least a consultant review in early pregnancy. Midwives and GPs should be able to refer women directly to both an obstetrician and a non-obstetric specialist.

- *Midwifery 2020: Delivering Expectations, 2010* (26)

This is the final report of the Midwifery 2020 programme which was co-commissioned in 2008 by the Chief Nursing Officers for England, Wales, Northern Ireland and Scotland.

The aim of the programme was to review the future role for midwives recognising recent and future changes in health care policy. The report recommends that midwives should be the Lead Professional for healthy women with uncomplicated pregnancies and act as the Key Co-ordinator of care for women with complex pregnancies. It also acknowledges that midwives need to have a greater role in public health to contribute to the reduction of health inequalities and improve maternal and family health.

The report highlights several key changes that are required to achieve the new vision for the midwifery workforce:

- Midwives' unique contribution to public health is that they work with women and their partners and families throughout pregnancy, birth and the postnatal period to provide safe, holistic care.
- Midwives should use their advocacy role for influencing and improving the health and wellbeing of women, children and families. This will include making the economic case for committing resources so that the midwife can deliver public health messages in the antenatal and postnatal periods, and ensuring that there is a midwifery contribution at policy, strategic, political and international level.
- Midwives should have a visible place in a community setting where women can choose to access them as the first point of contact.
- Midwives should have a good knowledge of the health and social care needs of the local community; be well networked into the local health and social care system; and be proactive in identifying women at risk, and engaging with the woman, her family and other services as appropriate
- Seamless maternity services which work effectively between community and hospital settings should continue to be developed. These will facilitate access to parenting programmes and good quality early years' education.

- *Standards for Maternity Care: Report of a Working Party, 2008* (27)

In 2008, the joint Royal Colleges published national standards for maternity care. The standards were intended to assist commissioners and providers to plan, develop and quality assure, equitable and high quality maternity services.

The standards integrated multiple sets of guidelines for maternity care into a single and comprehensive framework. Each standard is supported by audit indicators that can be used by providers for self-assessment or by commissioners for performance management.

There are 30 standards relating to different elements of the maternity care pathway which include:

- Looking forward to pregnancy
- Pre pregnancy care for women with existing medical conditions or significant family or obstetric history
- Access to maternity care
- Early pregnancy services
- Maternity booking and planning of care
- Women with social needs
- Pre-existing and developing mental health conditions in pregnancy
- Antenatal screening
- Routine antenatal care
- Postnatal assessment and care of the mother
- Supporting infant feeding
- Promotion of healthy parent–infant relationships
- Transition to parenthood
- Choice and appropriate care
- Development, implementation and review of local maternity services strategy
- Child protection and safeguarding babies

In addition to these key documents there have been a number of high profile reports focussing on specific issues or aspects of the maternity care pathway and HCP, these include:

- Pressure Points; Article Series, Royal College of Midwives, 2014
  Available online from:
  https://www.rcm.org.uk/get-involved/campaigns/pressure-points#
  These articles highlight various issues relating to the provision of postnatal care including mental health and breastfeeding support.

- Working for Health Equity: The Role of Health Professionals, Institute of Health Equity, 2013
  Available online from:
  http://www.instituteofhealthequity.org/projects/working-for-health-equity-the-role-of-health-professionals
  This report includes a statement from the Royal College of Midwives (p.99) outlining the midwife's role in tackling the social determinants of health

- Preparation for Birth and Beyond: A resource pack for leaders of community groups and activities, Department of Health, updated 2012
  Available online from:
  https://www.gov.uk/government/publications/preparation-for-birth-and-beyond-a-resource-pack-for-leaders-of-community-groups-and-activities
  This is aimed at those involved in planning or running antenatal education programmes and aims to provide a practical tool for developing a new approach to antenatal education that involves both parents and focuses on child development and the emotional transition to parenthood.

- Guidance for Health Professionals on Domestic Violence, Department of Health, 2012
  Available online from:
  https://www.gov.uk/government/publications/guidance-for-health-professionals-on-domestic-violence
  This resource was developed as part of the Health Visiting and School Nursing Transformation Programmes and provides guidance for Midwives, Health Visitors and School Nurses in identifying and addressing domestic violence issues

- Health Visiting and Midwifery Partnership – Pathway for pregnancy and early weeks. Department of Health and Royal College of Midwives, 2011
  Available online from:
  https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/152203/dh_133021.pdf.pdf
  This pathway was developed as part of the Health Visiting Transformation Programme and outlines the pathway for the co-delivery of care by Midwives and HVs to mothers and families in pregnancy and the early weeks of life.

- Teenage Parents Who Cares? A guide to commissioning and delivering maternity services for young parents, Department of Health and Department for Children, Schools and Families 2008
  Available online from:
  http://webarchive.nationalarchives.gov.uk/20130401151715/https:/www.education.gov.uk/publications/standard/Childrenandfamilies/Page11/DCSF-00414-2008

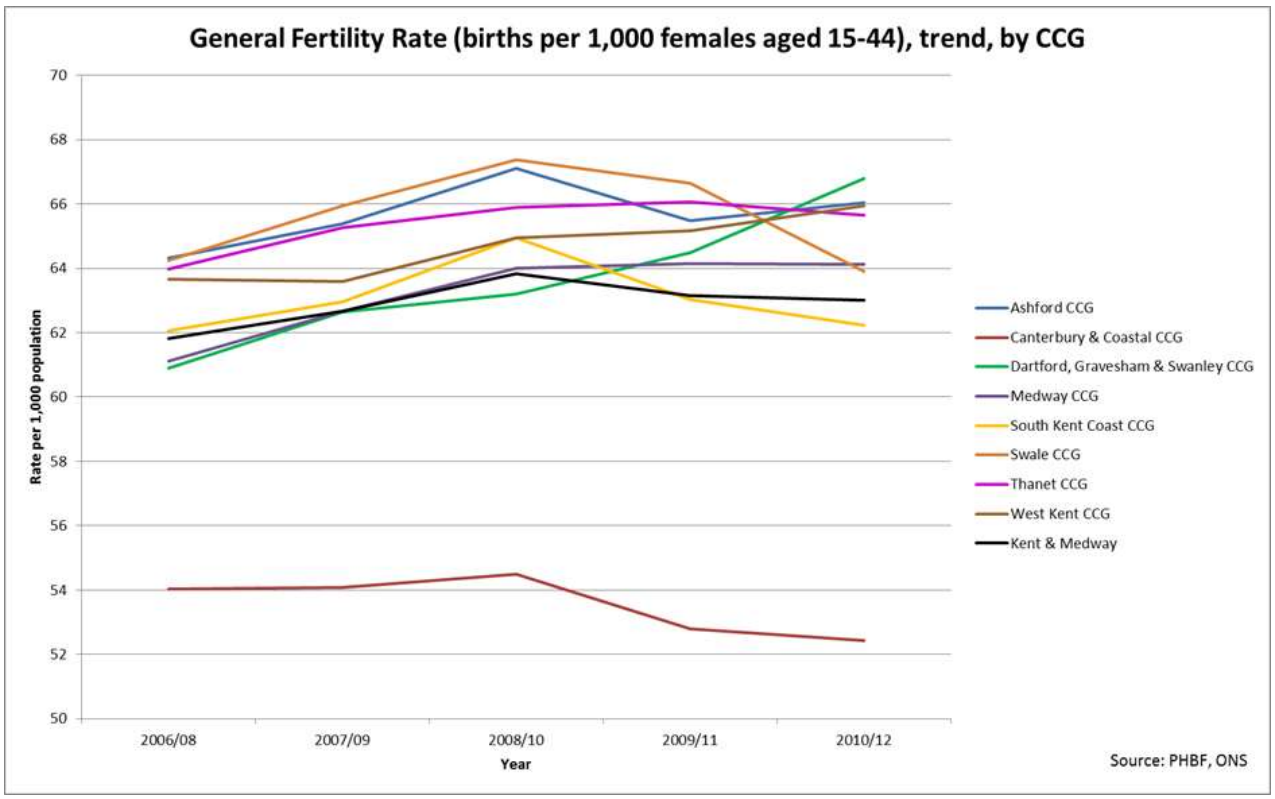
- **Local Context**
  - Demographics

Number of births by CCG (resident population, 3 year trends)

CCG	2010	2011	2012
NHS Ashford CCG	1503	1446	1595
NHS Canterbury and Coastal CCG	2035	1988	1928
NHS Dartford, Gravesham and Swanley CCG	3225	3341	3530
NHS Medway CCG	3553	3554	3664
NHS South Kent Coast CCG	2296	2221	2327
NHS Swale CCG	1415	1295	1218
NHS Thanet CCG	1636	1682	1642
NHS West Kent CCG	5553	5529	5587
Kent and Medway	**21216**	**21056**	**21491**

Source: Kent & Medway Public Health Observatory from Public Health Birth File

There were just under 18,000 births in Kent in 2012.



The general fertility rate is a rate of the number of births per 1,000 women aged between 15 and 44.

Analysis of trends in GFR over the last 6 years for which data is available shows no distinguishable trend in Kent as a whole and rates in most CCGs have fluctuated over this period. Only Dartford, Gravesham and Swanley and West Kent CCGs have seen a consistent upward trend in their GFRs over the last 6 years.

- Strategy

The following local strategies also influence the context in which this review has been conducted:

- *Every Day Matters: Kent's Multiagency Strategic Plan for Children and Young People 2013-2016* (28)

This plan provides the overarching vision for Kent's children and young people and is intended to inform the strategic direction of all organisations involved in the delivery of services for children in Kent over a 4 year period. The overarching vision is that every child and young person in Kent achieves their full potential in life, whatever their background. A core outcome for integrated children's services is to promote the health and wellbeing of all children and young people. The provision of early help, prevention and intervention is identified as one of the 5 priorities required to deliver the strategic outcomes. This will be achieved by:

- Enhancing the responsiveness and inclusivity of universal services that give families the right help early enough to resolve difficulties and reduce the need for further intervention.
- Improving the ability to be proactive in identifying the needs of children and young people and delivering timely intervention which requires responses from a number of agencies when children become vulnerable.
- Providing support in early years so that children have the best possible start in life, pre-empting future issues before they arise.

A number of recommendations are made for improvements in the provision of support during the antenatal and postnatal period, these include:

- Ensuring women, and their partners, have access to timely pre-pregnancy advice and support to enable early adoption of healthier lifestyle choices.
- Providing a free NHS Information Service to parents which include emails and texts providing NHS-approved advice.
- Delivering the Healthy Child Programme (0-5 years) which sees a lead role for the Health Visitor working across Children's Centres and General Practices in pregnancy to the first five years of life, offering every family a programme of screening, immunisations, developmental reviews, information and guidance to support parenting and healthy choices.
- Expansion of the Family Nurse Partnership programme ensuring intensive support, advice and information to first time young mothers with the aim of increasing family resilience by providing continuous care with the same Nurse during pregnancy up until the child is two years old.

Other Kent-wide strategies which also influence the context in which this review was undertaken include:

- Kent Early Intervention and Prevention Strategy 2012-2015
- Kent Child Poverty Strategy
- Kent Troubled Families Programme Business Case
- Mind the Gap: Building Bridges to Better Health for All – Kent's Health Inequalities Action Plan
- Live It Well
- Kent Hidden Harm Strategy

- *Kent Joint Health & Wellbeing Strategy; Outcomes for Kent 2014-2017* (29)

This draft strategy describes the desired outcomes for the health and wellbeing of the population of Kent over the next 3 years and the changes required to the health economy to achieve these outcomes.

One of the key aims is for every child in Kent to have the best start in life.

Recommendations for action to achieve this outcome are considered in terms of 4 priorities:

- Tackling health issues where Kent performs worse than the England average
- Tackling health inequalities
- Tackling gaps in provision
- Transforming services to improve outcomes, patient experience and value for money.

Recommendations for action in the antenatal and postnatal period to support every child to have the best start in life include:

- Reducing the number of pregnant women who smoke at time of delivery by strengthening midwifery and smoking cessation resources and provide a whole systems approach to engaging with and supporting pregnant smokers.
- Increasing breastfeeding Initiation rates & breastfeeding continuation at 6-8 weeks by promoting Unicef's Baby Friendly Accreditation and implementing the Infant Feeding Action Plan
- Continue to use the Common Assessment Framework (CAF) as the key tool for carrying out an early help assessment and planning the necessary actions to improve children's outcomes and support their additional needs.

- *CCG 5 Year Strategic Commissioning Plans*

The draft Kent Joint Health & Wellbeing Strategy recommends that constituent agencies in the health economy, including CCGs, develop a common vision and complementary strategies to support the achievement of the vision and outcomes identified in the Kent-wide strategy.
CCGs across Kent have recently produced their 5 Year Strategic Commissioning Plans for the period 2014-19. The content of each of these plans have been reviewed to identify whether they include aims and objectives which specifically relate to improvements in services and outcomes for pregnant women, mothers and infants. Only 4 of the 7 CCGs identified aims or objectives that specifically related to services or outcomes in the antenatal or postnatal period. Further details of each CCGs plan are provided below:

<u>Ashford & Canterbury Coastal CCGs</u>
The plans of these 2 CCGs are similar and echo the aim of the Kent JHWBS to give every child the best start in life & identifies improving services for children and young people as a core priority

The plans identify specific objectives related to the improving services for pregnant women, mothers and infants:

- To establish improved access and support in place for mothers in early stages of their pregnancy by 2015
- Demonstrable increases in breastfeeding initiation and continuation rates by 2016
- Improvements in ante natal and post natal maternity pathways by 2016

<u>Dartford Gravesham & Swanley CCG</u>
This plan doesn't include any specific strategic aims and objectives relating to services or outcomes for pregnant women, mothers and infants.

<u>South Kent Coast CCG</u>
This plan doesn't include any specific strategic aims and objectives relating to services or outcomes for pregnant women, mothers and infants. However the 2 year operating plan (2014-16) does include an objective to improve awareness of the early pregnancy pathway and services to reduce the level of mothers with concerns in early pregnancy presenting to A&E.

Swale CCG

Although the strategy includes the aim to transform the life chances for disadvantaged children this vision isn't distilled into any specific objectives that relate to pregnant women, mothers or infants.

Thanet CCG

Although none of the overarching strategic priorities focus specifically on improving services and outcomes for pregnant women, mothers and infants the strategy does highlight that services for children and young people are a priority area for improvement in order to deliver the strategic objectives.

The plan identifies a number of key outcomes which are required over the next 5 years to deliver improvements in services for children and young people, some of which relate specifically to the antenatal and postnatal period:

- Sufficient health visitors to provide enhanced care to children from birth to school age
- More preventative measures introduced from an early age leading to healthier children in Thanet
- Fully integrated children's services working seamlessly across boundaries to promote child health and well being

West Kent CCG

This plan doesn't include any specific strategic aims and objectives relating to services or outcomes for pregnant women, mothers and infants.

Although not every CCG has included pregnancy and the early years as a focus of their strategic plans, the prioritisation of pregnancy and the early years and the inclusion of aims relating to promoting the best start in life across the majority of these local strategies is in distinct contrast to the findings of the Audit Commission Report in 2010. (30) This found that across England the needs of children under 5 were rarely prioritised in Local Area Agreements. There has clearly been a step-change in the priority given to the needs of this age group both nationally and locally, largely driven by the national reports and strategies highlighted above.

- Reports

A number of local reports examining the provision and access to maternity services across Kent have also been published.

- *Maternity Matters Joint Strategic Healthcare Needs Assessment 2008 :Eastern and Coastal and West Kent Primary Care Trusts* (30)

In 2008 the Public Health Team produced an Epidemiological Needs Assessment for Maternity Services in East Kent 2008. The needs assessment was framed around the ambitions of the national Maternity Matters Strategy and examined services' capability to deliver the "Choice Guarantee" described in that document (see above for further information).

A number or recommendations were made for improvements to access to and delivery of maternity including:

Choice of how to access antenatal care

- In order to improve access women need to know that they can make an appointment with the midwife directly and that, if they are generally fit and well, there is no need to see the GP at this stage.
- Clarification is required on the current role and level of involvement of GPs in antenatal care in Kent and Medway and any financial or other incentives there are for this.

Type of antenatal care

- Further investigation into the provision of antenatal care is required on a maternity unit level comparing NICE guidelines and/or best practice with current provision.
- The proportion of women receiving each type of care should be measured regularly both as part of monitoring progress towards the Maternity Matters choice guarantees and for comparison with national provision.
- Providing maternity services in locations and times that are accessible to women and their partners will help to improve access and maintenance of contact with services.
- Engagement with maternity services will be improved if services are welcoming and user friendly for everyone, including fathers.
- PCTs should review the commissioning of antenatal classes with the intention of providing more classes in a variety of locations and at different times of the day to improve their accessibility.
- Vulnerable groups will need particular attention, if not individualised services, and may require some degree of outreach.

Postnatal care

- Mapping of the current provision of postnatal care would be advantageous in advance of planning any changes. Providing services in a wider variety of locations may improve the satisfaction of women using the service.
- There have been anecdotal reports of problems during the handover of care from midwife to health visitor. Co-locating midwives and health visitors is one possible way of rectifying this situation. This practice should be evaluated further and, if successful, considered for wider implementation.

Recommendations for vulnerable groups

- Women from vulnerable groups should be consulted to inform service design to ensure that services meet the needs of these populations and are provided in such a way as to reduce barriers to access and ongoing contact with services.
- Further work on the feasibility of midwives being incorporated into SureStart Centres in Kent is needed.

Teenage mothers

- Where they do not already exist, protocols for sharing information about teenage mothers within local services should be developed and implemented to ensure a coordinated package of support in line with multi-agency working to support teenage parents. The health and education services should work together on the issue of teenage pregnancy.

Women in Black or Minority Ethnic groups

- As BME groups are so diverse work will need to take place on a local level with these communities in order to gain a thorough understanding of what their needs are and how to provide relevant services locally.

- *Kent JSNA Maternity Chapter Update, 2011/12* (31)

This report provided updated statistics and analysis around some of the areas explored in the 2008 Health Needs Assessment. The needs assessment was framed around the ambitions set out in the National Maternity Matters Strategy

Recommendations were made for further investigation of elements of the maternal care pathway including:

- Analysis of where, when and how women first access maternity care
- Analysis of choice in where and how women receive antenatal care
- Review of numbers of antenatal contacts provided, including location (in comparison with NICE recommendations)
- Analysis of choice in where and how women receive postnatal care
- Analysis of health interventions for vulnerable groups, including teenage mothers, women in black or minority ethnic groups, and women in deprived areas
- Examination of expansion of maternity services to children's centres

The report also highlighted the need for further specific needs assessments including perinatal mental health. The report is available online from:
www.kmpho.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=236043

Local maternity services or the systems and services with interdependencies with maternity have been subject to a number of recent independent inspections:

- OFSTED inspection of Maidstone Town Childrens Centre Group, 2014 (32)

In June 2014 OFSTED undertook and inspection of Maidstone Town Children's Centre Group.

They observed that midwives do not deliver any antenatal services from the centres limiting the opportunities for prospective mothers to be introduced to Children's Centres prior to giving birth.

They recommended that strategic partnerships should be developed to enable antenatal services to be delivered directly from the centres and to engage a higher number of prospective parents into Children's Centre Services.

This issue is explored further within this report.

- Care Quality Commission Inspections

The Care Quality Commission is the regulator for all care providers in England and monitors providers' compliance with its standards on an ongoing basis.

- CQC Review of Health Services for Children Looked After and Safeguarding in Kent, 2014 (33)

In April 2014 the CQC undertook a review of health services for Children Looked After and Safeguarding in North and West Kent.

Key Findings:
The inspectors made the following observations which relate specifically to maternity services:

- There were robust systems in place across midwifery services in Kent for staff to take comprehensive family histories from pregnant women.
- Midwives are routinely contacting GPs when women self-refer to alert them of the pregnancy and request relevant information. This could be further strengthened by explicitly asking the GP to include any concerns they may have regarding parenting capacity.
- Midwives across the area report variable communication from GPs although there were good examples of good communication and liaison in the cases that were reviewed. Home visits by midwives have recently been introduced in the West Kent area for women for whom risk are identified however this is not yet embedded into routine practice.

- Information sharing between midwifery services and other health and social care professionals, particularly at initial stages of pregnancy and booking, is good although arrangements for this varied across the services visited. Multi-agency maternity liaison meetings have been initiated in Swale but these do not happen in other areas.
- Midwives and health visitors undertake joint visits where appropriate which supports continuity of care.
- There are specialist midwifery roles and clinics for vulnerable women including those with mental health and substance misuse problems and inspectors saw examples of very good care and practice for vulnerable women who were pregnant.
- There is an effective and highly valued mother and infants service (MIMHS) provided by the adult mental health trust. The only exception to this being Dartford and Gravesham NHS Trust where mental health provision is only provided via existing maternity services resources.
- Where a mother has a mental health problem, practitioners reported that the MIMHS service routinely attend child protection conferences.
- There were some concerns about the availability of support for teenage pregnant women. The family nurse partnership programme is targeted at specific areas with high rates of teenage pregnancy which creates some inequity of access.
- Pregnant women seen at Darent Valley Hospital are routinely offered the chance to be seen alone at an early stage in their pregnancy. This enables midwives to make enquiries about sensitive issues such as domestic violence that the mother may otherwise feel unable to disclose. These arrangements are not routine practice across all areas.
- Midwives prioritise attendance at pre-birth meetings and child protection conferences and attendance rates are high.
- Midwives can refer vulnerable women who are pregnant to children's social care at an early stage. However midwives experience variation in the timeliness of response and there is no written agreement or policy around pre-birth planning and the quality of pre-birth planning observed was extremely variable.
- There were some examples were poor recording undermined child protection practice for example, in updating child protection plans once a baby has been born.
- Arrangements for assessments of parenting capacity are unclear and there are challenges created by a lack of local mother and baby facilities which undermines optimal care planning and treatment.
- A recent change in policy at Darent Valley Hospital that allows fathers to stay on the maternity ward without time restriction is felt to be helpful in allowing parental interaction to be observed by staff.

The inspectors made the following recommendations:

- Maidstone & Tunbridge Wells NHS Trust should ensure that documentation used by midwives to collate information to inform assessments includes requests for information about parenting capacity.

NHS West Kent, Swale and Dartford, Gravesham & Swanley CCGs in partnership with Kent & Medway NHS and Social Care Partnership Trust should ensure that:

- There is an agreed multi-agency perinatal mental health pathway that ensures that new and expectant mothers requiring support for mental health issues have prompt access to appropriate support at all levels of services.
- There are clear arrangements for multi-agency pre-birth planning with clear responsibilities for undertaking parental capacity assessments.
- An analysis is undertaken of the provision of and access to mother and baby facilities with a plan developed to meet any unmet needs.
- An analysis of unmet need identified through the Common Assessment Framework (CAF) is undertaken, with a plan developed to address any gaps in provision identified.

Maidstone Tunbridge Wells NHS Trust, Dartford & Gravesham NHS Trust, Medway NHS Foundation Trust and Kent Community Healthcare Trust should ensure that:

- Appropriate arrangements are in place for information sharing and care planning across midwifery and health visiting services and partner agencies to promote the health and wellbeing of children and families using services.
- Health practitioners have a clear understanding of the common assessment framework & have good access to e-CAF as required.
- Practitioner referrals to children's social care clearly articulate the risks to the child or young person.
- Robust quality assurance systems are in place to ensure that health practitioners are routinely making appropriate enquiries and taking action to ensure that people are safe relating to domestic violence, in line with national guidance.

Full details of the findings and recommendations can be found in the inspection programme report available from:
http://www.cqc.org.uk/content/child-safeguarding-and-looked-after-children-inspection-programme-0#PublishedReports

A number of these findings and recommendations are reflected in this report.

- East Kent Hospitals University NHS Foundation Trust: Quality Report, 2014 (34)

The report included the following comments on maternity services:

- 1 reported Never Event relating to maternity services between 1st Dec 2012 and 30th Nov 2013 involving a retained swab following a caesarean section.
- The midwife to mother ratio was 1 to 33 at the time of inspection, the national standard is 1 to 28. The trust froze midwife posts in 2013 and then chose not to address this when the number of births increased. This demonstrated a lack of awareness and recognition of the impact of this decision

Full details of the findings and recommendations, including individual ratings of Maternity & Family Planning Services at QEQM & William Harvey Hospitals, can be found in the inspection programme report. (34)

A CQC inspection of Maidstone & Tunbridge Wells NHS Trust is due in autumn 2014

This report will demonstrate how many of the issues identified in these national and local reports are reflected in Kent's Maternity Services and highlight areas of strength and identify where development is required.

- Findings
    - **Overview of current maternity service configuration incl. costs**
        - Maternity Care Costs

There are a number of ways of defining the different elements of maternity care but the following is one of the most commonly recognised systems:

- Antenatal Care – care of the mother and baby during pregnancy
- Intrapartum Care – care of the mother and baby during labour and delivery
- Postnatal Care – care of the mother and baby after birth

These elements were used to develop the new payment system for the provision of maternity care which was introduced in England in April 2013. This system involves payments for each of the 3 sections of the maternity care pathway; antenatal, intrapartum and postnatal care. The tariff for each module of the pathway is split into levels based on the intensity of care needed during this element of the pathway.

Commissioners pay the tariff for each module of pregnancy to their preferred provider. Where a woman receives elements of care from an alternative provider (due to choice or transfer of care) it is the responsibility of the preferred provider to pay the alternative provider. (35)

The following table provides estimations of the average number of births and costs for CCGs of various sizes: (11)

CCG Population	Est. births per year	Est. maternity spend	Est. births to women over 35	Est. perinatal mortality	Est. Number of C-Sections
100,000	1400	£3m	250-300	9	336
200,000	2800	£6m	550-600	18	672
300,000	4000	£9m	800-900	25	960
500,000	7000	£15.5m	1400-1500	44	1680
700,000	9800	£21.5m	1950-2000	62	2352

Information on the exact maternity spend per CCG in Kent is not currently available.

In the absence of this information it is possible to calculate an estimated expected spend by applying the estimates above to the size of the CCG resident population:

CCG	Resident Population*	Estimated Maternity Spend
NHS Ashford CCG	121723	£ 3,651,690.00
NHS Canterbury & Coastal CCG	202389	£ 6,071,670.00
NHS Dartford, Gravesham & Swanley CCG	251877	£ 7,556,310.00
NHS South Kent Coast CCG	203618	£ 6,108,540.00
NHS Swale CCG	109641	£ 3,289,230.00
NHS Thanet CCG	136766	£ 4,102,980.00
NHS West Kent	467498	£ 14,492,438.00

*Source: ONS, mid-year estimates 2013

The estimates were calculated by calculating the cost per member of the population (using the estimated figure closest to the total population size) and multiplying by the size of the population.
i.e. Ashford = (£3million / 100,000) x 121723 = £3.651,690

NB These are crude estimates based on total population which doesn't take into account variations in the size of the female population of child bearing age. These estimates should therefore be interpreted with caution.

- Maternity Care Commissioning & Provision

Maternity Services in Kent are commissioned by the 7 CCGs in Kent:

- Ashford CCG
- Canterbury & Coastal CCG
- Dartford & Gravesham CCG
- South Kent Coast CCG
- Swale CCG
- Thanet CCG
- West Kent CCG

These CCGs are responsible for commissioning acute and community health services for children aged 0-5 years including maternity and mental health services for parents and children
This excludes:

- The universal elements of Healthy Child Programme 0-5 years, currently commissioned by NHS England which will transfer to Local Authorities in October 2015.
- National screening and immunisation programmes and specialised care, which will continue to be commissioned by NHS England.

Maternity services in Kent are provided by 3 NHS Trusts:

- Dartford & Gravesham NHS Trust
- East Kent Hospitals University Foundation Trust
- Maidstone and Tunbridge Wells NHS Trust

All services operate a self-referral system although the extent to which this is utilised varies with many women choosing to access midwifery services via their GP surgeries.

<u>Services provided by Dartford & Gravesham NHS Trust include:</u>

- A Consultant led Delivery Suite and Midwife led Birthing Centre are both located on the Darent Valley Hospital Campus. There is also an Early Pregnancy Assessment Unit, Obstetric Theatres and a newly expanded Neonatal & Foetal Assessment Unit providing a total of 18 cots on this site.
- Antenatal Clinics are held in GP Surgeries and Children's Centres and Darent Valley Hospital.
- The current midwife : live birth ratio is 1 midwife to 34 live births
- The Midwifery Team currently has specialist midwives for the following areas:
    - Screening –Band 6 midwife, 26.5 hrs per week protected time for role
    - Parent Education –Band 7 midwife, 37.5 hours per week protected time for role
    - Infant Feeding –Band 7 midwife, 30 hours per week protected time for role
    - Diabetes / HIV / Drugs –Band 7 midwife, 37.5 hours per week protected time for role
    - Safeguarding –Band 7 midwife, 37.5 hours protected time for role

Services provided by East Kent Hospitals University NHS Foundation Trust include:

A Consultant led Delivery Suite and Midwife led Birthing Centre are available at both Queen Elizabeth the Queen Mother Hospital in Margate (QEQM) and William Harvey Hospital in Ashford. Both hospitals also provide an Early Pregnancy Assessment Service as does the Kent and Canterbury Hospital. QEQM Hospital also has a Special Baby Care Unit with 14 cots whilst William Harvey Hospital has a Neonatal Intensive Care Unit with 25 cots.

Most Antenatal Booking In appointments are done at the woman's home but Antenatal Clinics are also held in a Children's Centres and a range of clinical settings across East Kent.

- The current midwife:live birth ratio is 1 midwife : 28.9 births (an improvement from the ratio of 1:33 reported by the CQC in their inspection report earlier this year (see section on "Strategic Context" for further details).
- The Midwifery Team currently has specialist midwives for the following areas:
    - Teenage Pregnancy – 12 midwives (1 Band 7, 11 x Band 6). These midwives do not have protected time for their role but provide care to teenage mothers as part of their standard caseload.
    - Infant Feeding – 1 Full-time Infant Feeding Co-Ordinator (Band 7). This is a dedicated post and the midwife has no other duties.
        - There are also 3 Lactation Consultants (all Band 6 midwives). 1 has 1 day per week protected time for this role however the other 2 have no protected time.
    - Mental Health – 4 Mental Health Lead Midwives (all Band 6) each with 8 hours per year protected time
    - Disability – 2 midwives (1 Band7, 1 Band 8) neither have any protected time for this role
    - Domestic Violence – 2 named midwives (Band 6) but neither are currently active in this role.
    - Child Safeguarding – 6 midwives (4 x Band 6, 2 x Band 7)
        - 2 at William Harvey Hospital with 1 day protected time per month shared between them
        - 2 at QEQM Hospital with 1 day protected time shared between them
        - 1 at Kent and Canterbury Hospital with 1 day per month protected time
        - 1 at Buckland Hospital Dover with 1 day per month protected time
        - All 6 midwives also have 1 day per year to attend an annual update.
        - The Trust also have a named nurse/midwife for Child Protection (1 x Band 8 full-time).

Services provided by Maidstone and Tunbridge Wells NHS Trust include:

- A Consultant-led service at the Tunbridge Wells Hospital at Pembury, which provides a delivery suite and surgical facilities. The hospital also has an Early Pregnancy Assessment Unit & Neonatal Unit with a total of 18 cots offering Intensive Care, High Dependency and Special Care for preterm and sick newborn babies
- A midwifery-led Birth Centre at Maidstone Hospital
- Antenatal Services are offered by Community Midwives across a range of community settings including Children's Centres, GP Surgeries and Sevenoaks Hospital
- The current midwife : live birth ratio is 1 : 30.7 (or 1:27.7 using the Birth Rate Plus Tool which includes 10% of support staff who have training to undertake additional roles)
- The Midwifery Team currently has specialist midwives for the following areas:
    - Healthy Weight – 2 midwives each with 2.5hrs protected time per week
    - Teenage Pregnancy – 2 midwives (incl. 1 current vacancy)with a shared total of 45hrs protected time per week
    - Infant Feeding – 1 midwife with 37.5 hrs protected time per week

- Safeguarding – 1 midwife but no protected time to fulfil the role
- Diabetes – 2 midwives with a total of 11.25 hrs protected time per week
- Multiple births – 1 midwife with 8 hrs protected time per week

There is clearly distinct variation across Kent in the type of specialist midwives and the amount of protected time they have to fulfil their roles. Whilst some of this variation may due to the skill mix in each team it could potentially lead to inequalities in the availability of specialist midwifery support for some of the most vulnerable mothers.

Recommendations:

- The Kent Public Health Team should work in collaboration with KMCS and Maternity Service to undertake a Health Equity Audit of provision and access to specialist midwifery services such as mental health, domestic violence and healthy weight. This should be undertaken as part of a comprehensive epidemiological Maternity Health Needs Assessment for Kent which also incorporates the findings of this Service Review. The findings of this Maternity Health Needs Assessment should inform the development of a Kent-wide Maternity Strategy and Maternity Service Specification.

There is currently no Kent-wide Maternity Service Specification. As a result there is also a lack of ownership of or a robust system for performance and quality monitoring process for Kent maternity services.

The Kent & Medway Commissioning Support Service are investigating the Service Specifications currently in use and will be leading the development of a Kent-wide Service Specification in collaboration with the Kent Public Health Team. This will be underpinned by the development of a Maternity Services Performance Dashboard.

Recommendations:

- The new Kent-wide Maternity Service Specification should include comprehensive and universal delivery of the full -9months to 1week element of the HCP and reflect all relevant NICE Guidelines for maternity care. A robust process of performance monitoring and challenge should be agreed to ensure adherence to the specification and encourage continuous service improvement.

- Kent Public Health and the Maternity, Children and Young Peoples Team in KMCS should work together to establish a Kent-wide and CCG specific Maternity Services Information Dashboard. This should incorporate both clinical and public health activity and outcomes data, making use of data available from the new national maternity services dataset which is due to become available in late 2014/ early 2015. The local dashboard should also align with the South East Regional Maternity Dashboard currently being developed by the South East Coast Maternity, Children and Young Peoples Clinical Network.

<u>Other Maternity Services accessed by Kent residents</u>

A significant number of Kent residents (particularly from Swale and areas north of Maidstone) also access the maternity, paediatric and gynaecology services provided by Medway NHS Foundation Trust at Medway Hospital. This Trust was not formally included in this review.

The Trust, in collaboration with Medway CCG, has recently completed their own review of maternity services provision in response to the findings of recent CQC Inspections. It was therefore agreed in collaboration with the Public Health Team in Medway that a further formal review wasn't necessary at this stage.

The aim of Medway's review was to assess whether the service specification was fit for purpose, to assess the Trust's compliance with the service specification and to review the progress in implementing the Recovery Action Plan put in place following the CQC inspection of the Trust in August 2013.

A review of the key findings & recommendations from the report that have relevance to the delivery of public health aspects of maternal care are summarised in the section "*Mapping delivery of the Healthy Child Programme in Maternity Services"*.

o Other Services involved in the Maternal Care Pathway

As highlighted in the introduction, maternity services do not deliver the antenatal and postnatal elements of the Healthy Child Programme in isolation. This section of the report describes some of the other services that contribute to the maternal care pathway. The interfaces and interdependencies between other services on the antenatal and postnatal care pathway are explored later in this section.

- Kent & Medway Health Visiting & Family Nurse Partnership Services

Both services are provided by Kent Community Health NHS Trust

Health Visiting

Health Visitors (HVs) are the Lead Professionals for delivering the 0-5 element of the Healthy Child Programme in collaboration with a range of partners including midwives.

Health Visitors are based in a range of settings including; GP Surgeries, Health Centres, Children's Centres & Community Hospitals and also make home visits. There is a named Health Visitor for each GP surgery and Children's Centre even if the service is not based in these localities.

Until recently in Kent, Health Visitors were not involved in the provision of the antenatal elements of the Healthy Child programme however the new investment for Health Visitor Service Transformation has enabled KCHT to expand the service offer to include antenatal contact for all first time parents and known vulnerable families. Health Visitors meet families between 28-34weeks of pregnancy to conduct a Family Health Needs Assessment.

The Antenatal HV appointment is currently available to approximately 60% of the Kent population with a target to achieve full coverage by March 2015.

The delivery of this service depends on accurate and timely notification of pregnant women from midwifery to local Health Visiting Teams. Although routine systems for the sharing of antenatal booking information between midwives and Health Visitors are in place in all 3 maternity service providers these systems are not currently uniform or 100% reliable. This is also true for the sharing of the "Concerns & Vulnerability" forms which can alert HV to the potential need for additional or more intensive support. A recent audit of information sharing between EKHUFT Maternity Services and local Health Visiting Teams revealed significant gaps in these information sharing processes. See section on "*System mapping – Service interdependencies and professional interfaces*" for further details.

After the antenatal visit, Health Visitors will usually conduct their first postnatal visit between 11-14 days after birth (although this can be up to 28 days postpartum).

HVs will liaise with midwives when arranging this appointment. They will also liaise with parents to offer a range of contact options (home visit or community venue). The service is currently investing in extending the availability of services to 8am-8pm Mon-Fri.

Further visits will be provided based on an assessment of the family's needs but will include a minimum of a further contact at 3-4 months (to include an assessment of perinatal mental health and a babycheck) and at 10-12 months to undertake a child development assessment and repeat the family health needs assessment.

The Health Visitor Service has also recently recruited 12 district Perinatal Mental Health Senior Health Visitors. Their role is to; increase the skills and capacity of the HV workforce to identify and support mental health needs,

provide support to HVs with women with MH needs on their caseload and provide a programme of intensive visits to mothers with MH needs where appropriate. The service is currently establishing links with MIMHS.

The Kent Health Visiting Service has also developed a nationally award winning initiative to support parents to improve parent/infant interaction and promote child development. The "Born to Move, Active Learner" programme is a joint HV and Children's Centre initiative. There are 2 HV Active Learner Champions in each district working with Children's Centres to promote and implement the programme.

Family Nurse Partnership

The Family Nurse Partnership is nationally funded, voluntary home visiting programme for first time young parents aged 19 or under. A Specially Trained Family Nurse will provide continuous care to parents via an intensive home visiting programme from early pregnancy until the child is age 2. International evidence has demonstrated that the programme can cost-effectively improve health, social and educational outcomes in the short, medium and long term.

The Family Nurse Partnership was introduced in Kent in 2011. Implementation areas were identified based on birth rates, levels of deprivation and the current number of eligible parents.

Two programmes were initially established in Swale and Thanet. The programme was expanded to Maidstone and Tonbridge & Malling in 2012 and further development is currently underway to deliver programmes in Dartford & Gravesham, Dover and Shepway.

FNP Current service capacity:

- Thanet - 2 x Full Time Equivalent (FTE) FNP Nurses with a total capacity for 50 families
- Swale - 2 x FTE FNP Nurses with a total capacity for 50 families

These services are fully established and are currently near full capacity with nurses engaged with 47 families in each locality (in July 2014). 1 family have graduated the programme so far at their child's 2nd birthday it is estimated that a further 30 families will graduate by the end of the year providing capacity to recruit new parents onto the programme in these areas.

- Maidstone - 2 x FTE FNP Nurses with a total capacity for 50 families
- Tonbridge and Malling - 2 x FTE FNP Nurses with a total capacity for 50 families

There a number of staff vacancies within these services and as such they aren't currently running at full capacity. In July 2014 there were a total of 53 families engaged in the programme across Maidstone & Tonbridge and Malling.

- Dartford & Gravesham – 1 x FTE FNP Nurse with a total capacity for 25 families
- Shepway – 1 x FTE FNP Nurse with a total capacity for 25 families
- Dover – 1 x FTE FNP Nurse with a total capacity for 25 families

These services are currently being established and should be operational in early 2015.

Liaison between FNP Nurses and midwives is variable across Kent with some areas and the FNP service does not always receive notification of eligible parents within the window during which parents are able to join the programme (between 16-28 weeks of pregnancy). The FNP Service is looking at opportunities to establish an automatic notification system of all women who meet the criteria to improve access to services.

FNP Nurses have face to face contact with midwives as they will often attend antenatal appointments with the young parents. They may also meet with midwives to discuss cases however this can vary between local maternity teams with good links established in Thanet and Swale but less formalised communication in the Maidstone and Tonbridge & Malling areas.

- Kent and Medway Mother and Infant Mental Health Service (MIMHS)

The MIMHS service is provided by Kent & Medway Partnership Trust.
The service provides a range of specialist interventions and treatment packages to mothers with mental health problems, which includes:

- Specialist assessment and treatment.
- Community home treatment.
- Direct liaison, advice and consultation with GPs when requested.
- Obstetric liaison.
- Consultation and advisory service to other professionals including primary care, secondary care and external organizations, e.g. Social Services.
- Provision of case discussion for individuals and groups of professionals from primary care, working with women who experience mental illness during the perinatal period.
- Training and education.

The provision of inpatient Mother & Baby Units is now commissioned centrally by NHS England. The closest units are in Eastbourne and Beckenham.

Kent MIMHS is trying to engage neighbouring trusts in exploring the viability of providing a Mother and Baby Unit for the Kent, Surrey & Sussex areas.

The Kent MIMHS service is open to women over the age of 18 who are either pregnant or have a baby up to 1 year old who. The service will also consider working indirectly with mothers under the age of 18 who are receiving Tier 3 CAMHS input.

The service does not accept direct referrals from primary care. Women must be referred into the Adult Mental Health Service who can then refer into MIMHS after an appropriate assessment. If a woman is already in receipt of secondary mental healthcare they can be referred directly into MIMHS.

There are currently significant disparities in service provision across Kent localities.

West Kent

- 1 x Consultant Psychiatrist providing 2.5 days of input
- 1 x Jr Dr providing 1 day of support
- 1 x Full-time Clinical Nurse Specialist

East Kent

- 1 x Consultant Psychiatrist providing 4 days of input
- 2 x Full-time Clinical Nurse Specialists

Medway

- 1 x Consultant Psychiatrist providing 2.5 days of input
- 1 x Full-time Clinical Nurse Specialist
- Medway NHS Foundation Trust also employs a Specialist Perinatal Mental Health Midwife.

Dartford / Gravesham / Swanley

There is no Consultant Psychiatrist support available in the DGS locality so MIMHS are currently unable to accept any referrals from secondary care mental health patients in this area. Pregnant women and mothers with significant mental health issues currently have no access to a specialist service and are managed within Community Mental Health Teams.

There is 1 Clinical Nurse Specialist who can provide the following for women in the DGS locality:

- Maternity services liaison
- A limited caseload of primary care patients with mental health problems
- Consultation and advisory service to GPs and Health Visitors

Unfortunately the Clinical Nurse Specialist post has been vacant since April 2014, further limiting the availability of the service to pregnant women and mothers living in Dartford, Gravesham and Swanley. A new nurse is starting in Sept 2014.

A recent CQC inspection of Kent & Medway Safeguarding recommended that: (33)

"NHS West Kent, Swale, and Dartford, Gravesham and Swanley CCGs and Kent & Medway Partnership NHS and Social Care Partnership Trust should agree a multi-agency perinatal mental health pathway that ensures that new and expectant mothers requiring support for mental health issues have prompt access to appropriate support at all levels of services."

There has been significant national focus on the provision of perinatal mental health services over the last few years with a number of high profile reports highlighting inadequacies in provision and making the case for the further investment in and development of services. It is worth noting the findings and recommendations of these reports:

The CMO Report in 2012 called for maternal mental health to be given equal prominence to maternal physical health and advocated for the full implementation of guidance relating to the identification and treatment of pregnant women and new mothers with mental health issues. (3)

The Conception to Age Two report highlighted the potential benefits of effective perinatal mental health services which include: (2)

- Improving the mother-baby relationship and bonding with the aim of creating a securely and attached baby by 12 months and preventing the baby becoming a child at risk of emotional disturbance.
- Reducing the risk of relapse or recurrence of a psychological disorder in the mother or father.
- Reducing the risk of self-harm, suicide or infanticide.
- Reducing inappropriate referrals or readmissions to adult psychiatric wards, reducing the length of inpatient stays and offering an alternative to admission.
- Preventing avoidable separation of mother and baby and supporting early return if separated.
- Facilitating admission to specialist Mother and Baby Psychiatric Units when indicated

Both the National Childbirth Trust and Maternal Mental Health Alliance have published a series of briefings and statistical analyses highlighting inequalities in access to perinatal mental health:

- *FOI Report on Access to Perinatal Mental Health across England, National Childbirth Trust 2014* available from:
http://www.nct.org.uk/press-release/new-foi-data-finds-huge-gaps-provision-care-perinatal-mental-health

- *Maternal Mental Health – Everyone's Business Campaign 2014, Maternal Mental Health Alliance*

This campaign aims to highlight issues relating to the experiences of women with perinatal mental health problems and make the case for action to address inequalities in the provision of perinatal mental health services. In their Call to Action, published in July 2014, the Maternity Mental Health Alliance (MMHA) set out 3 priorities for action:

- Accountability for perinatal mental health care should be clearly set at a national level and complied with.
- Community specialist perinatal mental health teams meeting national quality standards should be available for women in every area of the UK.
- Training in perinatal mental health care should be delivered to all professionals involved in the care of women during pregnancy and the first year after birth.

Further information is available here:
http://everyonesbusiness.org.uk/wp-content/uploads/2014/07/Call-to-ACT.pdf

- *The Costs of Perinatal Mental Health Problems, 2014* (36)

This report was published as part of the Everyone's Business campaign and highlights the discrepancy between the total economic & social costs of perinatal mental health and the costs of implementing improvements to perinatal mental health services to provide services which meet current national guidelines.

Perinatal mental health problems are estimated to carry a total economic and social cost to UK society of about £8.1 billion per each one-year cohort of births. In contrast the NHS would need to spend just £337million per year to bring perinatal mental health care up to the level recommended in national guidance.

A copy of the report is available here:
http://www.lse.ac.uk/newsAndMedia/news/archives/2014/10/MaternalHealthCosts.aspx

- *Specialist Mental Health Midwives - What they do and why they matter, 2013* (37)

This report calls for every maternity service to have a Specialist Mental Health Midwife with responsibility for championing the needs of vulnerable women and their families, increasing the capacity of maternity services to deal with mental health problems and ensuring there are suitable pathways of care in each local area.

The report sets out the case for why Specialist Mental Health Midwives are required and what their function should be. It is intended to provide a resource for maternity service commissioners and providers to introduce or strengthen the Specialist Mental Health Midwife

The report is available here:
http://www.baspcan.org.uk/files/MMHA%20SMHMs%20Report.pdf

The MMHA have also published maps of perinatal and mother and baby inpatient service coverage across England. These are available from:
http://everyonesbusiness.org.uk/wp-content/uploads/2014/07/FINAL-Maps.pdf

- *NSPCC All babies count: spotlight on perinatal mental health, 2013* (38)

This report highlighted the fundamental role that universal services, such as Midwives, HVs and GPs, have in identifying mothers who are at risk of or suffering from perinatal mental illness at the earliest opportunity and ensuring they get the support they require.
The report highlights the significant gaps in perinatal mental health provision across the country and highlighted the key actions that decision makers must take to address these gaps:

- A significant change is needed in universal services so that health professionals are confident in detecting, discussing and dealing with mental illnesses.
- Specialist midwives can act as champions for women with mental illness in their area; provide women with specialist support; help to develop local care pathways, and provide training and advice for other maternity staff.
- There should be strategic commissioning of perinatal mental health care pathways in every area, based on accurate data or evidence-based calculations on levels of need.
- A range of services should be available to ensure women are able to access appropriate support at the earliest opportunity.
- Women with perinatal mental illness should be able to promptly access psychological support, including both individual and group therapeutic services. Pregnant women and those with a baby should be a priority for psychological therapy (IAPT) services.
- Every area should have a specialist community perinatal mental health team with expertise in this area.
- Women with severe perinatal mental illness must have access to a specialist Mother and Baby Unit in order t access the intensive care they need without being separated from their babies.

The report is available here:

http://www.nspcc.org.uk/globalassets/documents/research-reports/all-babies-count-spotlight-perinatal-mental-health.pdf

- *A good start in life Improving perinatal and maternal mental health provision, 2014* (39)

This briefing provides a concise yet comprehensive summary of the issues relating to perinatal mental health in England. It highlights the prevalence of maternal mental health problems, the services that are needed and the contribution mental health organisations can make to improve perinatal provision in England.

The recommendations echo those made previously in the NSPCC report.

The report is available from:
http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/A_good_start_in_life_June2014.pdf

In 2012 the Department of Health published the National Maternal Mental Health Pathway. (40) The guidance provides a structured approach on common issues associated with maternal mental health and wellbeing, from pregnancy through the early months after the birth.

It sets out a timeline for collaborative work by Midwifery and Health Visiting Services to identify and provide support to mothers experiencing mental health problems in partnership with other colleagues including GPs, mental health services and the 3rd sector.

The pathway is available here:

https://www.gov.uk/government/news/maternal-mental-health-pathway-aims-to-provide-a-structured-approach

Recommendation:

- The evidence from this review supports the recent CQC recommendation regarding the development of a multi-agency perinatal mental health pathway. This should be undertaken on a Kent-wide basis to include all commissioners and providers of perinatal mental health services at all tiers. The pathway should be developed with reference to the national Maternal Mental Health Pathway (40)
  The pathway should enable equitable access to perinatal mental health support at all levels of need for pregnant women across Kent. The pathway should incorporate the new role of District Health Visitor Perinatal Mental Health Leads & explore their capacity to provide training and support to midwives and other stakeholders on the pathway.

- **Mapping delivery of the Healthy Child Programme in Maternity Services**

PREGNANCY UP TO 28 WEEKS GESTATION: UNIVERSAL

Promotion of Health and Wellbeing

A full health and social care assessment of needs, risks and choices by 12 weeks of pregnancy by a midwife or maternity healthcare professional.

Outreach to disengaged groups, improving accessibility of services to encourage early booking and encourage continuous contact throughout pregnancy - Commissioning Maternity Services - A Resource Pack to support Clinical Commissioning Groups NHSE 2012

Promoting continuity of care especially for disadvantaged parents or those with special needs - Commissioning Maternity Services - A Resource Pack to support Clinical Commissioning Groups NHSE 2012

Incl. discussion of Mental Health History (past or present severe mental illness, previous treatment by a MH professional) family history of perinatal mental illness - NICE CG62 Antenatal Care

Ask 2 depression screening questions (during past month have you felt down, depressed or hopeless or having little interest or pleasure in doing things) - NICE CG62 Antenatal Care

Incl. measurement of BMI but don't continually weigh women through pregnancy - NICE CG62 Antenatal Care / PH27 Weight Management before, during & after pregnancy

Screening for risk of gestational diabetes and offer of test if appropriate - NICE CG63 Diabetes in pregnancy

Provide the opportunity for women to disclose domestic violence issues in a secure environment - NICE CG62 Antenatal Care

Provide the opportunity for women to have a 1to1 consultation without her partner, family member, or legal guardian present on at least 1 occasion - NICE CG110 Pregnancy & Complex Social Factors

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	The booking in questionnaire is structured around NICE Guidance for antenatal care. Questionaire includes all NICE Guidance as above + national standard for FGM. The Family Background Questionnaire includes information on the woman and her partner's: Current mental health, history of drugs and alcohol misuse, previous contact with social services, probation or YoT and domestic violence risk screening questions. Theformat of the Antenatal Care Pathway Record is reviewed and updated every 6 months. Those booking late (i.e. after 12wks+)are highlighted as a concern a log of late bookers is regularly reviewed for safeguarding issues. Anecdotal evidence regarding the reasons for late booking suggest they are generally women who already have 2 or more children, transient individuals (i.e. international migrants or those moving around healthcare service borders) or system avoiders i.e. people who may have had previous safeguarding issues.	Hospital Trust Performance Dashboards / Local analysis of the demographics of late bookers The national target for booking in rates at 12+6 days is 90%	According to local provider data booking rates are good - 93.7% booked by 12+6 weeks.	There has been no analysis of the socio- demographics of women who typically present late to maternity services	Work should be undertaken by eachProvider Trusts should to analyse the demographics of women who present late for booking to identify those groups most likely to present late. Kent & Medway Public Health Observatory may be able to assist with this analysis. Commissioners and Providers should collaborate to identify and implement evidence-based interventions tointerventions for these groups to encourage and facilitate early access and encourage continuous engagement withto maternity care and encourage women to maintain regular contact throughout pregnancy.
EKHUFT	Women can self refer for a midwife appointment but the majority of women in East Kent book via their GP surgery (NB doesn't necessarily involve contact with the GP). Most booking in appointments occur in the woman's home but are also offered at a variety of clinical locations. EKUHFT use the Perinatal Institute Booking In questionnaire in handheld booking notes. Data is currently transferred manually from written notes onto the hospital electronic record system however Community midwives are being issued with ipads to enable them to upload data directly onto the electonic system. The Booking Questionnaire includes questions about; the woman's mental health history & family history of severe mental illness and 3 depression screening questions, recording of the woman's height, weight and BMI (although this is not prominent in the records (p.21) and there is no information, within the notes, on criteria for onward referral or pathways. There is no clear section for recording the gestational diabetes risk assessment results although this information may be recorded in various places through the notes. Women in a high risk group for gestational diabetes will be offered a glucose tolerance test. All women are advised to have the flu & pertussis vaccinations. There is space on the Antenatal Summary (separate to Pregnancy Notes) to record if a woman is seen alone and if they were asked about DV and the outcome and a coded system is used within the handheld notes to record if a woman has been asked about DV. There is also a prompt to assess this at booking and repeat the assessment during pregnancy. Midwives report that it can be difficult to find an opportunity to speak to some women on their own but will try to engineer time with a woman on her own if there are concerns.		Local provider data indicates that 80.14% of women in Jul13-Jun14 booked before 12+6 weeks.		
MTW	Some community midwives are based in GP Practices but most either in separate bases or in children's centres. Women can self refer for a midwife appointment or book via their GP. The majority are referred via the GP practice but may not necessarily see the GP themselves. The services is exploring opportunities to set up web-based referral in the future. Midwives notify the GP a patient is pregnant, where she's booked to deliver and highlight any issues. This also provides the opportunity for the GP to share any relevant information from their patient history a question regarding the patients parenting capacity was recently introduced following a recommendation from CQC. The Booking Questionnaire includes questions about; height, weight and BMI, previous history of gestational diabetes, emotional or psychological history, alcohol or substance misuse issus, current alcohol intake, smoking behaviour(incl. a discussion on quitting intentions). Women are continually assessed for risk based on pre-existing or conditions which arise in pregnancy such as diabetes. Midwives are trained to be aware of signs of domestic violence and will seek opportunities to speak to the woman on her own about potential risks but this may not always be at the booking in appointment. The service is currently piloting the inclusion questions regarding the risk of domestic violence in the "Family Background Questionnaire" which is completed prior to the booking in appointment and is kept by the midwife not in the handheld notes.		Local provider data indicates that 82% of women are booked in by 12+6 weeks. The data is currently being reviewed to determine the influence of the level of out of area bookings that MTW currently receive. Once data reliability has been confirmed the Trust plan to develop an action plan to target groups of women who are frequent late bookers.		

PREGNANCY UP TO 28 WEEKS GESTATION: UNIVERSAL

Notification to the Early Years team of prospective parents requiring additional early intervention and prevention

Incl those with physical disabilities or learning disabilities - PHE/DoH/RCM/NHSE Guidelines

Record the number of women with any complex social factor such as; poverty, homelessness, substance misuse, recently arrived migrant, asylum seeker or refugee, difficulty speaking or understanding English, age <20, domestic abuse - NICE CG110 Pregnancy & Complex Social Factors

Midwives should be trained on multi-agency needs assessment such as CAF and national guidelines on information sharing - NICE CG110 Pregnancy & Complex Social Factors

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	The Antenatal Care Pathway Record includes a Health & Family Support Assessment which identifies social factors such as teenage pregnancy, housing, finance, childcare and also if the parents have language or literacy difficulties or learning difficulties. The Family Background Questionnaire also includes information on previous contact with Social Services, Probation or YoT. All midwives are CAF trained and able to undertake a CAF assessment which then informs early intervention proactive work. A Child Protection Specialist Midwife supports the CAF process and oversees the CP Referral System for social care. They have set up safeguarding hubs to facilitate interagency collaboration to discuss high risk / vulnerable women and families. Parents <19 are given access to all services available for older parents but there is a midwife with a special interest in teenage pregnancy who provides targeted education programme. Young Pregnant Women at high risk will be referred to a consultant . Women <16 are routinely referred into social care as part of the vulnerable women's pathway. FNP is already active in South London and Community midwives have links with the FNPs in South London Boroughs. A new FNP Programme for Dartford and Gravesham is planned which will have the capacity for 25 women <19 this is likely to be established early in 2015.	Local audit of information sharing processes and referral pathways	Unknown	The rate of pregnancies for those age <19 in contact with DVH is currently falling (2.1% of all pregnancies) This results in low demand for specialist services for teenage parents. The referral pathway to Childrens Services is in pace but generally referrals are not accepted until pregnancy is viable and beyond 30 weeks. A meeting was held with Childrens Services earlier in the year to discuss the pre-birth pathway - outcome unkbnown.	Maternity Care, Early Help and Children's Services providers should meet to review the referral pathway for mothers requiring additional early intervention requiring early help and support and prevention antenatally. The and to identify pathway should be analysed to identify the potential causes of existing delays in the acceptance of antenatal referrals to Children's Services and agree actions to address them.to develop an action plan to address these issues.
EKHUFT	A Social Assessment is completed at booking which includes information on employment status, housing, benefits, social support & difficulties in speaking or understanding English. A Concern & Vulnerability form can be completed to assess and share information on specific concerns. Copies of this form are shared with; Social Services, Health Visitors, GP. All midwives have received CAF training and can undertake CAF assessments but not all are familiar or confident with the process. The Trust has its own Child Safeguarding Team which can provide support . The team are currently identifying Midwife CAF Champions who could also provide guidance and support. Any midwife can make a referral to social services although thresholds have changed recently so not all referrals are successful. There is a Midwife Lead for Teenage Pregnancy in each locality team although some are shared across localities due to the low number of TP. The TP Lead Midwife may hold a caseload of TP and will link closely to sexual health outreach or YAPS team. The services is planning a development day for all TP Lead Midwives in Oct 2014.			Women have experienced delays in receiving social services support even when a referral has been accepted. This means the opportunity to provide early help is often missed and management plans are rushed into place late in pregnancy. Midwives also spend alot of time chasing up their social services referrals.	
MTW	The antenatal booking questionnaire includes information on support at home, accommodation and broader family issues including social worker involvement and relationship problems. A Concern & Vulnerability form can be completed to assess and share information on specific concerns. Copies of this form are shared with; HVs, GPs, KCHT Safeguarding Named Nurse, SCBU and the Consultant Obstetrician where appropriate. Midwives can initiate a CAF or refer to social services. Parents <19 are given access to all services available for older parents but MTW also has 2 Teenage Pregnancy specialist midwives (incl. 1 current vacancy). Specialist midwives will either provide continuous care for teenage mothers or will provide specialist support to midwives with teenage mothers on their caseload and also provide a targeted education programme for teenage parents. There are currently FNP programmes running in Tonbridge & Malling and Maidstone with the capacity to support 50 families each. A further programme in Shepway will be established in late 2014 / early 2015 with capacity to support 25 families.			Potential gap in capacity to provide specialist support to teenage mothers due to job vacancy. 1 FNP programme is running in Tonbridge & Malling but this is currently at capacity. Midwives report frequent delays in the acceptance of social services referrals. Women often don't get access to social services until very close to delivery date and miss out on opportunities for early help. Midwives feel they spend a lot of time chasing referrals for action. The flow of information between midwifery and social services is patchy sometimes it is fed back but often midwives need to chase.	

PREGNANCY UP TO 28 WEEKS GESTATION: UNIVERSAL

Routine antenatal care and screening for maternal infections, rubella susceptibility, blood disorders and fetal anomalies. Health and lifestyle advice to include diet, weight control, physical activity, smoking, stress in pregnancy, alcohol, drug intake, etc. See NICE guidance on antenatal care CG 6

Is MECC training available to enable all midwives to provide brief advice on key lifestyle issues - PHE/DoH/RCM/NHSE guidance

Are the referral pathways to specialist lifestyle change services clear? - PHE/DoH/RCM/NHSE guidance

Identification, signposting and appropriate specialist referral of those with LTC incl. diabetes, epilepsy, asthma, CVD, hypertension - PHE/DoH/RCM/NHSE guidance

Specific information should be provided on; the importance of a healthy diet, the Healthy Start Programme eligibility & access, folic acid supplementation (400micrograms daily pre-conception to 12 weeks) & eating foods rich in folate, avoiding vit A supplementation and liver, information on the benefits of vit D consumption during pregnancy & breastfeeding (10micrograms daily) and identification of potential risk groups, food hygiene, - NICE CG62 Antenatal Care / NICEPH11 Maternal & Child Nutrition

Healthcare staff should be aware of the higher incidence of anaemia in women with tiwn and triplet pregnancies & perform a full blood count at 20-24 weeks & 28 weeks to identify the need for early supplementation - NICE CG129 Multiple Pregnancy

Exercise - beginning or continuing moderate exercise is safe, start pelvic floor exercises. exercises to avoid; contact or high impact sports & scuba diving - NICE CG62 Antenatal Care

Alcohol Consumption - avoid alcohol in the first 3 months of pregnancy due to risk of miscarriage. If women choose to drink they should consume no more than 1-2 units once or twice a week - NICE CG62 Antenatal Care

Smoking - ascertain smoking status of woman and other household members ideally via CO testing, provide information on the risks to mother & unborn child and hazards of exposure to secondhand smoke and the benefits of quitting for both mother & partner at any stage of pregnancy. Address concerns regarding quitting and offer personalised information on how to quit and the stop smoking services available incl. a telephone number, refer all women with a CO reading of 7 ppm or above to stop smoking services & check at the next appointment if she attended her referral, if women have a CO reading of 10ppm but do not smoke consider the possibility of CO poisoning and advise them to call the HSE Gas Advice Line - NICE CG62 Antenatal Care / NICE PH26 Smoking in Pregnancy

Ensure midwives who deliver intensive stop smoking interventions are trained to the same standard as NHS Stop Smoking Advisers - NICE PH26 Quitting Smoking in Pregnancy

Ensure all maternity healthcare staff receive training in how to assess smoking status and readiness to quit and the health benefits of quitting and know about the treatments and support available - NICE PH26 Quitting Smoking in Pregancy

Drugs - the use of cannabis should be discouraged - NICE CG62 Antenatal Care

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Information leaflets on Blood Tests in Pregnancy and the NSC Antenatal & Newborn Screening Programme are provided antenatally along with leaflets on; Diet in Pregnancy, Bexley Smoking Cessation Services & Whooping Cough in Pregnancy. These leaflets are backed up by prompts to discuss alcohol and drug misuse, smoking, diet and nutrition incl. vitamin D and folic acid however there is no specific information or discussion regarding exercise in pregnancy. BMI, smoking status, alcohol consumption and drug use is included in the Pregnancy Risk Assessment. Although Community Midwives promote HealthyStart vitamins there is no direct mention of it in the Antenatal Care Pathway Record and the HealthyStart leaflet is not routinely provided. There has been a case of avoidable rickets so there has been a focussed campaign on promoting vitamin D particularly for midwives. An annual Public Health Mandatory Study Day for midwives is run by all specialist midwives and includes input from the smoking cessation team and other providers as appropriate to raise awareness of public health issues during and after pregnancy however midwives do not currently receive the "Making Every Contact Count" training.	Breastfeeding initiation rates / Smoking rates at time of booking and time of delivery / NHS Screening Programme KPIs	Breastfeeding Initiation by provider 2013/14 : **65.1%** Kent Ave 2012/13: **72.1%** Eng Ave 2012/13: **73.9%** Breastfeeding Continutation at 6-8wks Data 2013/14 - not currently available due to inadequate data coverage nationally. Breastfeeding Continuation at 6-8Wks Kent 2012/13: **40.1%** (England Ave **47.2)** Data on smoking rates at time of delivery (**SATOD**) by **CCG** Q1 Apr-Jun 2014/15: Ashford **10.1%** / Canterbury & Coastal **8.1%** / DGS **14.9%** / South Kent Coast **13.8%** / Swale **17.4%** / Thanet **18.8%** / West Kent 9.4%. England Ave **11.5%** Source Health & Social Care Information Centre. Sig. Above Eng Ave / Sig. Below Eng Ave. For Data on AN/NB Screening Coverage see the results of the interview with Kent & Medway Screening & Immunisations Lead	No prompt to discuss the Healthy Start Programme or routine distribution of the Healthy Start information leaflet. No routine provision of advice or information on exercise in pregnancy. No provision of "Making Every Contact Count" training	Wherever practicable the paper-based information that is provided to parents across Kent on issues such as lifestyle, breastfeeding and preparation for parenthood should be standardised.The 3 maternity servicesAll 3 maternity service providers should work together to review the contents of the leaflets currently and information provided antenatally and postnatally to identify the most appropriate sources of information. and standardise the lifestyle, breastfeeding and preparation for parenthood information and advice available to women across Kent. The Kent Public Health Team should collaborate with CCGs to review the commissioning, provision and uptake of "Making Every Contact Count" training for midwives and other health professionals on the maternity care pathway and create an action plan to ensure MECC training is available to all staff to increase their confidence in providing opportunistic brief interventions on lifestyle change. NB NHS England is due to publish a MECC Action Plan in March 2015 which will include a focus on implementing MECC in maternity services .
EKHUFT	There are prompts and space to record the results of all routine antenatal screening tests throughout the notes. There is a section in the notes to record the details of and outcomes from discussions on; tobacco use, drug and alcohol use. There is a section providing written information on healthy eating and drinking, weight control, smoking, drug use, exercise, hygiene, domestic violence and room for the midwife to record they have reviewed this information. The following leaflets are also routinely included in the handheld notes; Start4Life "Off to the best start" Healthy Start Programme. EKUHFT have fully implemented Stage 1 of the Babyclear Smoking Cessation Programme (CO testing and "opt out" referrall to smoking cessation) and all midwives have received appropriate training. Direct referrals to smoking cessation services have increased. Midwives receive update training on diet, alcohol and weight management as part of their annual core training programme however they do not currently have access to specific training on "Making Every Contact Count" to help them provide brief advice on lifestyle issues.		Breastfeeding Initiation by provider 2013/14 : **69.1%** Kent Ave 2012/13: **72.1%** Eng Ave 2012/13: **73.9%** See above for Kent Breastfeeding Continuation rates and CCG Smoking at Time of Delivery rates.	The range & detail of lifestyle advice provided varies depending on midwife knowledge and interest it can also be limited due to appointment time constraints particularly if there are multiple issues to discuss. No provision of "Making Every Contact Count" training.	

PREGNANCY UP TO 28 WEEKS GESTATION: UNIVERSAL

Routine antenatal care and screening for maternal infections, rubella susceptibility, blood disorders and fetal anomalies. Health and lifestyle advice to include diet, weight control, physical activity, smoking, stress in pregnancy, alcohol, drug intake, etc. See NICE guidance on antenatal care CG 6

Is MECC training available to enable all midwives to provide brief advice on key lifestyle issues - PHE/DoH/RCM/NHSE guidance

Are the referral pathways to specialist lifestyle change services clear? - PHE/DoH/RCM/NHSE guidance

Identification, signposting and appropriate specialist referral of those with LTC incl. diabetes, epilepsy, asthma, CVD, hypertension - PHE/DoH/RCM/NHSE guidance

Specific information should be provided on; the importance of a healthy diet, the Healthy Start Programme eligibility & access, folic acid supplementation (400micrograms daily pre-conception to 12 weeks) & eating foods rich in folate, avoiding vit A supplementation and liver, information on the benefits of vit D consumption during pregnancy & breastfeeding (10micrograms daily) and identification of potential risk groups, food hygiene, - NICE CG62 Antenatal Care / NICEPH11 Maternal & Child Nutrition

Healthcare staff should be aware of the higher incidence of anaemia in women with tiwn and triplet pregnancies & perform a full blood count at 20-24 weeks & 28 weeks to identify the need for early supplementation - NICE CG129 Multiple Pregnancy

Exercise - beginning or continuing moderate exercise is safe, start pelvic floor exercises. exercises to avoid; contact or high impact sports & scuba diving - NICE CG62 Antenatal Care

Alcohol Consumption - avoid alcohol in the first 3 months of pregnancy due to risk of miscarriage. If women choose to drink they should consume no more than 1-2 units once or twice a week - NICE CG62 Antenatal Care

Smoking - ascertain smoking status of woman and other household members ideally via CO testing, provide information on the risks to mother & unborn child and hazards of exposure to secondhand smoke and the benefits of quitting for both mother & partner at any stage of pregnancy. Address concerns regarding quitting and offer personalised information on how to quit and the stop smoking services available incl. a telephone number, refer all women with a CO reading of 7 ppm or above to stop smoking services & check at the next appointment if she attended her referral, if women have a CO reading of 10ppm but do not smoke consider the possibility of CO poisoning and advise them to call the HSE Gas Advice Line - NICE CG62 Antenatal Care / NICE PH26 Smoking in Pregnancy

Ensure midwives who deliver intensive stop smoking interventions are trained to the same standard as NHS Stop Smoking Advisers - NICE PH26 Quitting Smoking in Pregnancy

Ensure all maternity healthcare staff receive training in how to assess smoking status and readiness to quit and the health benefits of quitting and know about the treatments and support available - NICE PH26 Quitting Smoking in Pregancy

Drugs - the use of cannabis should be discouraged - NICE CG62 Antenatal Care

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
MTW	There is space to record the results of all routine antenatal screening tests within the notes. There is a small section in the notes to note that the following issues have been discussed: tobacco use, diet, alcohol, food hygiene, folic acid & vitamin D but no space to record the outcome of discussions or recommendations for onward referall. There is also no prompt to revisit these lifestyle issues later in pregnancy. Height, weight and BMI are recorded at booking with a separate section to record the care plan for women with a BMI >30. No specific information or advice is included in the notes but the following leaflets are routinely provided within the antenatal information pack; Introduction to the Midwifery Team (includes links to the pregnancyandchildbirthguide.com an online resource created by local midwives), a copy of the NHS Direct Page on Health in Pregnancy which includes information on exercise, smoking, alcohol, drug use and px and OTC medication, diet, food hygiene and vitamins and supplements, Start4LIfe, Newborn & Antenatal Screening, A-Z of Pregnancy & Nutrition, Domestic Abuse Volunteer Support Services, leaflet is routinely provided. Telephone numbers and website addresses for the MTW maternity website, NHS Choices Pregnancy and Baby Guide and NHS Information Service for parents are provided on the back of the antenatal notes. The telephone number for the national smoking helpline is also provided on the back of the notes and MTW have partially implemented Stage 1 of the Babyclear Smoking Cessation Programme (CO testing and "opt out" referrall to smoking cessation) as not all midwives have received appropriate training. Midwives do not currently receive the "Making Every Contact Count" training although they are aware of the opportunity to use all antenatal appointments to discuss lifestyle choices.	Breastfeeding initiation rates / Smoking rates at time of booking and time of delivery / NHS Screening Programme KPIs	Breastfeeding Initiation by provider 2013/14 : **81.81%** Kent Ave 2012/13: **72.1%** Eng Ave 2012/13: **73.9%** See above for Kent Breastfeeding Continuation rates and CCG Smoking at Time of Delivery rates.	Lack of prompts to record outcome of discussions regarding lifestyle issues and need for onward referall. Midwives do not receive "Making Every Contact Count" training. Limited amount of written information provided in the antenatal notes although information leaflets and links to many online resources are provided. Lapse in healthyweight clinics in the Maidstone side locality due to sporadic demand. Specialist midwives have limited time to provide clinics.	Wherever practicable the paper-based information that is provided to parents across Kent on issues such as lifestyle, breastfeeding and preparation for parenthood should be standardised.The 3 maternity servicesAll 3 maternity service providers should work together to review the contents of the leaflets currently and information provided antenatally and postnatally to identify the most appropriate sources of information. and standardise the lifestyle, breastfeeding and preparation for parenthood information and advice available to women across Kent. The Kent Public Health Team should collaborate with CCGs to review the commissioning, provision and uptake of "Making Every Contact Count" training for midwives and other health professionals on the maternity care pathway and create an action plan to ensure MECC training is available to all staff to increase their confidence in providing opportunistic brief interventions on lifestyle change. NB NHS England is due to publish a MECC Action Plan in March 2015 which will include a focus on implementing MECC in maternity services .

PREGNANCY UP TO 28 WEEKS GESTATION: UNIVERSAL

Distribution of The Pregnancy Book to first-time parents; access to written/online information about, and preparation for, childbirth and parenting; distribution of antenatal screening leaflet.

Promotion of active birth techniques - PHE/DoH/RCM/NHSE Guidance

Is information provided in a format accessible to women with additional needs ie physical, sensory or learning disabilities? - NICE CG62 Antenatal Care

Information about pregnancy should be provided in a variety languages, formats and settings - NICE CG110 Pregnancy & Complex Social Factors

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	The Pregnancy Book is given to all first-time parents. The NSC Antenatal & Newborn Screening Programme is included in the notes pack along with the "The Birth of Your Baby" leaflet Midwives may discuss active birth techniques as part of the birth planning process, this is also discussed in Antenatal Classes. The leaflet "Preparation for Birth" is also provided in the notes pack which provides information on a wide range of antenatal classes available to parents. A wide range of information is also included on the Maternity Services section of the DVH website.	Collaborative comparative audit of information provided by each Provider Trust	Unknown	Limited availability of local information leaflets in alternative languages	For Maternity Providersmaternity care providers across Kent shouldto collaborate to review the demand for information leaflets in alternative languages and opportunities to jointly commission them where appropriate.
EKHUFT	"The Pregnancy Book" is no longer available. Written information is provided in the notes on work & benefits, preparing for the new baby and childbirth (including active birthing techniques). There's also a checklist of issues for midwives to discuss relating to plans for pregnancy and parenthood and room to record intentions and preferences. All women expecting their first child are invited to attend a 1 day antenatal class entitled "The Journey". These classes are provided once a month in each area and topics include; infant feeding and going home with baby. Women expecting their 2nd child will be invited if their circumstances make it appropriate. All women are also given information about "The Journey" aseries of antenatal education films created by EKHUFT to provide information for those who don't want to go or can't access antenatal classes. The films are accessible from: www.ekhft.nhs.uk/thejourney. The NSC Antenatal & Newborn Screening leaflet is included in the notes pack along with a leaflet on birth choices and maternity services in East Kent. National leaflets are available in other languages but local leaflets aren't generally translated due to cost implications.				
MTW	This book is no longer available. The web address of the MTW Maternity website is provided on the back of the antenatal notes. This website provides information on choices in labour including active birth. Web addresses for the NHS Choices Pregnancy & Baby Guide and NHS Information Service for Parents are also included in the notes. A link to the pregnancyandchildbirthguide.com, a website established by local midwives, is also provided in a welcome leaflet. Midwives will source copies of information leaflets in other languages when required but don't have access to leaflets that are accessible for people with sensory or learning disabilities.				

PREGNANCY UP TO 28 WEEKS GESTATION: UNIVERSAL

Discussion on benefits of breastfeeding with prospective parents – and risks of not breastfeeding.

Identification of mothers with previous breastfeeding problems or potential complications - PHE/DoH/RCM/NHSE Guidelines

Promotion of the "Bump to Breastfeeding" video Clip / Pregnancy book online & "Off to the Best Start" leaflet - NHS Breastfeeding Care Pathway / WHO & UNICEF Best Practice for Hospital and community care settings

Information in Infant Feeding Support Services - NHS Breastfeeding Care Pathway / WHO & UNICEF Best Practice for Hospital and community care settings

Discussion with partner/father (only recommended as a Progressive Measure in HCP) - NHS Breastfeeding Care Pathway / WHO & UNICEF Best Practice for Hospital and community care settings

Introduction to Infant Feeding Support Services - NHS Breastfeeding Care Pathway / WHO & UNICEF Best Practice for Hospital and community care settings

Ensure all those who work in maternity & children's services are made aware of the importance of breastfeeding and help to promote a supportive environment - NICE PH11 Maternal & Child Nutrition

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	There is a Lead Midwife for Infant Feeding and specific breastfeeding workshops are offered antenatally to all parents. There is a detailed section on Infant Feeding in the Antenatal Care Pathway Record and it provides a link to the Bump to Breastfeeding film online. Women can also be signposted to University of Greenwich who's student midwives offer breastfeeding assessments. Women will also be signposted to community infant feeding support groups and there is a specific section on breastfeeding on the Maternity Services Website providing links to other sources of support. The service also offer antenatal milk harvesting as part of the diabetic pathway.	Breastfeeding Initiation & Continuation rates	See above for data on current breastfeeding rates by provider and CCG	The range & depth of breastfeeding advice can vary depending on the midwife. Written information on local breastfeeding support groups is not included in the notes and there is only a small prompt for midwives to provide information on support groups which	See recommendation above: Wherever practicable the paper-based information that is provided to parents across Kent on issues such as lifestyle, breastfeeding and preparation for parenthood should be standardised. All 3 maternity service providers should work together to review the contents of the leaflets currently provided antenatally and postnatally to identify the most appropriate sources of information. Midwives should also ensure that contact details for local breastfeeding support groups are always provided antenatally.
EKHUFT	Written advice on infant feeding is provided in the notes and there is a section to record the discussion of various elements of breast feeding at the 20 week appointment including; benefits to mother and baby, promoting the "From Bump to Breastfeeding DVD" (provided free to all women), tips of feeding technique and information on support groups. An Infant Feeding Co-Ordinator is also in post & the CQUIN target for bfeeding initiation and continuation last year was very helpful to focus leadership. The Trust is going for Stage 2 BFI Accreditation Assessment however the assessment date is currently on hold due to sickness absence of the Infant Feeding Co-ordinator. Midwives are developing links withlocal breastfeeding peer supporters to provide support in the antenatal period. The Trust had a CQUIN target for improving breastfeeding initiation and continuation rates however this is no longer in place.				
MTW	Copies of the Bump to Breast DVD are provided to all mothers. There is a specific "Antenatal Infant Feeding Checklist" within the notes which should be completed by 34 weeks. This offers opportunities to discuss the benefits of breastfeding, the importance of skin to skin contact, getting feeding off to a good start and the importance of good attachment. There is also a link to the infant feeding section on the MTW Maternity Website. Midwives liaise very closely with local infant feeding support services and information on the local contacts are provided in the discharge pack. Midwives will engage fathers in discussions about breastfeeding if the opportunity arises and the service ran the "Man up" campaign to increase breastfeeding awareness and support amongst fathers last year.				

PREGNANCY UP TO 28 WEEKS GESTATION: UNIVERSAL

Introduction to resources, including Children's Centres, Family Information Services, primary healthcare teams, and benefits and housing advice.

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Community midwives undertake all booking in appointments in Children's Centres to enable women to familiarise themselves with services this would also provide the opportunity to signpost to other advisory services available via the Centre. Midwives do not provide specific information or advice on benefits and housing but they will provide the form FW8 for exemption to charges for prescriptions and NHS dentistry.	Local audit	Unknown	The degree of engagement and communication between Midwives and Children's Centres varies considerably across Kent. This is corroborated by further comments from the Head of Kent Integrated Family Support Services and the survey of District Early Years Manager included later in the results section.	For the Heads of Midwifery and Head of Kent Integrated Family Support Services to encourage Early Help Managers & Community Midwives to collaborate to review current links between local Children's Centres and midwifery and explore opportunities to improve communication and increase the delivery of maternity services within Children's Centres where appropriate.
EKHUFT	Most midwives will hold a clinic in the Children's Centre or have detailed information about what is available in children's centres locally. Midwives will inform Children's centres of pregnant women in their area if the women provides consent. Brief written information is provided on work and benefits and parents with specific queries are signposted to get advice from the Children's Centre or the Benefits Agency.				
MTW	Midwives will tell mothers about local childrens centres. Some parentcraft sessions are run in Children's Centres or representatives from Children's Centres will attend parentcraft classes however this isn't consistent across the whole of the patch.Provision of information from Children's Centres is limited. Later in pregnancy ParentCraft sessions may be run in Children's Centre with member of childrens centre. If that can't happen Children's Centre rep will drop into Parent Craft. Web addresses for the NHS Choices Pregnancy & Baby Guide and NHS Information Service for Parents are provided in the antenatal notes which offer alternative sources of information. A leaflet about the Money Advice Service is also routinely included in the antental pack.				

PREGNANCY UP TO 28 WEEKS GESTATION: UNIVERSAL

Support for families whose first language is not English.

? Are services culturally sensitive to the needs of different values, beliefs and cultures? - PHE/DoH/RCM/NHSE guidance

Services should be accessible to all women and be designed to take full account of their individual needs, including different language, cultural, religious and social needs or particular needs related to disability, including learning disability - Maternity Matters 2005

Women who do not speak or understand English should be offered an interpreter who is not a member of her family, legal guardian or partner - NICE CG110 Pregnancy & Complex Social Factors

Healthcare staff should receive training on the specific health needs of recent migrants / asylum seekers / refugees, their social, religious and psychological needs and the most recent policies on access and entitlements to care

Allow flexibility in appointment times & frequency where an interpreter is required - NICE CG110 Pregnancy & Complex Social Factors

Recent migrants etc - Ensure midwives have accurate information about a woman's home address and contact details by liaising with local agencies - NICE CG110 Pregnancy & Complex Social Factors

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Midwives will use telephone interpreter services particularly at booking in appointments wherever possible and try hard to avoid using family members. There are difficulties communicating with women who don't speak English in Labour as telephone interpreter services aren't appropriate. No specific training is provided to midwives on the health needs of recent migrants / asylum seekers. A midwife is currently conducting a clinical project on ladies from BME population to identify their health needs and translate this into training for midwives - due to run to November.	Local audit of interpreter services and patient experience surveys	Unknown	There is a large diversity of languages in the population served by the hospital and sometimes inadequate access to face to face interpreter services for maternity appointments and particularly in labour.	Heads of Midwifery should ensure that midwives have access totraining on the specific health needs of recent migrants / asylum seekers / refugees, their social, religious and psychological needs and the most recent policies on access and entitlements to care as per NICE Guideline 110 Pregnancy & Complex Social Factors
EKHUFT	An interpreter will be booked for lengthy planned appointments ie booking in as long as midwives know in advance. Face to face interpreters will also be used if important decisions or complications need to be discussed. Midwives are encouraged not to use family members or partners as interpreters. Midwives also use the "Big Word" telephone interpretation service for emergency situations. National leaflets are available in other languages but local leaflets aren't generally translated due to cost implications, interpreters will be asked to summarise key points of relevant leaflets. The midwivery team have produced guidance on treating non-english speaking women but this is due for review. In Dover they hold a separate clinic for ESOL and book an interpreter for a specific language to cover a whole clinic if there is a specific need.				
MTW	Midwives will book interpreters for booking in clinics and also have access to the Medway Council telephone interpreter service when required urgently. Leaflets in other languages can be provided when needed.				

PREGNANCY UP TO 28 WEEKS GESTATION: UNIVERSAL

Preparation for Parenthood

Information on services and choices, maternal/paternal rights and benefits, use of prescription drugs during pregnancy, dietary considerations, travel safety, maternal self-care, etc.

Information on the pregnancy care pathway and place of birth choices - NICE CG62 Antenatal Care

Advised of increased risk of DVT in long haul flights in general population and recommend use of compression stockings. Advise on appropriate use of car seatbelts (above & below bump) - NICE CG62 Antenatal Care

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DV	Information leaflets on birth choices and diet in pregnancy are provided antenatally. There is a prompt to record existing prescribed medications in the Antenatal Care Pathway Record but no prompt to discuss the use of these and other prescription drugs. The Maternity Services website provides a wealth of information on birth options including a virtual tour of the Maternity Unit . See above re maternal/paternal benefits.	Collaborative comparative audit of information provided by each Provider Trust	Unknown		See recommendatin above: The 3 maternity services should work together to review the contents of the leaflets and information provided antenatally and postnatally to identify the most appropriate sources of information and standardise the information and advice available to women across Kent regarding preparation for parenthood, rights and benefits, diet and medication and travel safety. available to women across Kent.
EKHUFT	See above re maternal/paternal rights and benefits. Midwives will provide the certificate for free prescriptions and dental treatment and the MatB1 form for employers. Written advices on use of drugs, diet, travel safety (including seatbelt position) and maternal self-care is all included in the notes although no specific advice regarding the use of compression stockings. Brief written information on birth choices is included in the notes along with the"Your Birth Your Choice" leaflet which is provided to all women. There is a detailed discussion on birth preferences which is Revisited at 36 weeks when a detailed birth plan is filled out.				
MTW	The Money Advice Service leaflet "Having a Baby" is included in the antenatal notes and information on birth choices is provided on the MTW Maternity website. There is a prompt for midwives to direct parents to sources of information on benefits and occupational hazards in pregnancy and section in the notes to prompt midwives to discuss birth choices and a section to record a birthing plan. A copy of the NHS Direct page on Health in Pregnancy is included in the antenatal information pack which includes advice on cannabis, prescription and non prescription drug use, diet and hygiene.				

PREGNANCY UP TO 28 WEEKS GESTATION: UNIVERSAL

Social support using group-based antenatal classes in community or healthcare settings that respond to the priorities of parents and cover:

the transition to parenthood (particularly for first-time parents); relationship issues and preparation for new roles and responsibilities; the parent–infant relationship; problem-solving skills (based on programmes such as Preparation for Parenting, First Steps in Parenting, One Plus One)

The specific concerns of fathers, including advice about supporting their partner during pregnancy and labour, care of infants, emotional and practical preparation for fatherhood (particularly for first-time fathers);

Discussion on breastfeeding using interactive group work and/or peer support programmes;

Standard health promotion.

Is there evidence of a range of models of antenatal and postnatal care including individual and group sessions, in and out of hours availability - Commissioning Maternity Services - A Resource Pack to support Clinical Commissioning Groups NHSE 2012

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DV	A comprehensive programme of antenatal classes is provided by Community Midwives and co-ordinated by a Full-Time Parent Education Co-Ordinator. This includes "New Horizons - early pregnancy", Parentcraft, Multiple Pregnancy, Teenage Parents Workshop, Waterbirth and hypnobirthing workshops, Caring for your Newborn & Breastfeeding Workshops. Midwives will also link with health visitors link up to provide access to other parenting groups.	Parent Education Evaluation Forms	Unknown	There is significant variation in the content, delivery and accessibility of parent education / antenatal classes across Kent	The 3 maternity service providers should work together to review the contents and delivery of antenatal education sessions, to share best practice, ensure the delivery of consistent messages to parents and equity of access to high quality education sessions for prospective parents across Kent. This work should be undertaken with reference to the Department of Health Guidelines: Preparation for Birth & Beyond: A Resource Pack for Leaders of Community Groups & Activities, DoH 2012.
EKHUFT	Written information is provided in the notes on preparing for the new baby and childbirth. There's also a checklist of issues for midwives to discuss relating to plans for pregnancy and parenthood and room to record intentions and preferences. All women expecting their first child are invited to attend a 1 day antenatal class entitled "The Journey". These classes are provided once a month in each area and topics include; infant feeding and going home with baby. Women expecting their 2nd child will be invited if their circumstances make it appropriate. All women are also given information about "The Journey" aseries of antenatal education films created by EKHUFT to provide information for those who don't want to go or can't access antenatal classes. The films are accessible from: www.ekhft.nhs.uk/thejourney.				
MTW	Parentcraft classes are run by community midwives in multiple community venues. These are optional for women and women can book themselves in. Usually 3 classes. Unusual to hear that women who wanted to go that couldn't get in. The MTW website has information on Birthing Centre & Tunbridge Wells Maternity Centre. Work ongoing with MSLC to ascertain what information women want on the website.		MTW's Maternity Services Liaison Committee have recently undertaken a survey of parents' views on the content of antenatal classes. This has led to agreement to undertake a wider evaluation of the provision of parent education including independent observation of sessions.		

PREGNANCY UP TO 28 WEEKS GESTATION: PROGRESSIVE

Ambivalence about pregnancy, low self-esteem and relationship problems

Problems should be addressed using:

- techniques to promote a trusting relationship and develop problem-solving abilities within the family (e.g. promotional/motivational interviewing; the Family Nurse Partnership Model and the Solihull approach):
- establish what individual support needs are;
- provide one or two structured listening support contacts;
- work in partnership with families to develop problem-solving skills;
- support to access antenatal care; and
- preparation for parenthood (which could include separate sessions for fathers only).

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Midwives operate in small local teams and offer continuity of care via a named midwife to encourage the development of a trusting relationship. There is no specific guidance on providing this type of support although a comprehensive programme of parentcraft classes is available to all.	Service User Surveys	Unknown	Midwives appear unclear about their role in providing support to couples and developing parenting skills antenatally (this is also reflected in the results in subsequent tables in this section). There is an assumption that this is a role for Health Visitors as part of the Antenatal or Newborn visits. There are currently 4 FNP Programmes running across Kent (Thanet, Swale, Maidstone and Tonbridge and Malling) with a further 3 due currently being established in Dartford & Gravesham, Dover and Shepway. When fully established these services will have the capacity to support 275 young parent families.	Commissioners and providers should clarify the role of midwives in the provision of parenting advice and support and the pathways for referral for additional support antenatally. Consideration should be given to the training needs of midwives to fulfill this role
EKHUFT	The identification and discussion of this issues is patchy and varies between individual midwives. Women may be offered longer or additional appointments if a need is identified but this is not universal.				
MTW	Midwives operate in local teams offering continuity of care antenatally & postnatally to encourage the development of a trusting relationship. New or ongoing issues would be highlighted on a Concern & Vulnerability form to facilitate information sharing and action planning with other agencies.				

PREGNANCY UP TO 28 WEEKS GESTATION: PROGRESSIVE

Women experiencing anxiety/depression in addition to the problems above

If no previous episode of depression or anxiety:

- social support (individual or group-based, including antenatal groups and parenting classes)
- assisted self-help (computerised cognitive behavioural therapy; self-help material presented to a group or individuals, by a health worker/paraprofessional).

The woman's GP should be informed of any suspected mental illness. Women could be referred to their GP for further assessment or direct to a specialist mental health service if severe mental illness is suspected - NICE CG62 Antenatal Care

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	The service has 1 Specialist Midwife for Mental Health who is involved in a triage pathway for onward referrals for women with mental health problems. However this is not a standalone post but this work is undertaken as part of her role as the Community Midwifery Manager. The referral pathway for women with low level mental health problems to NHS Talking Therapies not yet established however women are offered continuing care by the Obstetrician with a special interest in mental health..	SUS Data about perinatal MH/postnatal depression (EG ICD code F53.0) (would only see severe end of the spectrum) / Local audit of booking notes	Unknown	Potential for greater promotion of access to the NHS Talking Therapies. Opportunity to develop the role of the Specialist Midwife for Mental Health although this would require funding. Opportunities to use mental health promotion strategies such as 6 Ways to Wellbeing.	The Kent Public Health Team (KPHT) should continue to engage with maternity services to provide "6 Ways to Wellbeing" training" for staff and support midwives to incorporate this into their advice on lifestyle behaviours as part of their antenatal care. The KPHT should also explore opportunities to engage with other professionals involved in the delivery of the Healthy Child Programme (such as Health Visitors, GPs and Children's Centre Staff) and support them to incorporate the "6 Ways to Wellbeing" messages into their practice. CCGs should clarify if all providers of NHS Talking Therapies in Kent prioritise pregnant women accessing assessment and treatment. Maternity services should signpost these services to pregnant women with low level mental health issues.
EKHUFT	There is a Lead Midwife for Mental Health on every site however their capacity to provide direct support to women is extremely limited and they are often only able to provide advice to other colleagues. There is a lack of provision of time for all midwives to receive adequate training in relation to mental health issues and the majority of midwives are currently ill-equipped to respond to disclosures of mental health issues. A recent audit of perinatal mental health support revealed that; many women with current or past mild to moderate illness are not receiving appropriate care or advice &, some women with severe mental health issues weren't appropriately referred to the MIMHS service. In response the service is raising midwives' awareness of NHS Talking Therapies services & the Mental Health Matters Helpline. The Lead Midwives for MH meet quarterly with the MIMHS team to discuss cases and outcomes.		The maternity team at EKHUFT undertook an audit of Perinatal Mental Health in March 2012 which exposed the following issues: The quality of information on women with current or historical MH issues was inconsistent. Details of the severity timing and treatment received was only recorded in 50% of cases. Communication of information n between midwives, GPs and HVs for women with a previous history of depression or mild to moderate MH issues was poor. Of the 4 women identifed with serious mental health issues only 2 were referred to the MIMHS service and 1 had no specific management plan at all. There were numerous examples of MH assessments being undertaken, issues identified but no follow up on care planning.	Lack of awareness of support available and response is inconsistent. MH Lead Midwife role could be developed more but would need funding. Gaps in response to women who don't meet criteria for MIMHS ie mild to moderate depression.	
MTW	There is a significant gap in the support available to women experiencing lower level mental health issues. There is no midwife specialist for mental health. Midwives weren't aware of the opportunity to refer to NHS Talking Therapies and oftern refer women back to their GP for support. Women in crisis can be referred to the Hospital's Psychiatric Liaison .		Unknown	The Head of Midwifery is currently developing a business case for a Specialist Midwife for Perinatal Mental Health. Medway have full-time perinatal mental health specialist midwife and an effective tiered approach to the provision of support - could be a model to look into.	

PREGNANCY UP TO 28 WEEKS GESTATION: PROGRESSIVE

For women with previous episodes of non-clinical symptoms of depression and anxiety:

- brief (four to six weeks), non-directive counselling delivered at home (listening visits) by skilled professionals, and access to local social support
- referral for brief psychological treatments (such as cognitive behavioural therapy or interpersonal therapy).

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	The Community Midwife Manager is a trained psychotherapist & provides brief counselling sessions for women with mild to moderate mental health issues however capacity is limited. A Consultant Obstetrician also has a specialist interest in Mental Health with 4 hrs protected antenatal clinic time focus on MH. The triage pathway provides links to social care & MIMHS where appropriate. Midwives will also signpost to local voluntary services support but unclear if they are actively promoting IAPT services.	SUS Data about perinatal MH/postnatal depression (EG ICD code F53.0) (would only see severe end of the spectrum) / Local audit of antenatal care records	Unknown	Frustration at the lack of support for mothers with low level mental health issues. Potential to improve midwives awareness of NHS Talking Therapies and increase promotion of self-referral to these services for women as appropriate. Additional opportunities to use mental health promotion strategies such as 6 Ways to Wellbeing to improve mental health prevention.	See above
EKHUFT	Same issues as above, the approach & issues are the same as women with no previous history of mental illness		See above		
MTW	Same issues as above.		Unknown		

PREGNANCY UP TO 28 WEEKS GESTATION: PROGRESSIVE

Women who smoke

Women who smoke should be offered:

• smoking cessation interventions, including behavioural interventions combined with social support and incentives for achievement; and telephone counselling (NHS helplines);

• involvement of partners, if they agree, in the implementation of smoking-reduction/ cessation programmes; and

• additional strategies, such as planning of smoke-free environments for children (e.g. areas within the home that are smoke-free).

Awareness of specific issues related to smokeless tobacco in asian communities - NICE

Discuss the risks & benefits of NRT particularly with those who don't wish to engage with stop smoking services. Only offer is smoking cessation without NRT fails and once they have stopped smoking. Advise women wearing nicotine patches not to wear them at night - NICE CG62 Antenatal Care / NICE PH26 Quitting Smoking in Pregnancy

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Direct electronic referral to smoking cessation has been established for 5 years and there has been mandatory training for all midwives on smoking cessation for 3 years. Training all community + core antenatal services. Leaflet on Bexley Smoking Cessation Services included in the antenatal information pack. Implementing the Babyclear Programme. Operating an opt out referall system ie routinely refer unless woman says no. No structured way of re-visting smoking behaviour during antenatal, no structured follow up of referral. Asked Stop Smoking Service if feedback can be provided on number of women who take up referral.	Rates of smoking at booking / Rates of smoking at time of delivery (SATOD) / Stop Smoking referral rates & quit rates for pregnant women - Babyclear programme outcomes data	See 28 Weeks Univeral for latest SATOD Statistics	Some inequity in access to the BabyClear Programme across Kent as there are some midwives who have not yet received training. Lack of routine method of following up referral to stop smoking services. EKHUFT are looking to introduce a system of electronic feedback from Smoking Cessation Services via midwives' new ipads. Despite enthusiasm to implement the "Risk Perception" element of the Babyclear programme the identification and funding for midwives to deliver this programme is yet to be agreed.	The Kent Children's Health and Wellbeing Board should confirm the source of funding for the recurring costs of delivering the Babyclear smoking cessation initiative (including the establishing the additional Risk Perception element of the programme) Kent-wide as soon as possible. Midwives should liaise with the Smoking Cessation Service to identify opportunities to receive automatic feedback on women who do not accept the initial referral for support.
EKHUFT	EKUHFT have fully implemented Stage 1 of the Babyclear Smoking Cessation Programme (CO testing and "opt out" referrall to smoking cessation) and all midwives have received appropriate training. Although there is space in the notes to revist smoking behaviour later in pregnancy the completion of this is patchy. There is also currently no routine system to follow up the outcome of referrals to smoking cessation services but midwives are currently negotiating with Stop Smoking Services to provide feedback on the number of women who take up referral.				
MTW	The booking questionnaire includes prompts to ask women about their intention to quit and trained midwives are implementing Stage 1 of the Babyclear Programme (CO testing and "opt out" referrall to smoking cessation) however this is not yet universally available as there is a small number of midwives still requiring training. There is currently no system to inform midwives of women who haven't taken up the automatic referall but midwives will ask the mother if they've attended. Midwives would encourage them to attend or discuss risk reduction options				

PREGNANCY UP TO 28 WEEKS GESTATION: PROGRESSIVE

Women who are overweight or obese

Women who are overweight or obese should be offered:

Women who have a BMI >30 should be informed about the increased risks to her and baby, advised not to lose weight in pregnancy but losing weight after pregnancy won't affect breast milk quality/quantity - NICE PH11 Maternal & Child N

• weight control strategies to reduce risks to both mother and baby;

• advice about healthy eating and physical activity; dispel myths about eating in pregnancy ie eating for 2, advice on using the healthy start vouchers to increase fruit & veg intake (where eligible), moderate intensity physical activity, 30 minutes is safe, provide practical advice on suitable activities or advice on how to build up to this level - NICE PH27 Weight Management before, during & after pregnancy

• refer all women with BMI >30 to a dietician - NICE PH27 Weight Management before, during & after pregnancy

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Information on the risks of having a BMI >30 are provided in the Antenatal Care Pathway Notes. Women with a BMI >35 are referred to Pregnancy Plus Programme. This is an education and monitoring programme run by community midwives with dietetic support. There are currently 3 groups running in Dartford, Gravesham & Bexley. The programme has been acknowledged by NICE for best practice. Women with a BMI >35 are also referred to a Dietician N.B. NICE recommends that all women with BMI >30 should be referred to a dietician however there isn't sufficient capacity to implement this eligibility threshold. These women are also referred for Consultant Led Antenatal Care and are offered screening for diabetes. A Diabetes Specialist Midwife provides advice on the care of those screened at high risk of developing Gestational Diabetes. Training and education on obesity in pregnancy is provided to all staff via mandatory training programmes.	Local audit of booking notes / Audit of dietician referrals	Local data indicates that currently 21% of pregnant women have a BMI >30 and the rate is inreasing	There is currently insufficient dietetic support for those with acute needs, eligibility currently set at >35 but NICE recommends >30.	Heads of Midwifery should liaise with Dieticians and Service Commissioners to ensure that there is sufficient capacity to refer all women with a BMI >30 for dietetic support as per the NICE Guideline PH27. Kent Public Health Team are currently conducting consultation on Kent Adult Weight Management Services to ascertain the demand for a specialist maternal weight management service. The results of this consultation should be analysed to identify whether there is evidence of demand for the provision of additional weight management support for pregnant women and work with CCGs to agree commissioning responsibility for these services.
EKHUFT	A referral pathway has been established with the Community Dietician but there is a lack of consistency in acceptance of referrals with some recently being refused. Although BMI is recorded in the pregnancy notes there is no space to record referral to specialist services. Those with BMI >35 will be referred to Obstetrician & Anaesthetist but there are capacity issues in their clinics.EKUHFT have previously been involved in a research study with Slimming World which provided support for overweight or obese pregnant women for a limited period of time. Existing clinical equipment has been reviewed to ensure it is appropriate for heavier weight women. The service has purchased larger scales & BP cuffs for community midwives.		Unknown	Frustration that pregnant women aren't eligible for adult weight management programmes. Inconsistencies the acceptance of referrals to the Community Dieticians. No midwife with a specialist interest in Healthy Weight / Obesity	

PREGNANCY UP TO 28 WEEKS GESTATION: PROGRESSIVE

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• weight control strategies to reduce risks to both mother and baby;

• advice about healthy eating and physical activity; dispel myths about eating in pregnancy ie eating for 2, advice on using the healthy start vouchers to increase fruit & veg intake (where eligible), moderate intensity physical activity, 30 minutes is safe, provide practical advice on suitable activities or advice on how to build up to this level - NICE PH27 Weight Management before, during & after pregnancy

• refer all women with BMI >30 to a dietician - NICE PH27 Weight Management before, during & after pregnancy

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
MTW	Height, weight and BMI are recorded at booking with a separate section to record the care plan for women with a BMI >30. There are 2 Midwives with a special interest in Healthy Weight each of whom have a total of 6hrs protected time per week to fulfil this role (taken from existing midwifery establishment). These midwives run Healthy Weight Clinics for all women with a BMI >35. Women with a BMI >40 are referred to an obstetrician, anaesthetist and dietician. This threshold is considerably above the NICE guideline of BMI>30. There are also 2 Specialist Diabetes Midwives who have a total of 11.25 hrs per week of protected time to provide support to women with or at risk of developing diabetes. No specific information or advice on diet and exercise is included in the notes but the following leaflets are routinely provided within the antenatal information pack; Start4Life leaflet, a copy of the NHS Direct Page on Health in Pregnancy (includes information on diet & exercise) & the A-Z of Pregnancy & Nutrition.		Unknown	Provision of healthyweight clinics can be sporadic due to fluctuating demand with no clinics currently running in the Maidstone area.Specialist midwives also have limited protected time to provide clinics. The 2 midwives currently have a total of 6hrs per week to undertake their specialist role and this time has been taken out of existing midwifery establishment. The threshold for referral of women to a dietician is considerably above the NICE Guideline (BMI >40 compared to the recommended BMI >30)	

PREGNANCY UP TO 28 WEEKS GESTATION: PROGRESSIVE

Breastfeeding

• Discussion on infant feeding and support to tackle practical barriers to breastfeeding.
• Discussion of benefits and drawbacks for mother and child
• Discussion with the prospective father.

Opportunity to talk to Infant Feeding Co-Ordinator / Specialist Midwife - NHS Breastfeeding Care Pathway / WHO & UNICEF Best Practice for Hospital and community care settings

Awareness of factors which may trigger targeted support eg multiple birth / diabetes / breast surgery / c section / social-economic factors / teenage pregnancy / Healthy Start Recipients - NHS Breastfeeding Care Pathway / WHO & UNICEF Best Practice for Hospital and community care settings

Advise women with a history of allergies that there is insufficient evidence to suggest infant formula based on partially or extensively hydrolysed cow's milk helps to prevent allergies - NICE PH11 Maternal & Child Health

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	The Trust is currently at Stage 1 of the Unicef BFI process and have received a Certificate of Commitment. A reassessment is planned for Feb 2015 as work on this has lapsed. There is a large section in the notes given over to recording discussions about breastfeeding benefits and techniques. All women are able to attend breastfeeding workshops as part of the antenatal class programme. Midwives also support antenatal milk harvesting as part of diabetic pathway and these women will link with infant feeding midwife. The Infant Feeding Midwife is a trained Lactation Consultant	Breastfeeding Initiation & Continuation rates / Local audit of Antenatal Care Reords	See 28 Weeks Univeral for latest Breastfeeding Statistics	No significant gaps	
EKHUFT	Written advice on infant feeding is provided in the notes and there is a section to record the discussion of various elements of breast feeding at the 20 week appointment including; benefits to mother and baby, promoting the "From Bump to Breastfeeding DVD" (provided free to all women), tips of feeding technique and information on support groups. Midwives are aware of the factors which may result in women requiring additional support with breastfeeding and will discuss specific issues with the infant feeding co-ordinator who will phone the woman to offer advice. There is a Lactation Consultant but they are only commissioned for 1 day a week. Other midwives have lactation consultant specialist training but don't have any protected time to provide specific support.				
MTW	There is a specific "Antenatal Infant Feeding Checklist" within the notes which should be completed by 34 weeks. This offers opportunities to discuss the benefits of breastfeeding, the importance of skin to skin contact, getting feeding off to a good start and the importance of good attachment. There is also a section dedicated to infant feeding on the MTW Maternity Website and the pregnancyandchildbirthguide.com website. Midwives liaise very closely with local infant feeding support services and information on the local contacts are provided in the discharge pack. Midwives will engage fathers in discussions about breastfeeding if the opportunity arises and the service ran the "Man up" campaign to increase breastfeeding awareness and support amongst fathers last year. Midwives will talk to women 1to1 about their specific needs. The breastfeeding lead also meets with diabetic women to discuss collostrum harvesting which is also available to women at risk of premature birth. Anecdotal evidence that this system is working well.				

PREGNANCY UP TO 28 WEEKS GESTATION: PROGRESSIVE

For Parents at higher risk

At-risk first-time young mothers

• Intensive, evidence-based programmes that start in early pregnancy, such as the Family Nurse Partnership programme

• Multimodal support combining home visiting, peer support, life skills training and integration within social networks recommended for pregnant adolescent

Offer a named midwife who is the lead co-ordinator of care and provide a direct line number for this midwife - NICE CG110 Pregnancy & Complex Social Factors

Healthcare providers should encourage young mothers to attend antenatal appointments by providing antenatal care in the community and/or offering information on help with transportation / providing opportunities for the partner/father to be involved - NICE CG110 Pregnancy & Complex Social Factors

Offer age appropriate information in a variety of formats including information on care services, antenatal peer group education, benefits etc NICE CG110 - Pregnancy & Complex Social Factors

Train all healthcare providers in the safeguarding responsibilities for young mothers and her unborn baby and guidelines on consent to treatment - NICE CG110 Pregnancy & Complex Social Factors

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Teenage parents receive normal antental care with an individualised care planning based on social need or health need. Teenage parents have access to all antenatal classes as well as a specific Teenage Parenting Workshop run by a community midwife. Information is provided verbally, in writing and online via the service's website. Young Pregnant Women at high risk will be referred to a consultant . Women <16 are routinely referred into social care as part of the vulnerable women's pathway. FNP is already active in South London and Community midwives have links with the FNPs in South London Boroughs. A new FNP Programme for Dartford and Gravesham is planned which will have the capacity for 25 women <19 this is likely to be established early in 2015.	Family Nurse Partnership programme performance data / Audit of CAF records / Survey of young maternity services users	There are currently 4 FNP Programmes running across Kent (Thanet, Swale, Maidstone and Tonbridge and Malling) with a further 3 due currently being established in Dartford & Gravesham, Dover and Shepway. When fully established these services will have the capacity to support 275 young parent families.	Variation in access to FNP nurses for young parents across Kent although these are being established in the areas of greatest need. Some inconsistencies or gaps in the provision of Young & Pregnant or Teenage Parent Support Groups.	Specialist Teenage Pregnancy midwives should liaise with local Children's Centres and other community venues to clarify what extra support is available to young parents in their area and share this information with their midwifery teams.
EKHUFT	There is currently 1 FNP programme running in Thanet with the capacity for 50 families however this programme is currently virtually full. A new programme for the Dover area, with capacity for 25 families is due to be established late 2014/early 2015. Families are referred to FNP via midwives although the service is working towards a system of automatic notification of all women who meet the criteria for FNP. There have been examples of community midwives and FNP nurses working well together. Young & Pregnant (YaP) antenatal groups are also provided for teenagers by multi professionals however it is currently unclear if these are still available in all localities and whether the programme content has been reduced.				
MTW	Teenage parents have access to general parentcraft and TP Specialist Midwives will provide 1to1 parentcraft and will signpost expectant parents to their local Teenage Parent Groups at Children's Centres. There are currently FNP programmes running in Tonbridge & Malling and Maidstone with the capacity to support 50 families each. A further programme in Shepway will be established in late 2014 / early 2015 with capacity to support 25 families.				

PREGNANCY UP TO 28 WEEKS GESTATION: PROGRESSIVE

Parents with learning difficulties

- Information on support available to parents with learning disabilities, and assistance in interpreting information and accessing other sources of support.
- Specialist multi-agency support should include individual and group-based antenatal and parent education classes, and home visiting.
- Further support designed to address the parent's individual needs might include speech and language and occupational therapy – (from adult provider).

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Information on parents' with Learning Difficulties is recorded on the Family Background questionaire and in the Additional Needs section of the Antenatal Record. The service has a Community Midwife with specialist interest in learning difficulties and training in makaton - however they do not have protected time to undertake this role and are currently on maternity leave. Another midwife also has specialist training in mental capacity assessment. An Adult Protection nurse is available for advice. The Trust supports the use of Health Passports for people with learning disabilities and they are encouraged to bring these to maternity appointments. An individualised care package will be developed and and midwives will liase with Community Learning Disability Teams as part of their multidisciplinary communication. Midwives will initiate a CAF when appropriate.	Local audit of antenatal records/ Audit of information sharing with CTLDs / Analysis of the population of parents with LD	Unknown	The number of parents with learning disabilities is low but it can be challenging when they present as midwives have a lack of experience of supporting them. Midwives will routinely liaise with Community Learning Disability Teams to get support and develop a support plan for parents with Learning Disabilities.	Kent Public Health Team in collaboration with KCC Adult Learning Disabilities Service should identify the current numbers of parents with LD known to services in order to develop an accurate estimate of current and future need. This should inform the development of a kent-wide commissioning strategy for antenatal and postnatal parenting support for PWLD
EKHUFT	There are 2 midwifes Leads for Disability who can provide advice to community midwives but midwives may not always refer to them. Community midwives will work with the local Community Learning Disability Team to develop a support plan for parents with a LD. There is space in the section on social assessment at booking in to record whether the mother has a disability or whether they have communication difficulties or may need support to understand the pregnancy notes or filling in forms. Midwives can offer 1to1 home-based antenatal education for parents with LD if appropriate and a picture book titled "You and Your Baby" is also available for parents with LD.				
MTW	Parents with learning disabilities would receive a "Concerns & Vulnerabilites" assessment which would then be shared with other agencies in order to develop an action plan. There is no Lead Midwife for Learning Disabilities but if there are concerns midwives will refer to Lead Midwife for Safeguarding or the Specialist Nurse for Vulnerable Adults. Midwives will liase with Community LD Teams if necessary but not routinely. All midwives receive training on Mental Capacity Act and obtaining informed consent.				

PREGNANCY UP TO 28 WEEKS GESTATION: PROGRESSIVE

Drug abuse

• Referral of one or both parents to local specialist services as part of a multi-agency strategy.

Use a variety of methods to remind women of upcoming or missed appointments & offer information and help with transportation to apointments to support attendance - NICE CG110 Pregnancy & Complex Social Factors

• CHPP team to contribute to care package led by specialist service.

• Doula programmes (a combination of home visiting, role modelling and community supports) may also help to prevent attrition and increase sensitivity of mothers who are in recovery.

Midwives receive training on the social and psychological needs of women who misuse substances & non-healthcare staff receive training on how to communicate sensitively with women who misuse substances - NICE CG110 Pregnancy & Complex Social Factors

Midwives to offer information about the potential effects of substance misuse on her baby and what to expect when the baby is born - NICE CG110 Pregnancy & Complex Social Factors

Midwives to promote the benefits of needle exchange programmes - NICE

Midwives should work with social care professionals to overcome barriers to care for instance; ensuring attitudes of staff do not prevent women from accessing services, addressing women's feelings of guilt about their substance misuse, addresings women's fears about the involvement of children's services - NICE CG110 Pregnancy & Complex Social Factors

Women should be offered a named midwife or doctor with specialised knowledge and experience in the care of women who misuse substances and provide a telephone number for direct access - NICE CG110 Pregnancy & Complex Social Factors

Care planning should be co-ordinated across organisations with notes combined into a single record and information on progress shared and include information on opiate replacement therapy - NICE CG110 Pregnancy & Complex Social Factors

Alcohol abuse

• Referral of one or both parents to local specialist services as part of a multi-agency strategy.

• CHPP team to contribute to care package led by specialist service

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Women with drugs and alcohol issues are automatically referred to an obstetrician and will receive support from the Lead Midwife for Drug and Alcohol abuse who runs clinics alongside the obstetric clinic. Continuing care is maintained as clinically and socially indicated. There is a robust referral pathway to facilitate a multiagency response and women are frequently referred to social services.	Local audit of antenatal care records / Audit of information sharing and referral pathways to substance misuse or alcohol services	Unknown	No significant gaps	

PREGNANCY UP TO 28 WEEKS GESTATION: PROGRESSIVE

Drug abuse

Alcohol abuse

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
EKHUFT	A new drugs and alcohol assessment and referall system is just about to be introduced at booking. Women's drug and alcohol use will be scored with those with high scores offered a referal to the hospital's Alcohol and Substance Misuse Team at QEQM or the Turning Point service for women at Ashford. Turning Point develop "Trimester Care Plans" which will be shared with maternity services. Antenatal support including discussions with Paediatricians and visits to SCBU can be arranged if the baby is likely to be affected by drug and alcohol misuse.	Local audit of antenatal care records / Audit of information sharing and referral pathways to substance misuse or alcohol services	Unknown	No significant gaps	
MTW	There are no Specialist Midwives for Drugs and Alcohol issues however the number of women with these issues is relatively low. There is an effective referral pathway for women with drug and alcohol support services (developed in partnership with the provider CRI. Although there is relatively low demand for services women will often have a dual diagnosis with mental health issues and the support for these women is less well established. There is no joint care planning between midwives and the drugs and alcohol support services and information is not always shared with midwives.				

PREGNANCY UP TO 28 WEEKS GESTATION: PROGRESSIVE

Domestic violence

- Follow local protocols developed jointly by health, social care, police and the 3rd sector - NICE CCG 110 Pregnancy & Complex Social Factors
- Following assessment, provision of a safe environment in which victims of domestic violence can discuss concerns.

Reassure the woman that the information provided will be kept confidential - NICE CG110 Pregnancy & Complex Social Factors

Provision of flexible appointments to allow more time for women to discuss their experiences - NICE CG110 Pregnancy & Complex Social Factors

Offer a named midwife who is the lead co-ordinator of care & obatain an agreed contact number for the woman - NICE CG110 Pregnancy & Complex Social Factors

- Provision of information about sources of support for domestic violence.
- Referral to local specialist services as part of a multi-agency strategy.
- CHPP team to contribute to care package led by specialist service.

Train healthcare professionals in the identification & care of women who experience DV - NICE CG110 Pregnancy & Complex Social Factors

Consider providing joint training for health and social care professionals to better understand roles & responsibilities - NICE CG110 Pregnancy & Complex Social Factors

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	All maternity services staff receive comprehensive training in identifying and managing DV in line with the Trust's DV Guidelines. Midwives use the National CAADA DASH risk assessment form for DV . The Safeguarding Lead Midwife will attend MARACs for DV where appropriate. A Midwife with a Specialist Interest in Child Protection is able to provide advice to colleagues.Appointments without partners present are offered where possible to enable the assessment of risk. Information on Local DV 1stopShops is provided in the antental record. The maternity service also has an "Alert Toilet" where women can put a spot on their urine sample to alert midwives that they are vulnerable to DV. Local DV pathways were recently checked by CQC and no issues were identified. Local DV guidelines have been tested out of hours and with police and found to be robust.	Local audit of antenatal care records / Audit of information sharing and signposting to DV support services	Unknown	Lack of recent training on DV for all midwives. Lack of protected time for Lead DV Midwives to carry out their roles.	Heads of Midwifery should undertake a training needs analysis to determine midwives' competence and confidence in talking to and supporting women at risk of domestic violence.

PREGNANCY UP TO 28 WEEKS GESTATION: PROGRESSIVE

Domestic violence

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
EKHUFT	Local guidelines on managing the issues of domestic violence in pregnancy are available but they need updating. There are midwives identified as having lead roles Domestic Violence but they currently lack the capacity to provide specific support. A contact number for the National Domestic Violence helpline is included in the pregnancy notes, local numbers are not included as they can change. Midwives can refer to local domestic violence support services including local 1StopShops. Training in identifying and supporting women at risk of DV has been provided in the past but some midwives still feel uncomfortable in asking about DV as they are not always confident in what support they can offer. Women identified as being at risk of Domestic Violence may receive a higher number of postnatal visits from the Community Midwife and good liaison with the Health Visitor during the postnatal period is key and the EKHUFT Child Safeguarding Team may be involved if necessary.	Local audit of antenatal care records / Audit of information sharing and signposting to DV support services	Unknown	Lack of recent training on DV for all midwives. Lack of protected time for Lead DV Midwives to carry out their roles.	Heads of Midwifery should undertake a training needs analysis to determine midwives' competence and confidence in talking to and supporting women at risk of domestic violence.
MTW	Women are given the opportunity to discuss issues when absent from partner however opportunities can sometimes be limited. An alert card system is also in operation enabling women to raise issues discreetly when they submit their urine sample. Midwives are currently piloting the addition of a question regarding domestic violence on the "Family Background Questionnaire" to improve documentation of issues as this is kept by the midwife not in the handheld notes. Midwives receive training on signs of DV and raising the issue,Do use cards which are left with urine samples. Midwives are trained in looking for signs of DV and in raising the issue. Police & social services both also offer adhoc training sessions. Midwives will complete a Concern and Vulnerability Form if they are concerned to enable multi-agency information sharing. Midwives will also refer issues to MARAC if it is deemed necessary. There is a section providing advice on domestic violence on the back of the antental notes including the phone number for the national domestic violence helpline and a link to www.womensaid.org.uk. A leaflet on the local Domestic Abuse Volunteer Support Service is also provided in the booking in pack.				

PREGNANCY UP TO 28 WEEKS GESTATION: PROGRESSIVE

Serious mental illness

• Referral of one or both parents to specialist mental health/perinatal mental health service.

• CHPP team to contribute to care package led by specialist service.

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DV	There is a detailed section to record mental health history and screen for current depression and mental health issues is included as a risk factor in the Antenatal Risk Assessment. MIMHS is not currently commissioned for women in this area. There is a Perinatal Mental Health Team consisting of a MH Specialist Midwife who also has psychotherapy training, an Obstetrician with an interest in mental health and an Antenatal Clinic Manager but this doesn't always offer sufficient support for women with serious mental illness . Women are referred to Adult Mental Health Crisis Teams if acute issues arise and referrered to social services if there are concerns regarding child protection. There is limited inpatient access for pregnant women.	SUS Data about perinatal MH/postnatal depression (EG ICD code F53.0) (would only see severe end of the spectrum) / Local audit of antenatal care records		There is a serious gap in psychiatric support for pregnant women with serious mental illness as MIMHS is not funded in the Dartford & Gravesham area	Commissioners and providers should collaborate to produce a Kent-wide perinatal mental health pathway with equitable access to perinatal mental health support at all levels of need, including prevention services, for pregnant women across Kent. The pathway should be developed with reference to the national Maternal Mental Health Pathway [REF] (See Appendix X). The pathway should incorporate the new role of District Health Visitor Perinatal Mental Health Leads & explore opportunities for them to expand their role capacity to provide training and support to midwives and other stakeholders on the pathway.
EKHUFT	A recent audit of perinatal mental health support revealed that not all women with severe mental health issues were appropriately referred to the MIMHS service during the antenatal period. However Midwives & Obstetricians feel the referall pathway to MIMHS is unclear and would like to be able to refer directly rather than via Community Mental Health Services. Where a woman with serious mental health issues has been under the care of MIMHS during pregnancy a reobust multi-agency plan of care will be in place. However problems can occur if antenatal MIMHS care does not occur, either because a referral has not taken place or has been refused due to lack of capacity to treat all but the most severely ill. The 4 Lead Midwives for MH meet quarterly with the MIMHS team to discuss cases and outcomes. However these lead midwives are only allocated 8 hrs per year to undertake this role, severely limiting what they are able to achieve.		See previous sections for discussion of the results of the EKHUFT Perinatal Mental Health Audits	Lack of clarity in the referall pathway. Midwives feel some referrals are inappropriately refused by the Community MH Team. Capacity issues in the MIMHS team mean that there can be difficulties in accessing the service. Severe lack of protected time for MH Lead Midwives (8hrs per year annually)	
MTW	Access to MIMHS is working well for women who meet eligibility criteria. There is regular liaison between midwifery and MIMHS.				

AFTER 28 WEEKS GESTATION: UNIVERSAL

Promotion of health and wellbeing

Ongoing identification of families in need of additional support

Provide further information on breastfeeding incl. advice on technique and good management practices that may help a woman succeed - NICE CG62 Antenatal Care

Ask 2 depression screening questions (during past month have you felt down, depressed or hopeless or having little interest or pleasure in doing things) - NICE CG62 Antenatal Care

For women who smoke but haven't taken up the referral to stop smoking services, continue to discuss the benefits and the support available for quitting - NICE PH26 Quitting Smoking in Pregnancy

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	There is a large section in the notes given over to recording discussions about breastfeeding benefits and techniques. All women are able to attend breastfeeding workshops as part of the antenatal class programme. Changes in mental health status will be assessed as part of antenatal well-being & the family risk assessment will be repeated at every contact. Referrals will be followed up if not already picked up. Universal CO monitoring for smoking status at booking is being rolled out following midwifery training and will be repeated for women who tested positive but haven't taken up referall to smoking cessation.	Local audit of antenatal care records / Service user surveys	Unknown	See previous sections for comments & recommendations relating to these issues	
EKHUFT	Lifestyle issues are revisited periodically. The Risk Assessment is repeated in a second time during pregnancy and will include social risk factors. Mental health, smoking and drug & alcohol use are reviewed at booking and revisited at subsequent appointments with boxes to note if onward referall is required. The follow up of behaviour change intentions is variable as some midwives question their role in supporting behaviour change and therefore don't always prioritise questions during a busy consultation. Infant feeding discussed at booking with more detailed discussions at 28 weeks and 34 weeks. The quality of these discussions and record keeping isn't always thorough due to lack of clinic time. The Midwife will prioritise questions to ask based on a woman's needs. Information about Domestic Violence is recorded in the Antenatal Summary rather than the notes to protect confidentiality. There is a prompt to conduct a second assessment of domestic abuse and there is an anonymous box in the notes to indicate if the question has been asked and prompt other midwives to ask if the box is blank. Some midwives still feel uncomfortable in asking about DV as they are not always confident in what support they can offer.				
MTW	Continuity of care enables community midwives to build rapport and may provide opportunities to have ongoing discussion about lifestyle issues however there is a lack of prompts to revisit lifestyle behaviours or mental health and wellbeing within the notes. There is however a specific "Antenatal Infant Feeding Checklist" within the notes which will be completed by 34 weeks. This offers opportunities to discuss the benefits of breastfeeding, the importance of skin to skin contact, getting feeding off to a good start and the importance of good attachment. Antenatal colostrum collection is encouraged for all women whose baby may be at risk of hypoglycaemia to avoid the need to use formula.				

AFTER 28 WEEKS GESTATION: UNIVERSAL

Preparation for parenthood

Distribute the Parent's Guide to Money information pack, designed to help expectant parents plan their family finance

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	This leaflet has been discontinued. Community Midwives will work with children's centres to signpost to sources of support as all antenatal appointments are in children's centres. A CAF will be undertaken if appropriate to identify specific vulnerabilities and then Team around the child will be co-ordinated.	Collaborative comparative audit of information provided by each Provider Trust	Unknown		See previous recommendation: The 3 maternity services should work together to review the contents of the leaflets and information provided antenatally and postnatally to identify the most appropriate sources of information and standardise the information and advice available to women across Kent regarding preparation for parenthood & rights and benefits.
EKHUFT	This leaflet has been discontinued. Written information is provided in the notes on employment rights & benefits & these are included in the a checklist of issues for midwives to discuss in relation to plans for pregnancy however this may not always be discussed. Numbers for the Working Families Advice Line and Citizens Advice Bureau are also included in the notes.				
MTW	The Parent's Guide to Money has been discontinued but a leaflet on the Money Advice Service is included in the antenatal pack. A link to the NHS Choices Pregnancy & Baby Care website is included at the back of the notes. This website includes information on Rights and Benefits for parents. In addition the www.pregnancyandchildbirthguide.com website also has a section on "Being Parents" with information on maternity and paternity leave as well as other aspects of preparing for parenthood. Some midwives are still unsure of sources support / advice on financial matters.				

AFTER 28 WEEKS GESTATION: UNIVERSAL

Antenatal review for prospective mother and father with HCP team

Focus on emotional preparation for birth, carer–infant relationship, care of the baby, parenting and attachment, using techniques such as promotional interviewing to:

Provide information on post-natal self care and awareness of "baby blues" and postnatal depression - NICE CG62 Antental Care
– identify those in need of further support during the postnatal period; and
– establish what their support needs are.

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Integral part of antenatal assessment at all visits. Continuity of care with named Community of Midwife will enable changes to be identified. Extra antenatal visits will be offered if a risk is identified to montitor changes. Antenatal classes including Parentcraft and Caring for your Newborn also provide information and support. Health Visitors will also review these issues as part of their antenatal contact.	Local audit of antenatal care records / Service user surveys	Unknown	Health visitors will conduct a Family Health Needs Assessment at first contact, either antenatally where available or on their newborn visit. The aim of this assessment is to assess maternal and infant physical and emotional health and any factors that may influence family dynamics i.e. parenting styles, attachment etc. This assessment is used to determine the level of HV support required ie universal, universal plus or universal partnership plus, and also identify the need for referral for further packages of care where appropriate. However there is potential to develop the midwife role in preparing parents for life with their newborn beyond the provision of parent education classes and in addition to focussing on the physical aspects of pregnancy and birth experiences, especially as HV antenatal visits aren't currently universally available across Kent.	Commissioners and providers should clarify the role of midwives in the provision of parenting advice and support and the pathways for referral for additional support antenatally. Consideration should be given to the training needs of midwives to fulfill this role.
EKHUFT	Brief written information is provided in the maternity notes on postnatal wellbeing and depression. Further information is provided via "The Journey" video and antenatal classes. The Social Assessment can be repeated a 2nd time after booking and the "Concerns and Vulnerability" form can be completed at any time during pregnancy which will enable information on any postnatal support needs to be shared with Health Visitors, GPs etc. Midwives will provide 1to1 support to those with special needs ie learning disability but there is limited capacity for this.				
MTW	By this stage women with vulnerabilities should aready have been identified through a Concerns and Vulnerabilities form with support already in place. C&V forms can be completed and reviewed at any stage of pregnancy. Brief information on postnatal depression is provided in the antenatal notes with contact details for the Association for Postnatal Illness. The "Birth Options / Supervisors of Midwives Clinic" is available to enable pregnant women to discuss their previous experiences of birth 1to1. The www.pregnancyandchildbirthguide.com website provides information on the emotional and physical recovery after birth as well as tips on bonding with your baby. Health Visitors will also review these issues as part of their antenatal contact.				

AFTER 28 WEEKS GESTATION: UNIVERSAL

Inform about sources of information on infant development and parenting, the HCP and Healthy Start.

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DV	Antenatal classes including Parentcraft and Caring for your Newborn provide information and support however this isn't mandatory and is often not attended by those who need it most. There is a wealth of information on the maternity services website but neither this nor other national sources of support are highlighted in the Antenatal Notes. Although Community Midwives promote HealthyStart vitamins there is no direct mention of it in the Antenatal Care Pathway Record and the HealthyStart leaflet is not routinely provided.	Collaborative comparative audit of information provided by each Provider Trust / Survey of services users / National statistics on Healthy Start uptake - may not still be monitored?	Unknown	Variation in the promotion of the Healthy Start programme and provision or signposting to sources of information on infant development and parenting.	See previous recommendation: The 3 maternity services should work together to review the contents of the leaflets and information on these subjects to identify the most appropriate sources of information and standardise the information and advice available to women across Kent. Heads of Midwifery should ensure that all women receive information on the Healthy Start Programme antenatally.
EKHUFT	The Healthy Start leaflet is included with the notes at booking. Information on infant development and parenting is limited as the ongoing development of the baby is seen as a role for Health Visitors, the midwifery focus is on health and wellbeing in pregnancy and immediately after birth. Details of the NHS Information Service for Parents website are provided in the notes and most midwives will signpost women to these sources of advice. Health Visitors will also review these issues as part of their antenatal contact.				
MTW	There is a lack of information provided on infant development and parenting and the Healthy Start leaflet is not included with the booking notes. A link to the NHS Choices pregnancy and babycare website is provided on the back of the notes which includes a Birth to Five Development Timeline and intereactive parenting tool. The www.pregnancyandchildbirthguide.com website also has a section on "Being Parents" with information on many aspects of parenthood. Midwives are currently working with Maternity Services Liaison Committee to restructure the mtw.nhs.uk/maternity website and include women-centred information. Update with information on parentcraft classes. Health Visitors will also review these issues as part of their antenatal contact.				

AFTER 28 WEEKS GESTATION: UNIVERSAL

Distribute newborn screening leaflet.

Provide information on vitamin K Prophylaxis - NICE CG62 Antenatal Care

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	This leaflet is distributed at booking. A specific leaflet on Vitamin K prophylaxis is provided when this issue is discussed.	Local audit of antenatal care records / Service user surveys	Unknown	No signficant gaps	
EKHUFT	The leaflet is included with the Pregnancy Notes at booking, there is also extensive written information within the notes about all aspects of prenatal screening, blood tests and investigations and scans. Midwives will refer back to the leaflet when discussing newborn screening postnatally. This national leaflet is due to be updated in Sept/Oct				
MTW	The leaflet is included with the Pregnancy Notes at booking. There is a specific section to record choices regarding Vitamin K prophylaxis in the Birthing Plan.				

AFTER 28 WEEKS GESTATION: UNIVERSAL

Provide information in line with Department of Health guidance on reducing the risk of sudden infant death syndrome (SIDS)

Advice about sleeping position, smoking, co-sleeping, room temperature and other information in line with best evidence

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	A cot death leaflet (either Lullaby Trust or Foundation for Study of Infant Death) is distributed to every mother postnatally with advice reinforced by th midwife during their postnatal visits. There is no prompt to discuss this antenatally in the Antenatal Care Record.	Local audit of postnatal records or discharge notes / Local analysis of infant mortality data (SUDI deaths)	Unknown	No routine information or discussion of SIDS antenatally	Heads of Midwifery should ensure that all midwives facilitateA discussion on strategies to reduce the riskon the risks of sudden infant death syndrome and risk reduction strategies should take place antenatally along with the provision of written information.
EKHUFT	There is no specific information or prompt to discuss the risk factors for SIDS in the pregnancy notes. Midwives give out the Lullaby Trust "Safer Sleep for Babies" leaflet on discharge and a link to the Infant Sleep Information Service is included in the Postnatal Information Leaflet provided on discharge. This information should be supported by a discussion with the parents but there isn't always time if the ward is busy. Community midwives should reiterate the advice on postnatal home visits.				
MTW	There is no specific information or prompt to discuss the risk factors for SIDS antenatally. The Lullaby Trust "Safer Sleeping" leaflet is distributed to every mother postnatally and reinforced with a discussion of the 6 specific risk factors which is documented in the discharge documentation.				

AFTER 28 WEEKS GESTATION: UNIVERSAL

Distribute and introduce Personal Child Health Record

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	The Personal Child Health Record (Red Book) is distributed postnatally. There are administrative issues as the correct book must be provided i.e. Kent residents must receive Kent books - difficult with cross-border deliveries.	Local audit	Unknown	No significant gaps in the provision of the Personal Child Health Record	
EKHUFT	The Personal Child Health Record (Red Book) is given to parents immediately after birth whilst they are on the labour ward and goes home with the women. Given to Mums at home if having a homebirth.				
MTW	The Personal Child Health Record (Red Book) is distributed postnatally on the ward.				

BIRTH UP TO 1 WEEK: UNIVERSAL

Infant feeding

- Initiate as soon as possible (within one hour of delivery) using support from healthcare professional, or peer unless inappropriate;

It is not recommended that women are asked about their proposed method of feeding until after first skin to skin contact - NICE CG37 Postnatal Care

- 24-hour rooming-in and continuing skin-to-skin contact where possible (for at least an hour after birth - NHS Breastfeeding Care Pathway / WHO & UNICEF Best Practice for Hospital and community care settings)
- Ongoing, consistent, sensitive, expert support about infant positioning.
- Provide information about the benefits of colostrum and timing of first breastfeed.
- Support should be culturally appropriate and should include both parents.

Adequate rest for women without interruption caused by hospital routine & access to food & drink on demand - NICE CG37 Antenatal Care

Separation of the woman from the baby in the first hour eg for weighing, measuring and bathing, should be avoided unless clinically necessary - CG37 Antenatal Care

Written information on breastfeeding as a separate intervention is not recommended - NICE CG37 Postnatal Care

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	The Trust has achieved Stage 1 BFI - and is working towards Stage 2. The Infant Feeding Guidelines have recently been updated and include all the recommendations listed above. There are also a number of flowcharts for support in specific circumstances including; the care of healthy breastfeeding newborns, reluctant feeders and infants admitted with feeding problems.	Breastfeeding Initiation & Continuation rates / Local audit of Postnatal Care Reords / Local audit of ward environment & practices	See table for 28 Weeks Universal for data on current breastfeeding rates by provider and CCG	No significant gaps	
EKHUFT	24 hr rooming in is supported and early skin to skin contact. Maternity care support workers can provide breastfeeding support for mothers on the ward and some midwives trained as lactation consultants. Volunteer Breastfeeding Peer Supporters also attend wards their role is more to raise awareness of the community support services available than provide direct support to women on the ward. Information on colostrum and timing of first feed provided on the labour ward. Fathers are included in all discussions when they are present on the ward. Wards can be noisy and crowded which can make it difficult to rest and establish breastfeeding.				
MTW	Women are encouraged to have skin to skin contact in the first hour. 24 hour rooming in for babies with facilities for fathers to stay in single rooms. The Trust also run a number of positive initiatives, which are ongoing, to support breastfeeding mothers, including; Breast Buddies (peer supporters) frequently visit Tunbridge Wells maternity unit to provide support and advice to mums, a mix of specialist led drop-in breastfeeding clinics & peer supporter groups are run at various venues across the locality. A new tongue tie clinic has been introduced at Tunbridge Wells Hospital to ensure babies with tongue-tie can be treated as quickly as possible. MTW are also currently involved in a study looking at women who find it hard to breastfeed i.e after Caesarean Section. Looking at impact of Kangaroo Care on breastfeeding, maternal attachment, baby development etc . Results should be available by end of year. Previously published 1st UK study on use of Kangaroo Care in postnatal wards for premature babies - published 2011.				

BIRTH UP TO 1 WEEK: UNIVERSAL

Use the Baby Friendly Initiative or a similar evidence-based best practice programme to promote breastfeeding.

All Hospitals should have a breastfeeding policy with a lead healthcare professional responsible for overseeing implementation - NICE CG37 Postnatal Care

Provide guidance on baby-led feeding - NHS Breastfeeding Care Pathway / WHO & UNICEF Best Practice for Hospital and community care settings)

Midwives should assess the mothers breastfeeding skills and babys feeding technique and give feedback to the mother - NHS Breastfeeding Care Pathway / WHO & UNICEF Best Practice for Hospital and community care settings)

Mothers & fathers of infants in neonatal care should be offered kangaroo care as soon as baby's condition allows - NHS Breastfeeding Care Pathway / WHO & UNICEF Best Practice for Hospital and community care settings)

All mothers should be shown how to hand express milk & how to correctly store or freeze it - NHS Breastfeeding Care Pathway / WHO & UNICEF Best Practice for Hospital and community care settings)

Breast pumps should be freely available to all women in hospital and women should be offered instructions on how to use it - NICE CG37 Postnatal Care

Teats or dummies should not be offered to babies during the establishment of breastfeeding & no other food or drink should be offered to baby unless clinically indicated - NHS Breastfeeding Care Pathway / WHO & UNICEF Best Practice for Hospital and community care settings)

Peer support should be offered within 48hrs of transfer home - NHS Breastfeeding Care Pathway / WHO & UNICEF Best Practice for Hospital and community care settings)

Peers supporters should attend accredited training programme, gain child protection clearance, offer needs-based support either face to face, via telephone or via local groups, have accesss to a health professional to seek advice - NICE PH11 Maternal & Child Nutrition

Provide contact details for breastfeeding support services - NHS Breastfeeding Care Pathway / WHO & UNICEF Best Practice for Hospital and community care settings)

Midwives / Health Visitors should assess the parents' breastfeeding experience & offer advice (including indicators of good attachment, positioning and successful feeding) and document this in the postnatal care plan at every contact - NHS Breastfeeding Care Pathway / WHO & UNICEF Best Practice for Hospital and community care settings)

Women should be offered reassurance and advice on appropriate treatment if the following breastfeeding concerns are identified; nipple pain, engorgement, mastitis, inverted nipples, ankyloglossia (tongue tie), sleepy baby - NICE CG37 Postnatal Care

Fathers & partners should be given the opportunity to discuss infant feeding with the midwife / Health Visitor - NHS Breastfeeding Care Pathway / WHO & UNICEF Best Practice for Hospital and community care settings)

Avoid promoting infant formula or follow-up. Commercial packs containing infant formula or advertisements for infant formula should not be distributed - NICE CG37 Postnatal Care ? Check contents of Bounty Pack?

If supplementary feeds are necessary expressed breast milk should be provided, supplementation with fluids other than breast milk is not recommended - NICE CG37 Postnatal Care

Breastfeeding women who want advice on formula feeding should be offered it - NICE CG37 Postnatal Care

Advise that a healthy diet & regular moderate activity is important and that she doesn't need to modify her diet to breastfeed - NICE PH11 Maternal & Child Nutrition

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	SEE ABOVE - The Infant Feeding Guideline complies with all NICE Guidance listed above. Community midiwives use a breastfeeding assessment form to assess feeding on postnatal visits and record an action plan where appropriate. A Breastmilk Donor Bank is not available locally although this isn't an HCP or NICE Guideline requirement.	See above	See table for 28 Weeks Universal for data on current breastfeeding rates by provider and CCG	There is significant variation in access to tongue-ties services across Kent. See "Birth to 1 Week Progressive" for comments and recommendation regarding this issue	

BIRTH UP TO 1 WEEK: UNIVERSAL

Use the Baby Friendly Initiative or a similar evidence-based best practice programme to promote breastfeeding.

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
EKHUFT	The service has achieved BFI Stage 1 and is planning to go for Stage 2 - awaiting an update from infant feeding co-ordinator on assessment visit timing. The Infant Feeding Co-Ordinator is responsible for overseeing the implementation of the Breastfeeding Policy. Midwives are encouraged to undertake a feeding assesssment on every shift and every visit. Stickersare used to document the assessment in mothers' notes Kangaroo care is promoted in NICU. Midwives will discuss hand expressing techniques antenatally but mothers do not necessarily receive direct instruction on hand expressing milk postnatally. Breast pumps are freely available and the use of teats or dummies is discouraged during the establishment of breastfeeding. Peer Supporters attend the ward to provide information on support available in the community and the discharge leaflet contains details of all the local support groups in the childrens centres. Midwives are encouraged to assess breastfeeding technique on every shift or visit, this will include providing advice regarding any breastfeeding concerns. The local tongue tie service is not currently fully resourced. The Infant Feeding Co-Ordinator is currently undertaking a needs assessment to inform recommendations for commissioning this service. Midwives don't necessarily make a conscious effort to discuss bfeeding with every father but will involve them in discussions if they are present. Infant formula is not promoted or advertised and women who intend to bottle feed are asked to bring in their own supplies of formula. There is no donor breastmilk bank so formula is provided if women unable to breastfeed but these are kept locked in a cabinet, and its use is documented. Midwives are advised to provide information on healthy diet and exercise as part of the Postnatal Care Plan.	See above	See table for 28 Weeks Universal for data on current breastfeeding rates by provider and CCG	There is significant variation in access to tongue-ties services across Kent. See "Birth to 1 Week Progressive" for comments and recommendation regarding this issue	
MTW	The Trust is at BFI pre-implementation stage having received an updated Certificate of Commitment following an assessment visit in September. The Infant Feeding Lead will establish a BFI Strategy Committee and Implementation Group with the aim of achieving Stage 1 by March 2015. Midwives provide guidance on babyled feeding and 40% of midwives trained in assessing breastfeeding technique. A "Reluctant Feeder Advice Sheet" is provided in all postnatal rooms. Mothers are shown how to hand express milk and breast pumps are freely available on the ward. Breastfeeding peer supporters regularly visit the ward on the ward to ensure all women know how to access peer support and there are ward-based breastfeeding clinics. An Infant Feeding Care Plan is included in the Postnatal Care Record to formally record the provision of this information/support. This Care Plan is reviewed and an action plan devised before discharge. A leaflet with details of all breastfeeding support groups is included in the postnatal discharge pack. Milk kitchens and 1to1 bottle feeding demonstrations are provided for mothers formula feeding. A no teats or dummies policy is generally followed but there is occasional resistance from mothers. There is no infant formula promotion & mothers have to bring in formula and bottles if they wish to formula feed. Infant formula is kept on the ward for urgent need but this is locked away. There is no specific prompt to discuss breastfeeding with fathers postnatally although fathers are likely to be present during the discussion of the Infant Feeding Care Plan.				

BIRTH UP TO 1 WEEK: UNIVERSAL

Provide information about local support groups.

Advise women who leave hospital soon after birth that this should not impact on breastfeeding duration - NICE CG37 Postnatal Care

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Discharge planning is individually lead so the support offered is tailored to each family. Breastfeeding Peer Supporters attend the postnatal wards to provide support and details of local breastfeeding support groups are provided in the postnatal information pack.	Local audit of postnatal care records / Local survey of women's awareness of infant feeding support	Unknown	No significant gaps	
EKHUFT	Yes see above included in the Postnatal Information Leaflet and Peer Supporters attend the ward to make contact with new mothers.				
MTW	See above				

BIRTH UP TO 1 WEEK: UNIVERSAL

Parents and carers who feed with formula should be offered appropriate and tailored advice on safe feeding

Advice should include; how to make up feeds correctly, how to clean & sterilise bottles and teats and how to store formula milk - NICE CG37 Postnatal Care

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	The infant feeding guidelines includes the support to be provided for women who choose to formula feed which complies with NICE Guidance. An Infant Feeding Room is available for mothers & fathers to make up feeds and learn how to sterilise equipment for formula or breastmilk.	See aboveLocal audit of postnatal care records / Local survey of parents' experience	Unknown	No significant gaps	
EKHUFT	Midwives will discuss this with a mother and provide a leaflet with diagrams but they don't necessarily provide a demonstration unless the woman has specific needs.				
MTW	Parents are provided with 1to1 instruction on making up and storing feeds and a milk kitchen is available where both parents can practice.				

BIRTH UP TO 1 WEEK: UNIVERSAL

Provide information on vitamin supplements and Healthy Start.

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	This is not routinely promoted by midwives postnatally as it is seen as a role for the Health Visitor to follow up on their initial visit although the Healthy Start Leaflet will be distributed postnatally.	Local survey of parents' awareness of vitamin supplements and the Healthy Start scheme / National statistics on Healthy Start uptake if still be monitored?	Unknown	Potential to include a discussion or information on the HealthyStart Programme as part of postnatal care planning and discharge checklist.	Heads of Midwifery should ensure that all women receive the Healthy Start Leaflet postnatally
EKHUFT	Discussed antenatally and information leaflet provided. This is not currently routinely revisited postnatally as it is seen as a role for health visitor to follow up.				
MTW	The Healthy Start leaflet is not routinely included in the postnatal discharge pack.			Lack of promotion of the Healthy Start Programme either antenatally or postnatally. Potential to include a discussion or information on the HealthyStart Programme as part of postnatal care planning and discharge checklist.	

BIRTH UP TO 1 WEEK: UNIVERSAL

Provide information and advice to fathers, to encourage their support for breastfeeding.

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Fathers are able to be present 24/7 and are therefore encouraged to support feeding sessions whilst there is no information/advice specifically targeted for Fathers they are welcome at every contact or session.	Local survey of fathers' experience	Unknown	Potentially missed opportunity to specifically address any concerns fathers may have regarding their partner breastfeeding and engage them in promoting and supporting their partner to breastfeed.	Heads of Midwifery should collaborate to identify further opportunities to provide breastfeeding information specifically for fathers and to encourage them to provide breastfeeding support to their partners.
EKHUFT	"The Journey" antenatal class and online film will provide information on breastfeeding and fathers will be involved in discussion postnatally if they are on the ward but there is no information or advice specifically tailored to fathers.				
MTW	Single rooms enable fathers to stay with mothers and infants and so midwives have more opportunity to discuss breastfeeding with fathers postnataly. Fathers are also encouraged to get involved in Kangaroo care. The service ran the "Man up" campaign to increase breastfeeding awareness and support amongst fathers last year but there is no routine information/advice specifically targeted for fathers.				

BIRTH UP TO 1 WEEK: UNIVERSAL

Health Promotion

Distribution of Personal Child Health Record, if not already done antenatally

A discussion of emotional well-being (including changes in mood or behaviour that are outside of a woman's normal pattern), the family and social support available & their usual coping strategies should take place at every postnatal contact - NICE CG37 Postnatal Care

Encourage women to look after their mental health by taking gentle exercise, time to rest, getting help with looking after the baby and talking to someone about their feelings - NICE CG37 Postnatal Care

Methods and timing of the resumption of contraception should be discussed within the first week of birth

All healthcare professionals should maintain awareness of the risks, signs and symptoms of domestic abuse and know who to contact for advice and management - NICE CG37 Postnatal Care

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	The child health record is always distributed postnatally. Community midwives will discuss and review a mothers wellbeing during their postnatal home visits as well as assess their social support networks. Contraception methods are discussed at postnatal discharge and followed up in the community. Risk assessment for DV is continuous including on home visits.	Local audit of postnatal care records / local survey of womens' experiences	Unknown	No significant gaps	
EKHUFT	The Personal Child Health Record (Red Book) is given to parents immediately after birth whilst they are on the labour ward and goes home with the women or g iven to Mums at home if having a homebirth. An assessment of mothers' emotional wellbeing and support networks is undertaken on the postnatal ward and on community visits (included in Postnatal Care Plan). Advice on self care, exercise and mental health symptoms to look out for is provided in the Postnatal Care Plan and information is provided in the Postnatal Information Leaflet. There is a prompt to provide advice on contraception on the discharge checklist and details of contraceptive clinics are included on the Postnatal Information Leaflet. They will also be advised to discuss contraception at their 6-8 week check with their GP. Midwives liaise closely with sexual health outreach workers antenatally and postnatally during the care of teenage women and therefore there is more opportunity to discuss contraception for this group.				

BIRTH UP TO 1 WEEK: UNIVERSAL

Health Promotion

Distribution of Personal Child Health Record, if not already done antenatally
A discussion of emotional well-being (including changes in mood or behaviour that are outside of a woman's normal pattern), the family and social support available & their usual coping strategies should take place at every postnatal contact - NICE CG37 Postnatal Care
Encourage women to look after their mental health by taking gentle exercise, time to rest, getting help with looking after the baby and talking to someone about their feelings - NICE CG37 Postnatal Care
Methods and timing of the resumption of contraception should be discussed within the first week of birth
All healthcare professionals should maintain awareness of the risks, signs and symptoms of domestic abuse and know who to contact for advice and management - NICE CG37 Postnatal Care

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
MTW	The Child health record is distributed immediately after birth. Brief information on postnatal depression is provided in the antenatal notes with contact details for the Association for Postnatal Illness. An "Early Days" leaflet is distributed postnatally with information on the baby blues, potential complications for mother and baby, healthy eating and taking medicines when breastfeeding and information on domestic abuse. General contraception advice provided. A leaflet on exercise following childbirth is also distributed. Community midwives will discuss maternal health and emotional wellbeing which will be documented in the discharge summary. An update on Concerns & Vulnerabilities will be completed & documented as part of discharge from hospital to community care and again on discharge from maternity care to HVs. All midwives receive training in the signs of domestic abuse and are always aware for signs of DV. Women at risk of DV are often picked up in the antenatal period and it is rare for it to be discovered postnatally.	Local audit of postnatal care records / local survey of womens' experiences	Unknown	No significant gaps	

BIRTH UP TO 1 WEEK: UNIVERSAL

Distribution of Birth to Five to all mothers (within 3 days of giving birth - NICE CG37 Postnatal Care)

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	This information leaflet is no longer available. All mothers are provided with a Postnatal Discharge Booklet which includes a wealth of local information including; reducing the risk of SIDS, travel safety, baby bathing, postnatal exercises and postnatal health issues including signs of sepsis & postnatal depression. This is booklet is currently being revised.	Collaborative kent-wide comparative audit of postnatal information provided by each Provider Trust / Survey of parent's knowledge of these issues	Unknown		See previous recommendation regarding maternity provider collaboration to review all information provided postnatally and antenatally to standardise the information available to parents.
EKHUFT	Not currently available. A variety of leaflets and signposts to online information are provided on discharge.				
MTW	This leaflet is not currently available. A variety of leaflets and signposts to online information are provided on discharge and it is expected that HVs will follow this up.				

BIRTH UP TO 1 WEEK: UNIVERSAL

Injury prevention

All home visits should be used as an opportunity to assess relevant safety issues and promote safety education - NICE CG37 Postnatal Care

Healthcare professionals should promote the correct use of basic safety equipment such as infant seats and smoke alarms - NICE CG37 Postnatal Care

Healthcare professionals should facilitate access to local schemes for provision of safety equipment - NICE CG37 - Postnatal Care

Healthcare professionals should be alert to risk factors & signs and symptoms of child abuse and follow local child protection policies where concerns are identified - NICE CG37 Postnatal Care

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	The postnatal booklet contains information on safe bed sharing and travel safety. Community midwives will assess and promote safety at all home visits and be alert to signs of child abuse. CO monitors are available from the local Fire Brigade.	Local audit of postnatal records / Audit of A&E attendances by children <1	Unknown	No significant gaps	
EKHUFT	Midwives usually undertake one antenatal home visit and will provide guidance on buying safety equipment and installing car seats there is also a prompt to discuss a safe home environment and equipment as part of the Plans for Pregnancy section of the antenatal notes. Postnatally midwives are prompted to have a provide information on safe practices such as car seats, cot mattresses, smoking and animals during home visits (see Postnatal Care Plan). All midwives recieve regular training on spotting the signs of child abuse and local child protection procedures.			No significant gaps	
MTW	Injury prevention is seen primarily as a role for HVs as there are limited opportunities to discuss this antenatally. There is no prompt to discuss this postnatally in the Postnatal Care Record however midwifes would raise concerns if they witnessed unsafe practice/equipment during home visits.			Potential missed opportunity to enable parents to start planning a safe environment during the antenatal period. Midwives could use home visits to provide information on safe practices such as car seats, cot mattresses, smoking and pets during home visits. Further information is required on the role of HV in injury prevention postnatally as this wasn't available at the time of writing	The Head of Midwifery for MTW should review the postnatal provision of information on injury prevention and ensure midwives take the opportunity to review the safety of the home environment and provide appropriate safety advice on home visits.

BIRTH UP TO 1 WEEK: UNIVERSAL

Maintaining infant health

Anticipatory, practical guidance on reality of early days with an infant, healthy sleep practices and bath, book, bed routine to increase parent–infant interaction, using a range of media (e.g. Baby forums)

At each postnatal contact parents should be offered information and advice on assessing their babies general condition, how to identify signs and symptoms of common health problems in babies - NICE CG37 Postnatal Care

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Detailed advice on safe sleeping practices and how to bath your paper is included in Postnatal Discharge Booklet. Although detailed information on health concerns for both mother and infant are included as an appendix to the "Postnatal Care Plannig and Information Guidelines" this information is not incorporated into the Postnatal Discharge Booklet and it is unclear if this information is provided elsewhere	Collaborative kent-wide audit of postnatal information provision / Local survey of parents' experiences	Unknown	No significant gaps	
EKHUFT	Midwives provide general information and advice about the health of the newborn. Midwives will discuss reality of early days with an infant to help parents come to terms with new responsibilites, safe sleeping.				
MTW	Parentcraft sessions enable midwives to discuss the realities of having a baby with prospective parents. The "Early Days" leaflet also provides information on potential health problems for the mother and baby. The Community Midwife will also provide suppport and reassurance new parents during home visits. A link to the NHS Choices website which includes a Birth to Five Development Timeline and intereactive parenting tool is also included in the antenatal notes. A link to the Cry-sis helpline is provided in the antenatal notes and to provide reassurance to parents. The Trust is currently participating in an NSPCC study on coping with crying and provide a DVD to every family with tips on coping with crying (aimed at preventing shaken baby syndrome), the study runs to Oct 2015.				

BIRTH UP TO 1 WEEK: UNIVERSAL

Birth experiences

Provide an opportunity for the father, as well as the mother, to talk about pregnancy and birth experiences, if appropriate BUT NICE CG37 says a formal debriefing about birth experiences is not

Provide information and assurance on physiological recovery after birth, common health concerns & normal patterns of emotional changes in the postnatal period - NICE CG37 Postnatal Care

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Parents are offered debriefing at the bedside and in the community. They are also provided with contact details of the Birth Debriefing Service. Information on physiological & emotional recovery after birth is included in the Postnatal Information Leaflet.	Local audit of postnatal care records / Survey of parents' experiences / Local evaluation of birth debriefing services	Unknown	No significant gaps	
EKHUFT	The Postnatal Careplan recommends that mothers should be asked about their birth experience whilst on the ward and when visited in the community. Examination and discussion of the woman's physiological and mental wellbeing is also included. Information on recovery after birth and signs and symptoms to look out for, including emotional changes,is provided in the Postnatal Information Leaflet and should be discussed as part of the Postnatal Care Plan. A "Birth Afterthoughts Service" is available to all women via self referral at any stage to discuss experiences and ask questions. A leaflet about this service is provided on discharge. The service is midwife led but does not involve counselling, if problems are identified there may be onward referral to counselling or paediatrics. Feedback from the "Birth Afterthoughts Service" to individual members of staff offers midwives the opportunity to reflect on their practice.				
MTW	Community midwives will discuss birth experiences as part of home visits. If it has been an exceptionally difficult birth women will be provided with 1to1 follow up. The pregnancyandchildbirthguide.com website is signposted in the antenatal welcome leaflet and this provides information on physical and emotional recovery after childbirth. The "Early Days" leaflet, distributed postnatally, also includes information on physical and mental wellbeing.				

BIRTH UP TO 1 WEEK: UNIVERSAL

Promoting sensitive parenting

Introduce parents to the 'social baby', by providing them with information about the sensory and perceptual capabilities of their baby using a range of media (e.g. The Social Baby book/video (Murray and Andrews, 2005) or Baby Express age-paced newsletters) or validated tools (e.g. Brazelton or Nursing Care Assessment Satellite Training – NCAST).

Assess emotional attachment at each postnatal contact and home visits should be used as an opportunity to promote parent to baby emotional attachment - NICE CG37 postnatal care

Group-based parent-training programmes should be available to parents who wish to access them - NICE CG37 Postnatal Care

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Midwives rarely have the opportunity to formally assess emotional attachment as their contact with mothers is limited. This is regarded as a role for Health Visitors. Midwives will talk about newborn baby reflexes and how they help protect the baby.	Local audit of postnatal care records / Survey of parents' experiences	Unknown	Health visitors will conduct a Family Health Needs Assessment at first contact, either antenatally where available or on their newborn visit. This assessment includes any factors that may influence family dynamics i.e. parenting styles, attachment etc. This assessment is used to determine the level of HV support required ie universal, universal plus or universal partnership plus, and also identify the need for referral for further packages of care where appropriate. Whilst some midwives will also assess emotional attachment as part of their programme of home visits, the opportunities to do this are limited and many do not currently feel well equiped to provide routine assessment of emotional attachment and discuss babies development in the early days.	Commissioners and providers should clarify the role of midwives in the provision of parenting advice and assessment of emotional attachment and the pathways for referral for additional support postnatally. Consideration should be given to the training needs of midwives to fulfill this role.
EKHUFT	The Postnatal Careplan suggests midwives should assess the mothers relationship with her baby during her stay in hospital and on home visits. There is also a prompt to provide information on the "Social Baby" whilst on the ward and when back at home. However in reality emotional attachment is rarely formally assessed as midwives have limited contact with mother and baby. Midwives would look out for signs of detachment or indifference and may liaise with the health visitor to discuss concerns. A link to the NHS Choices website which includes a Birth to Five Development Timeline and intereactive parenting tool is included in the Postnatal Information Leaflet.				
MTW	Community midwives will address this as part of programme of home visits but will usually only see families a maximum of 3 times therefore opportunity is limited. Midwife will pass on concerns re attachment and parenting to HV to follow up or send a Band 3 Support Worker to provide additional support and advice ie breastfeeding, attachment. If midwives feel women have many needs they will be seen more than 3 times. A link to the NHS Choices website which includes a Birth to Five Development Timeline and intereactive parenting tool is also included in the antenatal notes.				

BIRTH UP TO 1 WEEK: UNIVERSAL

Promote closeness and sensitive, attuned parenting, by encouraging skin-to-skin care and the use of baby carriers

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Skin to skin care is promoted on the ward and in the home.	Local audit of the promotion of skin to skin care on wards / Local survey of parents' experiences	Unknown	No significant gaps	
EKHUFT	Skin to skin care is promoted from birth on the wards but midwives could probably do more to promote it longer term at home visits. Midwives don't actively promote baby carriers may recommend them if babies won't settle. Kangaroo care is promoted on all neonatal wards.				
MTW	MTW is currently one of the leading trusts in the country for promoting Kangaroo Care and encouraging skin to skin care. Clear advantages already being seen with term as well as premature babies.				

BIRTH UP TO 1 WEEK: UNIVERSAL

Provide information and support to fathers, as well as mothers, that responds to their individual concerns and involves active participation with, or observation of, their baby – over several sessions, if possible.

Both parents should be encouraged to be present during any physical examination to promote participation of both parents in the care of their baby - NICE CG37 Postnatal Care

Provide information on the availability of postnatal peer, statutory & voluntary groups and organisations within their local community - NI CE CG37 Postnatal Care

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Fathers have 24/7 access to the postnatal ward and are encouraged to be involved in the care of the infant from the outset.	Local survey of parent's experiences	Unknown	No significant gaps	
EKHUFT	There are prompts in the Postnatal Careplan to promote participation of fathers in parenting and support whilst on the ward and during home visits. Midwives will routinely ask both mothers and fathers about their concerns and provide advice and information as appropriate. Both parents are also encouraged to be present at blood tests or physical examinations.				
MTW	Dads are encouraged to stay overnight with new Mums so have many opportunities to interact and be involved and speak to midwives about concerns.				

BIRTH UP TO 1 WEEK: UNIVERSAL

Hearing screening

Newborn hearing screening soon after birth (up to four weeks if a hospital-based programme, and five weeks if community-based).

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	This is done at bedside or followed up by newborn screeners in the home if early discharge or a homebirth.	NHS Screening KPI NH1 / NH2 - Newborn Hearing Screening	See section on findings from interview with K&M Screening & Immunisations Lead for current performance data, comments and recommendations		
EKHUFT	Usually done in hospital before discharge or newborn screeners will follow it up at home.				
MTW	This is done at bedside or followed up by newborn screeners in the home if early discharge or a homebirth.				

BIRTH UP TO 1 WEEK: UNIVERSAL

SIDS

Reduction of the risk of SIDS – advice about sleeping position, smoking, co-sleeping, room temperature and other information in line with best evidence

Safer infant sleeping should be discussed at every postnatal contact - NICE QS37 Postnatal Care

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Families routinely receive the Lullaby Trust information leaflet on SIDS as standard and detailed information about reducing the risk of SIDS is included in the Postnatal Discharge Leaflet. Individual SIDS risk assessment are conducted on postnatal visits - opportunity to pick up additional risks eg sofa sleeping, bedroom temperature etc. Risk reduction will be discussed at all postnatal visits. The CONI (Care of the Next Infant) scheme is being reintroduced locally. This Health Visitor lead scheme supports families who have experienced SIDS before and after the birth of their new baby.	Local audit of postnatal records or discharge notes / Local analysis of infant mortality data (SUDI deaths)	Unknown	See "Birth to One Week Progressive for comments on access to the CONI scheme	
EKHUFT	Midwives give out the Lullaby Trust "Safer Sleep for Babies" leaflet on discharge and a link to the Infant Sleep Information Service is included in the Postnatal Information Leaflet provided on discharge. This information should be supported by a discussion with the parents but there isn't always time if the ward is busy. Community midwives should reiterate the advice on postnatal home visits but do not always get the chance to assess babies sleeping position.			No significant gaps	
MTW	The Lullaby Trust "Safer Sleeping" leaflet is distributed to every mother postnatally and reinforced with a discussion of the 6 specific risk factors which is documented in the discharge documentation. This is also revisited by the community midwife on home visits.			No significant gaps	

BIRTH UP TO 1 WEEK: UNIVERSAL

By 72 hours

Comprehensive newborn physical examination to identify any anomalies that present in the newborn. This includes screening of the eyes, heart and hips (and the testes for boys), as well as a general physical examination

The examination should incorporate a review of parental concerns, the baby's medical history including; family, maternal, antenatal and perinatal history - NICE CG37 Postnatal Care

Where a woman is discharged from hospital before the physical examination has taken place, fail-safe arrangements should be in place to ensure that the baby is examined.

The aims of any physical examination and the results should be fully explained to parents and recorded in both the postnatal care plan and personal child health record - NICE CG37 Postnatal Care

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Most acute and community midwives are trained to perform the newborn examination so this is predominantly done by midwives but if the baby is considered high risk the assessment will be carried out by a Paediatrician. Results recorded in both the postnatal care plan and child health record. Parents encouraged to be present at every examination.	NHS Screening KPI NP1 / NP2 Newborn & Infant Physical Examination	See section on findings from interview with K&M Screening & Immunisations Lead for current performance data, comments and recommendations		
EKHUFT	The system for undertaking the newborn physical examination is well established but the failsafe system to ensure every baby is examined either in the ward or at home needs development to ensure it is water tight.				
MTW	A significant number of midwives are trained to complete the newborn examination therefore no known problems with coverage				

BIRTH UP TO 1 WEEK: UNIVERSAL

Following identification of babies with health or developmental problems: early referral to specialist team; advice to parents on benefits that may be available; and invitation to join parent

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Referral pathways have been implemented according to national newborn screening programme protocols.	Audit of postnatal maternity records / Audit of referral to specialist services	Unknown	No significant gaps	
EKHUFT	Midwives will discuss issues with specialists antenatally if identified early or will refer to specialist services as soon as they are identified. There is currently no routine system for notifying midwives about fetal anomalies picked up later postnatally. This would give maternity staff and sonographers a chance to reflect on if there was something they could have picked up antenatally.				Refer issue to John Rodriguez / Trish Dabrowski
MTW	There are clear and effective referral pathways for babies identified with health issues via screening.				

BIRTH UP TO 1 WEEK: UNIVERSAL

Additional support and monitoring, as assessed by health professional.

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Community Midwives normally undertake 3 postnatal visits. Visits can be extended or provide more if additional support is appropriate. This would usually be done in collaboration with a Senior Midwife.	Audit of community maternity records	Unknown	No significant gaps	
EKHUFT	See above				
MTW	See above				

BIRTH UP TO 1 WEEK: UNIVERSAL

At five to eight days (ideally five)

Screening for hypothyroidism, phenylketonuria, haemoglobinopathies and cystic fibrosis+ Screening for medium chain acyl-coA dehydrogenase deficiency (MCADD)

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	This is conducted in the home. Uptake is generally high and if parents decline a test there is onward discussion of advantages and disadvantages.	NHS Screening KPI NB1 / NB2 / NB3 - Newborn blood spot screening	See section on findings from interview with K&M Screening & Immunisations Lead for current performance data, comments and recommendations		
EKHUFT	Screening Co-Ordinator in post and systems are working well. There are a high number of requests for avoidable repeat tests due to testing error. Re-doing the test is costly and can be stressful. This has been a long-standing problem which has been difficult to resolve.				
MTW	This is predominantly undertaken in the community with midwives and support workers trained to do bloodspot testing. There are some issues with avoidable repeats as in other areas.				

BIRTH UP TO 1 WEEK: UNIVERSAL

Ongoing review and monitoring of baby's health, to include important health problems, such as weight loss.

Babies should be weighed at birth & in the first week as part of an overall assessment of feeding - health professionals and support staff should receive training on how to weigh infants accurately - NICE PH11 Maternal & Child Health

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Babies weighed at birth and in the first week as part of the home visit. Community midwives will also complete an infant feeding assessment. The Infant Feeding Guidelines include a pathway for babies who have >10% weight loss which may involve referral to Paediatric services.	Local audit of community maternity records	Unknown	No significant gaps	
EKHUFT	Babies are weighed at birth and a number of times in the community before discharge. A baby with significant weight loss would be referred to a Paediatrician.				
MTW	A review of feeding method is included as part of the transfer of care to Community Midwives. Babies are weighed at birth and then at 10 days. Guidelines are in place for the management of babies with significant weight loss.				

BIRTH UP TO 1 WEEK: UNIVERSAL

Administration of vitamin K in accordance with protocol.

If parents decline intramuscular vitamin K, oral vitamin K should be offered as a second-line option - NICE CG37 Postnatal Care

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Vitamin K is offered via IM injection or orally. Most parents choose the injection. Midwives will discuss the risks and benefits of Vitamin K with parents antenatally and again with parents who decline Vitamin K. The safeguarding route can be pursued in rare circumstances when administration is in the best interests of a child at high risk.	Local audit of postnatal maternity records	Unknown	No significant gaps	
EKHUFT	Administration of Vitamin K is discussed antenatally and offered to all babies orally or by injection. Uptake is high.				
MTW	The administration of Vitamin K is discussed antenatally as part of the birth plan. Vitamin K is offered via IM injection or orally there are increasing numbers of parents requesting oral administration.				

BIRTH UP TO 1 WEEK: UNIVERSAL

Health protection – immunisation

Parents should be offered routine immunisations for their baby according to the DoH Schedule - NICE CG37 Postnatal Care

BCG is offered to babies who are more likely than the general population to come into close and prolonged contact with someone with tuberculosis

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	A TB risk assessment is undertaken antenatally and babies at risk will be referred to TB nurses for vaccination. This pathway currently being reviewed.	Local audit of BCG uptake rates in at babies from at risk populations	See section on findings from interview with K&M Screening & Immunisations Lead for current performance data, comments and recommendations		
EKHUFT	The protocol for identifying babies at risk is currently being tightened with midwives now asking more questions to id at risk babies and developed a flagging system to provide an alert to do the postnatal referra. Mothers will be advised that their infant requires BCG vaccination and a postnatal referral will be made to the TB nursing team. There is a meeting with K&M imms and vaccs to discuss developing this pathway				
MTW	TB risk is identified via the Family Origin questionnaire at birth and the Paediatric Team provide BCG vaccination clinics.				

BIRTH UP TO 1 WEEK: UNIVERSAL

Hepatitis B vaccine is given to all babies of mothers who are hepatitis B carriers or where other household members are carriers of hepatitis B. The first dose is given shortly after birth.

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	The first dose is provided by midwives at birth and then subsequent doses provided by HV or GP. The K&M SIT manage a database of pregnant women identified as Hep B carriers. Database is regularly monitored to ensure babies at risk receive 1st dose of vaccine and are then followed up to ensure completion of the schedule. K&M SIT are considering commissioning the Neonatal Hep B vaccination programme from the HV system. There is national discussion about offering the Neonatal HepB vaccination universally to all infants.	Local audit of Hep B uptake rates in mothers/carers with hepB	See section on findings from interview with K&M Screening & Immunisations Lead for current performance data, comments and recommendations		
EKHUFT	Mothers are screened for HepB antenatally and a referral pathway is established. The first vaccine dose is given soon after birth. GPs provide the follow up dose. GP will receive this information as part of the discharge summary but midwives don't follow it up to ensure it's been provided.				
MTW	Mothers who are carriers of HepB will be identified via antenatal blood tests. The first dose is provided by midwives at birth and then subsequent doses provided by HV or GP. The K&M SIT manage a database of pregnant women identified as Hep B carriers. Database is regularly monitored to ensure babies at risk receive 1st dose of vaccine and are then followed up to ensure completion of the schedule. K&M SIT are considering commissioning the Neonatal Hep B vaccination programme from the HV system. There is national discussion about offering the Neonatal HepB vaccination universally to all infants.				

BIRTH UP TO 1 WEEK: UNIVERSAL

Health protection – immunisation

Women who were sero-negative on screening for rubella should be offered MMR following birth & before discharge - NICE CG37 Postnatal Care

Women should be advised that pregnancy should be avoided 1 month after MMR but breastfeeding can continue - NICE CG37 Postnatal Care

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DV	Rubella sero-negative women are offerered vaccination on the postnatal ward, contraception advice is offered at the same time as vaccination. Information on women requiring a follow-up dose of MMR will be provided in the Discharge Summary which is shared with GPs however there is currently no feedback mechanism for GPs to confirm to midwives that the woman has received her full course of MMR.	Local audit of MMR uptake rates in eligible mothers	See section on findings from interview with K&M Screening & Immunisations Lead for current performance data, comments and recommendations		
EKHUFT	Women who are seronegative for rubella are offered the MMR whilst on the ward and offered appropriate contraception advice. The second dose should be offered by the GP. The GP will receive this information as part of the discharge summary but midwives don't follow it up to ensure it's been provided.				
MTW	Rubella sero-negative women are offerered vaccination on the postnatal ward, contraception advice is offered at the same time as vaccination. GPs are informed of the administration of the initial dose and the requirement for a repeat dose as part of the discharge summary. This is also provided to the Screening Co-Ordinator and the mother.				

BIRTH TO ONE WEEK: PROGRESSIVE

Babies with health or developmental problems or abnormalities

• Early referral to specialist team; advice on benefits that may be available; invitation to join parent groups

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Referral pathways will be initiated antenatally if issues are identified early and this will also influence the place of birth. Issues identified via Newborn Screening or via postnatal visits will be addressed via well established pathways. Posters advertising a variety of parent support groups are displayed in the maternity unit.	Audit of postnatal maternity records / Audit of referral to specialist services	Unknown	No significant gaps	
EKHUFT	Midwives will discuss issues with specialists antenatally if identified early or will refer to specialist services as soon as they are identified. If a baby is identified as at risk of developmental problems a Paediatric outpatients appointment will be arranged for ongoing care.				
MTW	There are clear and effective referral pathways for babies identified with health issues via screening.				

BIRTH TO ONE WEEK: PROGRESSIVE

Package of additional support and monitoring as assessed by health professional.

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	See above	As above	Unknown	No significant gaps	
EKHUFT	If a baby has specific health or developmental needs or abnormalities, midwives may be able to provide increased support in the home postnatally under their selective postnatal visiting system. Midwives may also continue to visit for longer than the standard 10 days postnatally. Midwife / Health Visitor communication will ensure continuity of care after the mother and baby are discharged from Maternity Services				
MTW	See above				

BIRTH TO ONE WEEK: PROGRESSIVE

Problems such as conflict with partner and lack of social support

• Techniques to promote a trusting relationship and develop problem-solving abilities within the family (e.g. promotional/motivational interviewing; Family Partnership Model; the Solihull Approach; and One Plus One Brief Encounters) should be used to:

– establish what each parent's individual support needs are;

– provide one or two structured listening support visits;

– work in partnership with families to develop problem-solving skills.

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	This is not currently seen as a core role for the midwife due to limited time during postnatal visits. It is assumed this will be picked up by Health Visitors both antenatally and postnatally.	Local audit of community postnatal records / FNP Data / Analysis of data from Early Help Services	Unknown	Health visitors will conduct a Family Health Needs Assessment at first contact, either antenatally where a visit is made or on their newborn visit. The aim of this assessment is to assess maternal and infant physical and emotional health and any factors that may influence family dynamics i.e. conflict or lack of support. This assessment is used to determine the level of HV support required ie universal, universal plus or universal partnership plus, and also identify the need for referral for further packages of care where appropriate.	
EKHUFT	The Postnatal Careplan suggests midwives should assess the mothers relationship with her partner and the rest of her family during her stay in hospital and on home visits. If a midwife suspects partner conflict or lack of social support this will be flagged up to other professionals involved in the care of the family e.g. GP or HV. This may be done via completion of a "Concern and Vulnerability" form or by direct discussion or both. The midwife may allocate more time to visiting parents in such circumstances and may encourage the mother to seek support from Children's Centres. The Health Visitor will provide structured listening visits and work with families over a longer period of time.				
MTW	This is not currently seen as a core role for the midwife due to limited time during postnatal visits. It is assumed this will be picked up by Health Visitors both antenatally and postnatally. HB to insert more info on				

BIRTH TO ONE WEEK: PROGRESSIVE

Promoting sensitive parenting

- Assessment of parent–baby interaction using validated tools (e.g. NCAST).
- Sensitive, attuned parenting (by both mothers and fathers) should be promoted, using media-based tools (e.g. The Social Baby book/video or Baby Express newsletters) or validated tools (e.g. Brazelton or NCAST).
- Information and support to the father, including opportunities for direct observation and interaction with the child.
- Individualised coaching (by a skilled professional) aimed at stimulating attuned interactions at one day, two days and seven days and involving both fathers and mothers where possible.

Parents or main carers who have infant attachment problems receive services designed to improve their relationship with their baby - NICE QS37 Postnatal Care Quality Standard

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Parent-baby interaction is assessed at every visit using the Safeguarding Parenting Triangle tool. The Health Visitor is seen as the lead professional for assessing and providing parenting advice.	Local audit of community postnatal records / Parent surveys	Unknown	Whilst some midwives will assess emotional attachment as part of their programme of home visits, the opportunities to do this are limited and many do not currently feel well equiped to provide routine assessment of emotional attachment and discuss babies development in the early days. This is a potentially missed opportunity for midwives to identify and provide early help or referral for families who may benefit from further support	See previous recommendation: Commissioners and providers should clarify the role of midwives in the provision of parenting advice and assessment of emotional attachment and the pathways for referral for additional support postnatally. Consideration should be given to the training needs of midwives to fulfill this role.
EKHUFT	The Postnatal Careplan suggests midwives should assess the mothers relationship with her baby during her stay in hospital and on home visits. There is also a prompt to provide information on the "Social Baby" and involve fathers in the care of their babies and supporting their partners both whilst on the ward and when back at home. However in reality emotional attachment is rarely formally assessed as midwives are not trained to assess parent-baby attachment and have limited contact with mother and baby. Midwives would look out for signs of detachment or indifference and may liaise with the health visitor to discuss concerns. A link to the NHS Choices website which includes a Birth to Five Development Timeline and intereactive parenting tool is included in the Postnatal Information Leaflet.				
MTW	No specific tools used to assess parent-baby attachment this isn't considered a core role for midwives and is assumed that HV will assess this during their initial visits. A link to the NHS Choices website which includes a Birth to Five Development Timeline and intereactive parenting tool is included in the Antenatal Information Pack.				

BIRTH TO ONE WEEK: PROGRESSIVE

Infant feeding and children at risk of obesity

- Additional individual support and access to advice, to promote exclusive breastfeeding.
- Provide information about local support groups.
- Information on Healthy Start and vitamin supplements.
- Information on delay in introducing solids until six months.

Mothers should be provided with individual support for specific needs such as tongue tie and mastitis - NHS Breastfeeding Care Pathway / WHO & UNICEF Best Practice for Hospital and community care settings)

Additional support with positioning and attachment should be offered to women who have had; a narcotic or general anaesthetic, a caesarian section, delayed initial contact with their baby - NICE CG37 Postnatal Care

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	See Birth to 1 Week Universal. Referral for tongue tie is currently very difficult. There is no defined pathway for tongue tie services across Kent and the services is not fully funded.	Breastfeeding Initiation & Continuation rates / Local audit of Postnatal Care Reords / Tongie-tie service referral data	See table for 28 Weeks Universal for data on current breastfeeding rates by provider and CCG	There is significant variation in the models of provision and access to tongue-ties services across Kent.	Commissioners and Maternity Services across Kent should undertake a needs assessment for tongue tie services and explore cost-effective models for delivery (such as the midwifery led service in MTW) in order to ensure equitable access to tongue-ties services for infants across Kent.
EKHUFT	Maternity care support workers can provide breastfeeding support for mothers on the ward and some midwives are trained as lactation consultants. Volunteer Breastfeeding Peer Supporters attend the ward to provide information on support available in the community and the Postnatal Information Leaflet contains a link to local and national sources of breastfeeding support. Midwives are encouraged to undertake a feeding assesssment on every shift and every visit, this will include providing advice regarding any breastfeeding concerns. The local tongue tie service is not currently fully resourced. The Infant Feeding Co-Ordinator is currently undertaking a needs assessment to inform recommendations for commissioning this service. The Healthy Start programme is discussed antenatally and an information leaflet provided. This is not currently routinely revisited postnatally as it is seen as a role for health visitor to follow up.				
MTW	See Birth to 1 Week Universal. PLUS The Infant Feeding Specialist receives referrals for women with specific infant feeding issues. She has also established a new tongue tie clinic. A comprehensive referral pathway for GPs and HVs is yet to be established due to limited resources so most referrals are received from the ward. Most infants are currently being seen within 2 weeks of birth and within 24-48hrs of referral. 3 more midwives will be trained to carry out the procedure by early next year. Information on the Healthy Start Programme is not routinely provided postnatally. Advice on delaying weaning is provided by Health Visitors.				

BIRTH TO ONE WEEK: PROGRESSIVE

Parents who smoke

- Smoking cessation interventions should be offered to women in the immediate postnatal period.
- Advice should include the prevention of exposure of infants to smoke and the creation of smoke-free households

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Smoking cessation support is offered postnatally for those who haven't accepted a referral. Referrals for other family members can be done and any time during or after pregnancy. Advice on harm reduction includes reducing exposure and creating smoke-free households.	Rates of smoking at time of delivery (SATOD) / Stop Smoking referral rates & quit rates for pregnant women - Babyclear programme outcomes data / Local audit of community postnatal care records	See 28 Weeks Univeral for latest SATOD Statistics	Kent Public Health Team have recently developed a community-led initiative to promote smoke-free homes to parents. This was initially piloted in Northfleet but it is now planned to roll the programme out to the 5 areas with the highest smoking prevalence with implementation in the remaining 6 areas of Kent next year. However this programme does not specifically target new parents. See section on "Key issues from interviews with other stakeholders" in the main report for further details.	See previous recommendation: Midwives should liaise with the Smoking Cessation Service to identify opportunities to receive automatic feedback on women who do not accept the initial referral for support.
EKHUFT	Written and verbal information is provided postnatally about the risks associated with passive smoking and the creation of a smoke free home. Postanatal referral to Stop Smoking Services is not offered routinely but can be arranged on request.			There is also a lack of feedback loop within the Babyclear programme for midwives to receive information from the smoking cessation service on thewomen who don't accept smoking cessation referrals. This limits the opportunities midwives have to follow up smoking cessation intentions and offer further support either antenatally or postnatally.	
MTW	Smoking cessation and the importance of providing a smoke-free household is discussed postnatally as part of the discussion re SUDI risk factors.				

BIRTH TO ONE WEEK: PROGRESSIVE

SIDS

Advice on reducing the risk of SIDS when there are increased risks (e.g. smoking, co-sleeping) for demographically high risk groups (e.g. first-time mothers, single mothers, families on low income).

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	All families will receive the same information on SIDS, there is no specific identification or targeting of those at higher risk.	Local audit of postnatal records or discharge notes / Local analysis of infant mortality data (SUDI deaths) / Local audit of postnatal care records	Unknown	The Care of Next Infant (CONI) programme is a national health-visitor led service for parents who have suffered a sudden and unexpected death of a baby. It is run by the Lullaby Trust in collaboration with NHS Staff and supports families before and after the birth of their new baby to reduce anxiety. CONI programmes are running in East Kent however there is currently no service in the North or West of Kent. This issue is being addressed by KCHT HV Service. Midwifery and Paediatric services in both areas have now been engaged and the Lullaby Trust have been commissioned to provide multi-disciplinary training to staff over the next few months which will provide the foundation for the CONI service to be introduced in these areas.	
EKHUFT	The same SIDS advice is offered to all parents. A midwive will offer further advice to parents if she observed behaviour that is likely to increase the risk of SIDS.				
MTW	Advice is provided universally via leaflets and risk assessment on discharge, there is no targetting of advice to high risk groups.				

BIRTH TO ONE WEEK: PROGRESSIVE

Birth to 1 week: For families at higher risk

Including at-risk first-time young mothers; parents with learning difficulties; drug/alcohol abuse; domestic violence; serious mental illness- as previously At-risk first-time young mothers described.

- Intensive, evidence-based programmes that start in early pregnancy, such as the Family Nurse Partnership programme
- Multimodal support combining home visiting, peer support, life skills training and integration within social networks recommended for pregnant adolescents.

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Teenage parents receive normal postnatal care with individualised care planning based on social need or health need. Young Pregnant Women at high risk will be cared for by a consultant . Women <16 are routinely referred into social care as part of the vulnerable women's pathway. FNP is already active in South London and Community midwives have links with the FNPs in South London Boroughs. A new FNP Programme for Dartford and Gravesham is planned which will have the capacity for 25 women <19 this is likely to be established early in 2015.	Family Nurse Partnership programme performance data / Audit of CAF records / Survey of young maternity services users	See description of Family Nurse Partnership Service Provision for the latest performance statistics for this programme	Variation in access to FNP nurses for young parents across Kent although these are being established in the areas of greatest need. Some inconsistencies or gaps in the provision of Young & Pregnant or Teenage Parent Support Groups.	See previous recommendation: Specialist TP midwives should liaise with local Children's Centres and other community venues to clarify what extra support is available to young parents in their area and share this information with their midwifery teams.
EKHUFT	Most families at high risk would have been identified in the antenatal period, information shared using the Concern & Vulnerability form and a CAF undertaken if appropriate. This would have resulted in a multi-professional care plan which will be actioned once the baby is born. Support is available from the EKHUFT Safeguarding Team and Children's Services when needed. Midwives will encourage teenage parents to attend local support groups. Health Visitors provide postnatal depression support groups which midwives will support if requested.				
MTW	Support will be initiated antentally and continuity of care will enable midwives to further identify needs as they establish a relationship with the parents throughout pregnancy. CAFs will be initiated when needed either antenatally or postnatally. Families at higher risk may receive daily visits in the first week and may be kept under midwifery supervision longer if needed. Teenage parents will be seen postnatally by the TP Specialist Midwife if they've seen her antenatally. Many teenage parents will already be engaged in the Family Nurse Partnership programme which continues for the 1st 2 years.				

BIRTH TO ONE WEEK: PROGRESSIVE

Parents with learning difficulties

- Information on support available to parents with learning disabilities, and assistance in interpreting information and accessing other sources of support.
- Specialist multi-agency support should include individual and group-based antenatal and parent education classes, and home visiting.
- Further support designed to address the parent's individual needs might include speech and language and occupational therapy – (from adult provider).

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	The service has a Community Midwife with specialist interest in learning difficulties and training in makaton - however they are currently on maternity leave. Another midwife also has specialist training in mental capacity assessment. An Adult Protection nurse is available for advice The Trust supports the use of Health Passports for people with learning disabilities and they are encouraged to bring these to maternity appointments. An individualised postnatal care package will be developed and midwives will continue to liaise with the Community Learning Disability Team. Midwives will initiate a CAF when appropriate.	Local audit of antenatal records/ Audit of information sharing with CTLDs / Analysis of the population of parents with LD	Unknown	The number of parents with learning disabilities is low but it can be challenging when they present as midwives have a lack of experience of supporting them. Midwives will routinely liaise with Community Learning Disability Teams to get support and develop a support plan for parents with Learning Disabilities.	See previous recommendation: Kent Public Health Team in collaboration with KCC Adult Learning Disabilities Service should undertake an audit of the current numbers of parents with LD known to services in order to develop an accurate estimate of current and future need. This should inform the development of a kent-wide commissioning strategy for antenatal and postnatal parenting support for PWLD
EKHUFT	There are 2 midwifes Leads for Disability who can provide advice to community midwives for parents with LD but midwives may not always refer to them. Community midwives will work antenatally and postnatally with the local Community Learning Disability Team to develop a support plan for parents with a LD. A picture book titled "You and Your Baby" is also available for parents with LD.				
MTW	Community midwives will identify parents with LD and undertake a CAF or refer direct to Social Services if necessary. Midwives can refer to the Trust Specialist Nurse for Vulnerable Adults for advice on serious concerns. An individualised care plan will be agreed.				

BIRTH TO ONE WEEK: PROGRESSIVE

Drugs and alcohol abuse

- Referral of one or both parents to local specialist services as part of a multi-agency strategy.
- CHPP team to contribute to care package led by specialist service.
- Doula programmes (a combination of home visiting, role modelling and community supports) may also help to prevent attrition and increase sensitivity of mothers who

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	Problems are usually identified and addressed antenatally but midwives can also refer to specialist support postnatally. The Specialist Substance Misuse Midwife will follow up parents with drug and alcohol issues postnatally and ensures care plans are followed up.	Local audit of postnatal care records / Audit of information sharing and referral pathways to substance misuse or alcohol services	Unknown	No significant gaps	
EKHUFT	QEQM are currently implementing a pilot in-house substance misuse team which is available to provide support to midwives. A new system to identify parents who are abusing or at risk of abusing drugs and alcohol is about to be launched therefore referral to specialist services should take place antenatally.				
MTW	Problems are usually identified and addressed antenatally but will be continually reviewed and midwives can refer to specialist support postnatally.				

BIRTH TO ONE WEEK: PROGRESSIVE

Domestic violence

- Follow local guidelines.
- Following assessment, provision of a safe environment in which victims of domestic violence can discuss concerns.
- Provision of information about sources of support for domestic violence.
- Referral to local specialist services as part of a multi-agency strategy.
- CHPP team to contribute to care package led by specialist service.

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	See "Pregnancy - 28 Weeks Progressive"	Local audit of postnatal care records or case review / Analysis of police data on DV incidents involving pregnant women	Unknown	Lack of recent training on DV for all midwives. Lack of protected time for Lead DV Midwives to carry out their roles.	Heads of Midwifery should undertake a training needs analysis to determine midwives' competence and confidence in talking to and supporting women at risk of domestic violence.
EKHUFT	Local guidelines on managing the issues of domestic violence in pregnancy are available but they need updating. There is a Lead midwife for Domestic Violence but they currently lack the capacity to provide specific support. A contact number for the National Domestic Violence helpline is included in the pregnancy notes, local numbers are not included as they can change. Midwives can refer to local domestic violence support services including local 1StopShops. Training in identifying and supporting women at risk of DV has not been provided recently & some midwives still feel uncomfortable in asking about DV as they are not always confident in what support they can offer.				
MTW	Midwives are trained in looking for signs of DV and in raising the issue. Midwives can complete a Concern and Vulnerability Form if they are concerned to enable multi-agency information sharing. Midwives will also refer issues to MARAC if it is deemed necessary.There is a section providing advice on domestic violence on the back of the antental notes including the phone number for the national domestic violence helpline and a link to www.womensaid.org.uk. A leaflet on the local Domestic Abuse Volunteer Support Service is also provided in the booking in pack.				

BIRTH TO ONE WEEK: PROGRESSIVE

Serious mental illness

- Referral of one or both parents to specialist mental health/perinatal mental health service.
- CHPP team to contribute to care package led by specialist service.

	Currently do/ provide	How can we measure	Current performance	Gaps/ comments	Proposed Action/ What can we provide
DVH	MIMHS is not currently commissioned for women in this area. There is a Perinatal Mental Health Team consisting of a MH Specialist Midwife who also has psychotherapy training, an Obstetrician with an interest in mental health and an Antenatal Clinic Manager but this doesn't always offer sufficient support for women with serious mental illness . Women are referred to Adult Mental Health Crisis Teams if acute issues arise and referrered to social services if there are concerns regarding child protection. There is limited inpatient access for pregnant women.	SUS Data about perinatal MH/postnatal depression (EG ICD code F53.0) (would only see severe end of the spectrum) / Local audit of postnatal care records / Referral data from specialist mental health or Maternal & Infant Mental Health Services		There is a serious gap in psychiatric support for pregnant women with serious mental illness as MIMHS is not funded in the Dartford & Gravesham area	See previous recommendation: Commissioners and providers should collaborate to produce a Kent-wide perinatal mental health pathway with reference to the national Maternal Mental Health Pathway. The pathway should enable equitable access to perinatal mental health support at all levels of need for pregnant women across Kent. The pathway should incorporate the new role of District Health Visitor Perinatal Mental Health Leads & explore opportunities for them to expand their role to provide training and support to midwives.
EKHUFT	Where a woman with serious mental health issues has been under the care of MIMHS during pregnancy a reobust multi-agency plan of care will be in place. However problems can occur if antenatal MIMHS care does not occur, either because a referral has not taken place or has been refused due to lack of capacity to treat all but the most severely ill. The 4 Lead Midwives for MH meet quarterly with the MIMHS team to discuss cases and outcomes. However these lead midwives are only allocated 8 hrs per year to undertake this role, severely limiting what they are able to achieve.		See previous sections for discussion of the results of the EKHUFT Perinatal Mental Health Audits	Lack of clarity in the referall pathway. Midwives feel some referrals are inappropriately refused by the Community MH Team. Capacity issues in the MIMHS team mean that there can be difficulties in accessing the service. Severe lack of protected time for MH Lead Midwives (8hrs per year annually)	
MTW	Women are able to access MIMHS until their child's 1st Birthday. There is good access to MIMHS for mothers who meet eligibility criteria. There is regular liaison between midwifery and MIMHS.				

Results of the review of maternity service provision in Medway

As mentioned previously in this report, Medway NHS Foundation Trust in collaboration with Medway CCG, have recently completed their own review of maternity service provision. (41)

This review identified a number of issues that have relevance to the delivery of the public health aspects of maternal care, these include:

- Pre-conception care – a lack of clarity as to who is responsible for providing support to women planning pregnancy who may have pre-existing medical conditions or lifestyle issues such as smoking or obesity that may require them to need further support in pregnancy.
- Mental Health Support – whilst it was acknowledged that the MIMHS service offers support to women with severe or acute mental health needs there is a lack of support for women with lower level mental health needs and those that experience bereavement.
- Poor communication – Poor communication between midwifery services and GPs, Health Visitors and Social Workers and a lack of collaboration to provide family-centred care. GPs also highlighted concerns that they are becoming de-skilled at providing care for pregnant women.

Further work was recommended to understand and describe these gaps with the work to be overseen by the Children's Clinical Strategy Group.

It is interesting, if not unsurprising, that the issues identified in the Medway review echo many of the findings of this review of Kent providers. These findings also strongly correlate to the conclusions of a number of recent national reviews including:

The 5 key challenges identified in the CCG Maternity Commissioning Resource pack, referred to earlier: (11)

- Patchy pre-conception care leading to a lack of opportunity for early engagement with women in pre-conception or early pregnancy planning.
- Variation in the provision of specialist mental health services for pregnant women or training to address mental health issues. Patchy provision of support for pregnant women with chronic, low-level mental health problems with confused responsibility between primary care, mental health and maternity services.
- Rising birth rates creating challenges for organisations to maintain safe services in terms of both staffing levels and physical capacity.
- Increasing complexities of pregnancy and birth driven primarily by increases in the number of older mothers, those with a high BMI or pre-existing medical conditions.
- Lack of integration between Midwives, GPs and Health Visitors on a streamlined maternity and early years care pathway.

Issues regarding the implementation of the Healthy Child Programme identified in the WAVE Trust report which highlights: (2)

- The volume of information required to be delivered and recorded by midwives during the 12 week booking in assessment which can make it difficult to identify concerns and vulnerabilities at an early stage.
- Delays or inconsistencies in the sharing of information with others involved in the care of the mother and family when vulnerabilities are identified.

- Disinvestment in antenatal education which has resulted in resources being focussed on the birth rather than wider issues regarding the care of the baby postnatally.
- Inadequate engagement of the most vulnerable parents to be in antenatal education classes.
- A lack of understanding or focus on the emotional wellbeing of the infant or the promotion of sensitive parenting by midwives postnatally.

This correlation suggests that these issues are not unique to the 3 providers included in this review but common amongst other services locally and nationally. There is opportunity for local, regional and national collaboration to share knowledge, expertise and ideas as to how to address these and many of the other issues highlighted in this report. The South East Coast Maternity, Children and Young People Clinical Network (SECMCYPCN) appears to offer an ideal forum to undertake this work.

Recommendation:

- Kent Commissioners, Commissioning Support Services, Providers and Public Health Team should identify and agree appropriate representatives to join the SEC Maternity Children and Young People's Clinical Network and initiate or support existing work to address the issues identified, acting as a conduit for sharing knowledge and learning with the clinical network and colleagues in Kent.

Examples of good practice:

DVH:

- There is a comprehensive programme of parent education classes co-ordinated by a full-time Parent Education Specialist Midwife. The classes currently available include:
    - New Horizons – an early pregnancy class
    - Antenatal breastfeeding workshop
    - Specific groups for women with multiple pregnancy and teenage parents
    - Water birth and hypnobirthing workshops
    - Caring for your newborn
- Women with a BMI >35 are referred to the "Pregnancy Plus" service. This is an educational and monitoring programme specifically for pregnant women with a BMI >35. It is run in the community by Community Midwives with Dietetic Support. There are currently 3 groups running in Dartford, Gravesham & Bexley. The programme has been acknowledged by NICE for best practice.
- The maternity unit at DVH has a "Domestic Violence Alert Toilet", a specific cubicle where women can put a sticker on their urine sample to covertly alert midwives that they are vulnerable or concerned about domestic violence.
- There is good support for parents with learning disabilities (LD). The Trust supports the use of Health Passports for people with LD and midwives encourage them to bring them to maternity appointments. Midwives will also routinely liaise with Community LD Teams to develop an individualised care package.

EKHUFT:

- Provision of 12 full-time Specialist Teenage Pregnancy Midwives who provide care for teenage parents as part of their standard caseload.
- Each Community Midwifery Team has an identified CAF Champion
- "The Journey" an antenatal education film created by EKUHT available on YouTube to provide information for those who don't want to or find it difficult access antenatal classes.
- The Dover Community Midwifery Team hold a separate clinic for women for whom English is a Second Language and book an interpreter for a specific language to cover a whole clinic if there is a specific need.
- A new drugs and alcohol assessment is just about to be introduced at booking with referral pathways into the QEQM in-house Alcohol and Substance Misuse Team at QEQM for women or the Turning Point Service in Ashford.

MTW:

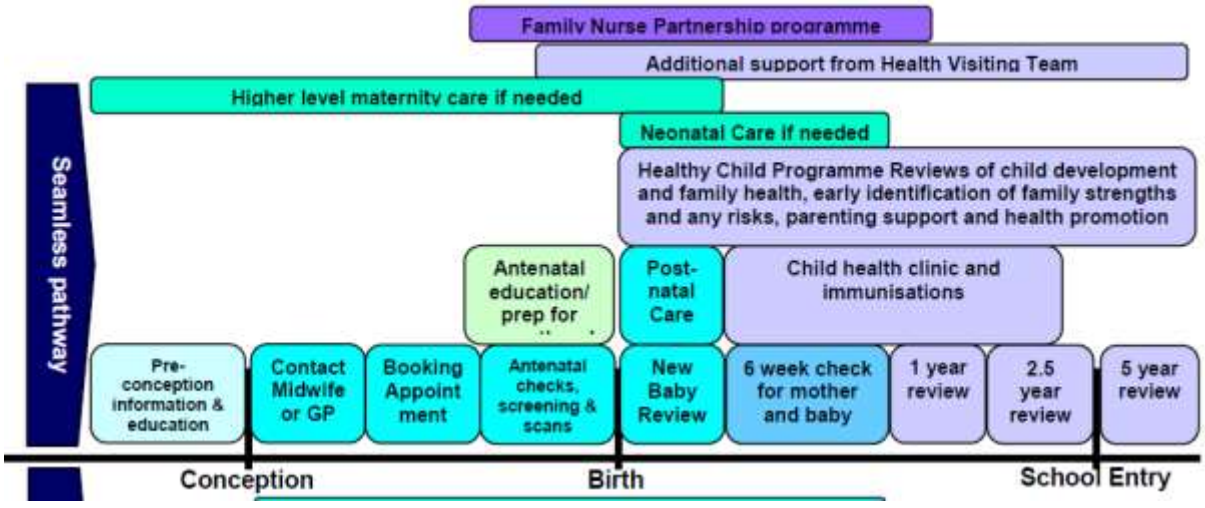
- A new tongue tie clinic has been introduced at Tunbridge Wells Hospital to ensure babies with tongue-tie can be treated as quickly as possible.
- MTW is currently one of the leading trusts in the country for promoting Kangaroo Care and encouraging skin to skin care. Clear advantages are already being seen with term as well as premature babies.
- MTW research programme. The Trust's Maternity Department are currently involved in 2 research projects relating to health promotion and injury prevention:
    - A national study looking at women who find it hard to breastfeed i.e. after Caesarean Section. Looking at impact of Kangaroo Care on breastfeeding, maternal attachment, baby development etc. Results should be available by end of year. Previously published the first UK study on use of Kangaroo Care in postnatal wards for premature babies, 2011.
    - An NSPCC study on coping with crying and provide a DVD to every family with tips on coping with crying (aimed at preventing shaken baby syndrome), the study runs to Oct 2015.

- **System mapping – Service interdependencies and professional interfaces**

As highlighted in the introduction, maternity services do not deliver the antenatal and postnatal elements of the Healthy Child Programme in isolation. A joint Department of Health and NHS England report published in 2013 outlines the care pathway for the universal elements of the Healthy Child Programme and provides an indication of the complex interfaces and interdependencies between services: (42)

- Following confirmation of pregnancy, women will be signposted to maternity services and a full health and social care assessment carried out. Eligibility for the FNP programme will be assessed at this point in areas where FNP is available and information sharing between service providers to ensure that women receive the antenatal components of the HCP programme.
- Those least likely to access services will be actively followed-up to ensure equal uptake of all elements of the HCP.
- The midwife will be the lead professional for the family until 14-28 days after the birth of the baby ensuring access to the universal and additional aspects of the HCP matched to individual needs of mothers to be and their families. There may be a separate preventive care pathway for the most vulnerable children.
- Universal provision up to 28 days will include a physical examination of the baby, newborn hearing and blood spot screening.
- The Health Visiting Service will make contact with families in pregnancy and offer the HCP to all children and families according to the recommended, evidence-based schedule.
- The Health Visitor or Family Nurse will ensure that systems are in place for referral to other services and secondary care. Health Visitors, Family Nurses, GPs and Children's Centres will have systems in place for effective communication, audit and information sharing for all aspects of the HCP
- The GP will deliver aspects of the HCP both antenatally and postnatally and in particular the screening, surveillance and the immunisation programme, with opportunistic health promotion offered at each contact.
- The HCP also relies of the following systems:
    - Integrated pathways of care with maternity, school health and other services such as those for disabled children.
    - Referral pathways to other NHS secondary care services that address identified needs including speech and language therapy, infant and parental mental health, NHS safeguarding supervision and advice, primary care, paediatrics, smoking cessation, contraceptive services and maternity services.
    - Referral pathways to non-NHS services including safeguarding, social care, children's centres, early year's education and parenting support.

This pathway is summarised in the following graphic: (11)



The NICE Clinical Guideline for Postnatal Care (CG37) (43) acknowledges these complexities, recommending that there should be local protocols about written communication, particularly about the transfer of care between clinical sectors and healthcare professionals. These protocols should be regularly audited.

The NICE Clinical Guideline for Pregnancy & Complex Social Factors (CG110) (44) also recommends that Midwives should be trained on multi-agency needs assessment such as CAF and national guidelines on information sharing.

In her 2012 Annual Report the Chief Medical Officer also recommends that policymakers need to ensure that care for pregnant women and new mothers is holistic and integrated both vertically and horizontally. (3)

This section of the report explores some of the current interfaces and interdependencies between maternity services and other services on the antenatal and postnatal care pathway in Kent including:

- GPs
- Health Visitors / FNP Practitioners
- Children's Centres
- Social Workers
- Mother & Infant Mental Health Services

Comparison of communication from a midwifery perspective

The following tables provide an overview of midwives' perspective on communication with other professional groups on the Maternity Care Pathway.

	Obstetricians	Mother & Infant Mental Health Service	GPs	Health Visitors
DVH	Good	Limited as currently no MIMHS provision in North Kent	GPs tend not to get involved in antenatal and postnatal care routinely. If a problem is identified in pregnancy midwives will refer to a Paediatrician. Midwives will routinely share information from the booking in appointment and the Social Concerns & risk assessments. Community Midwives visit surgeries monthly to maintain information. Most women self-refer so GPs will find out women are pregnant when notified of booking in. GPs will routinely receive a copy of the Postnatal Discharge Summary.	Strong links. Health Visitors routinely receive a copy of the Antenatal Booking Summary and Postnatal Discharge Summary. HoM meets with the Provider Lead for Health Visiting twice weekly. Community Midwives and HV meet regularly and liaise operationally via shared working in childrens centres. There can be lack of continuity in patient care as midwives are attached to GPs whereas HV is assigned based on postcode.
EKHUFT	There are formal Clinical Guidelines for midwifery referrals to a Consultant Obstetrician during the antenatal, intrapartum and postnatal periods. Midwives are able to make direct referrals into Obstetric Clinics or into Daycare or Labour wards for urgent issues. The guidelines also clearly outline when a Consultant On-Call should be informed during labour and those situations when Consultants will be expected to attend the ward.	Midwives or GPs cannot refer directly to MIMHS but can alert the service that a referall to the Community Mental Health Team has been made. The Lead Midwives for MH meet quarterly with the MIMHS team to discuss cases and outcomes.	A copy of the booking in summary is routinely sent to the GP to alert them they have a pregnant patient and invite them to disclose any relevant information to the midwife. A xopy of the discharge summary is also routinely sent to GPs	Proforma for letter to HV after 36 week scan included in maternity record. Letter facilitates sharing of information on any concerns raised or change in circumstances during pregnancy & details of the management plan. Information on the birth and infant health is recorded in the Red Book which the mother keeps for review by all healthcare professionals. A copy of the discharge summary is also routinely sent to HVs
MTW	Midwives can make direct referrals into Obstetrician clinics and there is good information sharing	Information sharing could be better. All referrals have to go through the Adult Mental Health Intake Team and may be inappropriately refused whereby MIMHS may have accepted them, these women will be referred back to GP for care. Barriers in referral process can be frustrating for midwives who don't know where else to get support. Working relationships with MIMHS is very good	Paperbased system encourages two way information sharing regarding patient history but difficult to get GPS to respond. Few midwives are based in GP surgeries. No regular meetings with GPs to review care. Not aware of any GPs who undertake maternity care.	HV will receive automatic notification of delivery from maternity services and a summary of discharge information. Midwife will contact HV if there is a specific issue. Some feeling that HV care overlaps with midwifery before they have been discharged - overlapping appointments. Not currently a trustwide forum to meet regularly for HVs and Midwives but community midwives will make arrangements to meet regularly with local HVs.

Provider	FNP Pracititioners	Children's Centres	Social Workers
D V H	Limited but will be strengthened with the introduction of the FNP programme in Dartford and Gravesend	Strong but midwives feel there is a threat of losing venues due to the CC review and are consiering moving back into GP surgeries. Community Midwife Manager meets with CC Manager quarterly	Very Strong. Attend wards frequently, strong referral pathways, case conferences in community environments.
E K H U F T	There is good communication between midwives and FNP Practitioners where it is available in the Swale area.	Many Community Midwifery Clinics are held within children's centres and women will be invited to sign up with the children's centre by the receptionist when they attend. All pregnant teenagers will be flagged up to the Young & Pregnant Coordinators within the children's centres. Links with Children's Centres are less well developed in areas where midwives do not use Children's Centres as clinic venues. Some midwives also attend the DABs (Children's Centre District Advisory Boards), but this is not consistent across the whole of East Kent and can be limited due to lack of time available for a midwife to attend.	Midwives seek anonymous consultations with Social Services if necessary and make referalls as appropriate. Midwives will have ongoing involvement in case conferences where necessary.
M T W	Head of Midwivery attends the FNP Advisory Board.	Some but not all midwives are based in Childrens Centres. Midwives often attend Children's Centre meetings but this doesn't happen in all areas. Not always capacity for midwives to attend meetings. No formal strategic meetings between midwives and Childrens Centre managers	Frequent delays in acceptance of social services referrals. Often left until very close to delivery date. Midwives spend a lot of time chasing referrals for action. Patchy as to flow of information back from social services to midwives - sometimes it is fed back but often midwives need to chase. Trying to set up multi-agency maternity meetings, as per Medway model, to improve communication. MTW deal with a number of different Social Service Teams - KCC, E Sussex - 20% of bookings

There is clearly distinct variation in the methods and quality of communication between midwives and other professionals across Kent with many opportunities for clarification and improvement.

A local clinical protocol for Antenatal & Postnatal Communication and Risk Assessment was developed in partnership by EKHUFT & Eastern & Coastal Kent Community Heath NHS Trust in 2011. This protocol covers the procedures for the sharing of health and social information about mother, infant and family between Midwives, Health Visitors and GPs during the antenatal and postnatal periods in the east of the county.

KCHT in partnership with EKHUFT recently completed an audit of compliance with this protocol. The findings highlighted both effective and ineffective practice including:

- Of the 5 mothers in the sample who chose a homebirth during the audit period, there was no evidence of information being provided by either the GP or HV to the community midwife on issues which could impact on the welfare of the mother and baby or the safety of professionals.
- 79% of HV records contained a copy of the antenatal booking form however 21% of records did not meaning that the HV was unaware of these pregnancies until they received the new birth notification.
- A Midwife to HV Liaison Letter should be sent at 34-36 weeks gestation. This letter confirms the woman's current address, contact details, GP and relevant pregnancy details. 79% of HV records did not contain a copy of this letter indicating the HVs did not have access to this information antenatally.
- In 15% of cases where a Concern & Vulnerability form was generated by the midwife, this had not been received by either the HV or Child Protection Teams.
- A significant number of midwives approached HV, GPs and the Child Protection Team to provide additional information when medium/high levels of concern were identified.
- Referrals made to Social Services in cases of medium/high level concerns were of good quality with 8/13 referrals resulting in a Child Protection Conference.
- 9 pre-birth plans were generated however details of only 7 were found in the Child Protection Team or HV records suggesting that these teams did not receive details of 2 of the plans.
- In 12% of cases HVs identified concerns in their records but did not complete a GP vulnerable child notification form to share the information with the GP.

A number of recommendations were made in response to these findings including:

- Improving communication between HVs and Midwives
- Undertaking a joint midwifery and HV visit when concerns are identified in the antenatal period
- Reminding midwives of the requirement to complete and send the Midwife to Health Visitor Liaison letter between 34-36 weeks.
- Increase the use of the Universal Services HV / School Nurse Notification to GP of Vulnerable Child/Children form by HVs to improve information sharing with GPs

Recommendation:

- It is likely that these communication issues are replicated across Kent and it is recommended that each provider, in collaboration with GPs and HVs, undertake an audit into multi-disciplinary communication and information sharing using the audit tool developed by EKHUFT & KCHT as a template. The audit cycle should be completed with the development of a local action plan to address the issues identified and an agreed timescale for re-audit.
    a. EKHUFT should also complete the audit cycle by undertaking a re-audit which includes analysis of GP communication which was not included in the original audit.

- The East Kent Clinical Protocol for Antenatal & Postnatal Communication and Risk Assessment is now overdue for review. It is recommended that KCHT should use this opportunity to lead the development and agreement of a Kent-wide communication and risk assessment protocol to ensure consistent information sharing methods between Midwives, Health Visitors and GPs are agreed between and implemented across the county.

- Findings from interviews with other professionals on the Maternity Care Pathway

The following sections highlight some of the issues regarding interfaces and interdependences from the perspective of other professionals on the Maternity Care Pathway. See appendix 6 for a full list of interviewees.

CCG Clinical Advisers & CCG Commissioners for Children, Young People & Maternity

A number of shared themes emerged from these interviews:

- Improving rates of early booking and exploring the potential to introduce a new target for making an initial appointment with midwifery by 10 weeks +3 days
- Concerns regarding access to MIMHS and the provision of support for pregnant women with lower levels of mental health need.
- Reducing levels of smoking in pregnancy
- Improving breastfeeding initiation and continuation
- Support for pregnant women who are overweight or obese
- Reduction in involvement of GPs in the care of pregnant women as women self-refer to midwifery and may not see their GP again before their postnatal check.
    - This can have a de-skilling effect on GPs ability to support pregnant women with or without complications and also results in lost opportunities for GPs to consolidate the lifestyle advice and behaviour change discussions initiated by midwives.
- Inadequate information sharing between maternity services, GPs & Health Visitors at booking in and discharge.
    - Although GPs routinely receive notification of their patient's booking in and discharge from Maternity Services the information contained within these reports is often inadequate for instance the results of blood tests and the requirement for the provision of a 2nd dose MMR vaccinations for mothers.
    - There is also a lack of a multi-disciplinary forum where midwives, health visitors and GPs can discuss cases, review practice and share learning.

The last 2 issues have been acknowledged nationally in the NHS England Report "Commissioning Maternity Services - A Resource Pack to support Clinical Commissioning Groups". (11) This report highlights the decreasing involvement of primary care in the delivery of maternity care and a loss of skills and confidence amongst GPs to provide routine pregnancy care. They recommend that the relationship and contribution that general practice makes to maternity care should be clarified in order to facilitate service improvement. The report also cites to two further reports from The Kings Fund (45) and the joint Royal Colleges (10) which both provide guidance on developing and improving the relationship between primary care and maternity services. This includes developing GPs role in preconception care and highlighting the support GPs provide to pregnant women with underlying medical conditions. Recommendations are also made for policy to reiterate the importance of information sharing between midwives & GPs to ensure optimum provision of specialist maternity care.

Recommendation:

- For the Kent Child Health & Wellbeing Board to identify an appropriate forum to take on responsibility for monitoring and reporting on the implementation of the recommendations of this review. Options include:
    - The new Kent-wide project group for Collaborative Commissioning for Children's and Maternity Services
    - The new Local Maternity Service Quality Groups (currently proposed by South East Commissioning Support Unit) whose terms of reference could include monitoring and reporting on the implementation of the recommendations of this report.
    - Expanding the existing KCC led Early Help and Healthy Child Programme Task and Finish Group to become a more permanent Kent-wide multidisciplinary forum for Primary Care, Maternity Services, Early Help and Social Care providers to discuss issues relating to the delivery of the HCP in the early years and monitor the implementation of the recommendations of this review.

Kent & Medway Screening & Immunisations Lead (K&MSIL)

The following issues were highlighted as a result of this interview:

- Hepatitis B vaccination for babies of mothers who are Hepatitis B (HepB) carriers or where other household members are carriers of hepatitis B:
    - The first dose is provided by midwives at birth and then subsequent doses provided by HV or GP.
    - Kent & Medway Screening & Immunisations Team (K&M SIT) manage a database of pregnant women identified as Hep B carriers. This enables regular monitoring to that ensure babies at risk receive the 1st dose of vaccine postnatally and are then followed up to ensure completion of the schedule.
    - K&M SIT are considering commissioning the Neonatal HepB vaccination programme from the HV system to improve the delivery of the 2nd dose of the vaccine.
    - There is ongoing national discussion about offering the Neonatal HepB vaccination universally to all infants.

- BCG vaccination for babies who are more likely than the general population to come into close and prolonged contact with someone with tuberculosis (TB)
    - Babies at risk are usually identified via the Family Origins Questionnaire during the antenatal booking appointment.
    - Referrals are then made postnatally to TB Nursing Team for the baby to receive the vaccination.
    - There is currently no Kentwide formal routine follow-up mechanism to ensure all of babies at risk of TB receive vaccination.
    - K&MSIT have established a task group in collaboration with the 3 acute trusts to review and consolidate the BCG Immunisation Pathway.

- MMR vaccination for women who are sero-negative for Rubella:
    - The first dose of MMR will be provided my midwives on the ward postnatally. The 2nd dose will be provided by Primary Care
    - There is currently a lack of feedback to midwives to ensure that MMR vaccination courses are completed by Primary Care but Kent & Medway Screening & Immunisations Team (K&MSIT) are currently working to improve processes to notify HV of mothers MMR status to ensure the 2nd dose of vaccination is followed up as part of care provided by the HV.

- Antenatal Pertussis and Flu vaccination for mothers
    - The Pertussis vaccination is currently delivered by GPs.
    - The number of GPs who are entering information on Pertussis vaccination coverage is relatively low (53-62%) this makes it very difficult to obtain accurate data to monitor vaccination uptake rates. The average uptake rate for GPs who entered data is 52.2%. This issue is being addressed nationally.
    - There has recently been a Serious Incident involving a Kent GP failing to offer a pregnant woman the Pertussis vaccination. A Root Cause Analysis has been undertaken which resulted in a series of recommendations for GPs, Midwives, HVs, CCGs and the K&MSIT. Further information is available from the K&MSIT.
    - Uptake for the Seasonal Flu vaccination by pregnant women is well below the national target of 75% (uptake rates range from 25% - 41% in Kent CCGs).
    - A Seasonal Flu vaccination promotion campaign is due to be launched in the next month which will include prompts for Midwives, HV and Children's Centres to remind women about taking up the offer of a vaccine.
    - It had been suggested that midwives could collect information on uptake of these vaccinations during their antenatal appointments. However maternity services have highlighted that they currently lack the capacity to do this. The K&M SIL is currently leading discussions regarding the development of an Immunisation Co-Ordinator post within maternity services or if responsibility for immunisations co-ordination could be added into to the role of the Antenatal and Newborn Screening Co-Ordinators. The provision of and Immunisation Co-Ordinator within each Maternity Service would support the development of more robust monitoring processes for maternal and neonatal vaccination programmes.

- Antenatal Screening (AN) Programme for Infectious Diseases (proportion of women screened for Syphilis, HIV, Hepatitis B and susceptibility to Rubella)

    - Coverage for HIV screening is very good with all Trusts above the acceptable level of 90%.
    - MTW and DVH are currently achieving 100% compliance with the target to refer pregnant women who are Hepatitis B positive to an appropriate specialist and for them to be seen within 6 weeks. The latest data indicates that EKHUFT only achieved this in 75% of cases however that this may often be due to non-attendance or cancellation of appointments by the women. It has been suggested that an exception report is produced to highlight these issues.

- AN Screening Programme for Sickle Cell and Thalassemia
    - Coverage for this screening programme is above the acceptable level (95%) and close to or exceeding the achievable standard (99%) in many areas. Units are also currently achieving the acceptable level for the timeliness of testing (50% of women screened and informed of the result by 10 weeks gestation).

- Down's Syndrome
    - There is currently variation in the KPI relating to the timeliness and completeness of laboratory request forms. Rates for EKHUFT and DVH were below the 97% threshold. Local action is being taken to address this issue.

- Newborn Bloodspot Screening Programme
    - Coverage for this screening test is considerably above the performance threshold of 95% with an average coverage of 98.5% across Kent and Medway.

- Both East Kent and West Kent are achieving above the achievable level (98%) for communicating test results to parents within 6 weeks of birth.
- There are ongoing issues regarding the number of avoidable repeat bloodspot tests with rates above the acceptable level of 2% across all Trusts. Local action is underway to address this issue and new standardised guidelines for Bloodspot Screening are due to be issued by the UK National Screening Committee imminently.

- Newborn Hearing Screening Programme
  - Coverage in East Kent is close to or above the achievable performance threshold for all CCG areas.
  - Coverage data for this programme is not currently available for West Kent CCG.
  - There are issues regarding the timelines of hearing screening tests across East & West Kent and work is ongoing between K&MSIT and CCGs to address this.

- Newborn & Infant Physical Examination
  - Data collection on the coverage and timeliness of this screening test is not currently taking place.

All these matters form standing agenda items for the Kent & Medway Immunisations Board & Kent & Medway Antenatal / Newborn Screening Committee who regularly review progress and agree clear plans of action for these issues.

Head of Kent Integrated Family Support Services

The following issues were highlighted as a result of this interview:

- Ongoing difficulties with Children's Centres receiving timely and accurate data on Live Births to enable Children's Centres to engage with new parents.
- Variability in liaison and communication between Children's Centres and Midwives across Kent.
- Variability in the provision and engagement of midwives in "Young & Pregnant" (YaPs) groups provided in Children's Centres across Kent.
- Perceived reduction in the provision of Antenatal Clinics and Parent Education Classes by Maternity Services in Children's Centres. See Findings from Early Help Managers' Survey. See "*Results of Early Help Managers' Survey*" below for further details.
- A recent OFSTED inspection of Children's Centres in Maidstone specifically highlighted the inadequacy of the links between Maternity Services and Children's Centres in that area.
- A survey of Early Help Managers across Kent was undertaken to ascertain the level of engagement between Maternity Services and Children's Centres and the amount of maternity service delivery taking place in Children's Centres and service delivery by maternity services in Children's Centres across Kent See "*Results of Early Help Managers' Survey*" below & Appendix 7 for further details.
  The Head of Midwifery for Maidstone & Tunbridge Wells NHS Trust was also asked for her perspective on this issue.
  She identified the following potential causes of a reduction in collaboration between Children's Centres and Midwifery:
  - The opening of the Birthing Centre in Maidstone resulting in midwives using this as their preferred venue for antenatal clinics.
  - Ongoing uncertainty regarding the outcomes of the Children's Centre Review and the implications on Children's Centres capacity to provide appropriate facilities for antenatal clinics.
  - Frequent changes in Children's Centre management teams making it difficult to establish and maintain relationships.

- The information from the survey and the interviews has been shared with both the Head of Kent Integrated Family Support Services and the Head of Midwifery for Maidstone & Tunbridge Wells NHS Trust.

This information has been shared with the Head of Midwifery for Maidstone and Tunbridge Wells, the Head of Kent Integrated Family Support Services and the relevant Early Help Manager who are working together to develop an action plan to address these issues.

Recommendation:

- For the Heads of Midwifery and Head of Kent Integrated Family Support Services to encourage Early Help Managers & Community Midwives to collaborate to discuss the findings of the Early Help Group Managers' Survey and review current links between local Children's Centres and midwifery and explore opportunities to improve communication and increase the delivery of maternity services within Children's Centres where appropriate.

Senior Public Health Specialists

Debbie Smith PH Specialist – Smoking Cessation & Inequalities

- Babyclear

This programme is a midwifery lead intervention to help reduce prevalence of smoking in pregnancy it is based on a model developed by the Tobacco Control Collaboration Centre.

Programme details:

- Community Midwives receive training in using the CO monitors to assess smoking status at booking in appointments and offering very brief interventions for smoking cessation. Further negotiation is required to introduce repeat CO testing at 36 weeks to provide a more accurate measure than self-reported smoking at time of delivery.
- A direct referral pathway to smoking cessation services is established.
- Smoking cessation administration staff receive training on how to take a behavioural change approach to inviting women to take an appointment.
- Stop Smoking Advisors receive training on taking an evidence-based approach to encouraging pregnant women to quit and how to deliver update training for midwives
- An electronic system for managing referrals and recording CO levels at booking is developed.
- Phase 2 of the programme involves establishing the Risk Perception element of the programme. This is aimed at the estimated 50% of pregnant smokers who will not engage with smoking cessation services on initial referral. Midwives are placed in antenatal scan departments to provide a brief intervention to enable women to understand the risk to their baby. It is anticipated that 50% of pregnant women exposed to this intervention will go on to engage with smoking cessation services. It is estimated this would require 0.5 FTE Band 5 midwife to deliver the intervention for each provider.

Obstacles / Opportunities

- Addressing initial concerns regarding the capacity of smoking cessation services to respond to referrals by offering training to Healthy Living Pharmacies on how supporting pregnant women to quit.
- The source of funding for the recurring costs of CO testing is yet to be confirmed putting the future sustainability of the programme in doubt. A minimum amount of funding is required to ensure the continuation of the service long enough to demonstrate cost-effectiveness.
- Funding for the risk perception element of the intervention is also yet to be agreed.

- There is the potential to commission future insight work on how to support women who choose to self-quit without engaging in support services
- Kent has the opportunity to participate in research project in partnership with Tommy's funded by the NHS Innovation Fund looking at how to support young pregnant Mum's.

Recommendation:

- The Kent Health and Wellbeing Board should confirm the source of funding for the recurring costs of delivering the Babyclear smoking cessation initiative (including the establishing the additional Risk Perception element of the programme) Kent-wide as soon as possible.

- Smoke Free Homes Pilot

This is another collaborative project between Kent Public Health Team and the Tobacco Control Collaboration Centre alongside Activmobs, a social enterprise organisation aiming to empower individuals and communities to make changes to their lives.
The pilot programme was developed and implemented using a community assets based approach and action research methodology.
The project was piloted in North Kent and involved the engagement of local communities including individuals and organisations, in the testing and development of specific resources to support parents to understand the risks of passive smoking to children and the benefits of smoke-free environments and support local professionals to feel confident in engaging in conversations with parents and empowering them to establish a smoke free homes.
Following extensive work to gain insight on beliefs and behaviours around passive smoking and smoke-free homes a smoke free homes toolkit was developed to promote the message and support parents to establish a smoke free home. A range of community workers were also trained to use the toolkit to engage in conversations and brief interventions with parents.
The Kent Public Health Team are currently assessing the learning outcomes from this pilot with a view to commission the programme in five other areas in Kent with the highest smoking prevalence this financial year. Funding will be sort to deliver the programme in the remaining 6 areas of Kent in 2015/16.

Linda Smith Drugs & Alcohol Harm Reduction Lead

- Kent County Council have recently launched their new Alcohol Strategy 2014-16 with an overarching ambition to reduce alcohol-related harm to individuals, families and communities in Kent including the aim to:
  - Improve individuals' health and wellbeing through access to effective early interventions and recovery-focused treatment and care services for those who need them, including pregnant women.
- A number of CCGs are currently piloting an integrated alcohol care pathway incorporating an automatic electronic referral system for GPs to refer into specialist alcohol support services. This pilot will be reviewed to assess the potential to roll-out the system to other services such as midwifery.
- The Kent Public Health Team is currently able to offer free training for health and social care professionals to equip them with the skills to undertake very brief alcohol interventions. It is currently unknown if any Kent Maternity Service Providers have received this training.

- Kent Public Health Team fund the development & maintenance of the "Live it Well Website" www.liveitwell.org.uk.
    - The website is designed to promote wellbeing and better mental health for people in Kent and Medway by acting as a source of information, help and guidance.
- The Kent Public Health Team are also able to deliver short training sessions on understanding and promoting the "6 Ways to Wellbeing" approach to improving wellbeing and resilience. These training sessions were offered to midwives during the process of this review and the Public Health Team are now negotiating the provision of training for midwives with the Heads of Midwifery.
- There is concern that midwives may be unaware of the opportunity to recommend self-referral to NHS Talking Therapies for women with low levels of mental health need. Pregnant women are often prioritised by these services. This concern was supported by evidence from the interviews with most Heads of Midwifery uncertain if their midwives were actively promoting access to NHS Talking Therapies.

- Ivan is also currently leading the development of a health needs assessment for the Gypsy Traveller and Roma population in Kent. There are an increasing number of Roma families in Kent who have migrated from Eastern Europe. .

- Recent NICE Guidance CG110: Pregnancy and Complex Social Factors recommended that: (44)

"Midwives should have accurate information for recent migrants including a woman's home address and contact details by liaising with local agencies"

"Healthcare staff should receive training on the specific health needs of recent migrants / asylum seekers / refugees, their social, religious and psychological needs and the most recent policies on access and entitlements to care"

Unfortunately this review has revealed that there is currently a lack of information available on the specific needs of this population with respect to maternity services and a lack of accurate data on their use of these services. There are also gaps in the provision of training on the specific health needs of recent migrants.
These families are known to be vulnerable and have specific needs. The ongoing lack of data makes it difficult to identify these needs and a lack of training for midwives can make it difficult address these needs

Recommendations:

- The Kent Public Health Team (KPHT) should continue to engage with maternity services to provide "6 Ways to Wellbeing" training" for staff and support midwives to incorporate this into their advice on lifestyle behaviours as part of their antenatal care. The KPHT should also explore opportunities to engage with other professionals involved in the delivery of the Healthy Child Programme (such as Health Visitors, GPs and Children's Centre Staff) and support them to incorporate the "6 Ways to Wellbeing" messages into their practice

- CCGs should clarify if all providers of NHS Talking Therapies in Kent prioritise pregnant women accessing assessment and treatment. Maternity services should be encouraged to signpost these services to pregnant women with low level mental health issues.

- Kent Public Health Observatory should work with CCGs and Health Service Providers to increase knowledge of the size and location of the Roma population. Maternity Services need to improve their data capture systems to enable the easy identification of Roma women and families accessing their services.

- Heads of Midwifery should ensure that midwives have access to training on the specific health needs of recent migrants / asylum seekers / refugees, their social, religious and psychological needs and the most recent policies on access and entitlements to care as per NICE Guideline 110 Pregnancy & Complex Social Factors. (45)

Val Miller PH Specialist – Weight Management & Infant Feeding

- Infant Feeding

Kent Public Health Team are currently commissioning a range of programmes and services to increase breastfeeding initiation and continuation across Kent. This includes:

- Commissioning and funding the provision of a new Kent-wide Infant Feeding Service for 3 years (starting in Oct 2014).
- Pump primed Kent NHS Hospital Trusts, Kent Community Health Trust and Children's Centres with the fees required to achieve full Baby Friendly Initiative accreditation (up to Stage 3).
- Funded the provision of a year's supply of the "Bump to Breastfeeding" DVD to all Kent maternity services.
- Targeted breastfeeding support in Swale to address the low levels of breastfeeding in this area compared to the rest of Kent, including;
    - Establishing a locally led Infant Feeding Action Group to review the care pathway for universal breastfeeding support and care for women with difficulties breastfeeding.
    - Behavioural insight research to establish the community norms and factors that influence breastfeeding behaviour in this community.
    - Piloting the "Best Beginnings" programme; support for midwives to embed the provision and discussion of the Bump to Breastfeeding DVD in practice.

- Weight Management

In line with NICE Guidelines, pregnant women are not referred to community weight management services during pregnancy. (47) There are currently no Tier 2 weight management services specifically for pregnant women in Kent however the Kent Public Health Team have recently undertaken a public consultation and review of Adult Weight Management Service Provision. The review included the question:

Do you agree that there should be classes to support pregnant women to be a healthy weight?

Over 70% of females and over 50% of males who responded to the consultation either strongly agreed or agreed that these services should be provided.

Recommendation:

- Kent Public Health Team should respond to the results of the Adult Weight Management Consultation and work with CCGs to agree commissioning responsibility for healthy weight services for pregnant women.

Alexis Macherianakis & Jo Tonkin PH Consultant / PH Specialist - Teenage Pregnancy

Kent County Council is currently developing a Teenage Pregnancy Strategy in collaboration with a wide range of stakeholders, including midwives. This will set the strategic direction for collaborative work to reduce rates of teenage pregnancy and improve outcomes for teenage parents and children over the next 3 years.

Local Health & Wellbeing Boards will be asked to oversee the production and monitoring of local action plans for achieving the ambitions of the strategy.

Recommendation:

- Local Health & Wellbeing Boards should include a review of the provision of antenatal support to young parents as part of their action plan in response to the Teenage Pregnancy Strategy.

- Findings from the Early Help Managers' Survey

Following discussions with the Head of Kent Integrated Family Support Services it was agreed that a brief survey of Early Help Group Managers should be undertaken to explore the links between Children's Centres and Midwives in more detail. A paper-based and online survey was designed (see Appendix 7) and distributed to the Early Help Group Managers via email. 11 responses were received and the results are summarised below.

Q4: Do Midwives provide any of the following services direct from your Children's Centre(s)?

	YES	NO	Total
Antenatal Clinics	9	2	11
Antenatal/Parentcraft Classes	7	4	11
Postnatal Clinics (aka Well Baby Clinics)	3	6	9
Other	2	3	5

9 out of the 11 Group Managers reported that Antenatal Clinics were held in at least 1 of the CCs they managed. Those Group Managers who reported that they don't currently have any Antenatal Clinics in their CCs are; Maidstone and Maidstone, Tonbridge & Malling.

7 out of the 11 Group Managers reported that Antenatal or Parentcraft Classes were held in at least 1 of the CCs they managed.
Those Group Managers who reported that they don't currently hold any Antenatal Classes in their CCs are; Canterbury, Maidstone, Maidstone & Tunbridge Wells Rural and Thanet South.

Only 3 out of the 9 Group Managers who responded to this element of the question reported that Midwives held Postnatal / Wellbaby Clinics in their CCs.
Those Group Managers who reported this include; Ashford, Canterbury and Thanet South.

Other services offered included a Drop-In Blood Test Results Service in Gravesend.

Q5: Do Children's Centre Staff provide information for OR participate in the provision of antenatal/parentcraft classes either within the Children's Centre or elsewhere?

	YES	NO	Total
Number of responses	7	4	11

7 out of the 11 Group Managers reported that CC staff in the Centres that they managed provided information for or participated in the provision of Antenatal Classes in at least 1 of their CCs.

Those Group Managers who reported that staff in the CCs that they manage do not participate or provide information for Antenatal Classes include: Canterbury, Maidstone, Tonbridge & Malling, Maidstone & Tunbridge Wells Rural and Whitstable.

Q6: Do you provide any other specific support for pregnant women and their partners in your Children's Centre(s)? (e.g. healthy eating in pregnancy, smoking cessation, support for young parents to be)

	YES	NO	Total
Number of responses	8	3	11

8 out of the 11 Group Managers reported that their CCs provide specific support for pregnant women & their partners.
Those Group Managers who reported that their CCs didn't offer any specific support to pregnant women include; Folkestone, Maidstone, Tonbridge & Malling and Thanet South.

The additional services offered by some centres include:

- Young Parent (YAP) groups in Canterbury, Maidstone, Sheppey & Whitstable
- Postnatal weaning workshops, baby massage and healthy eating workshops in Ashford
- Baby Life Saving & a Bumps to 18 months weekly drop in group in Canterbury
- Pregnancy Plus Weight Management Service in Gravesend

Q7: How do you liaise with the Midwives working in your area?

	No.
Informally	9
Formally	6
Other	3

2 areas reported no or very limited contact with Midwifery Services (Maidstone and Maidstone, Tonbridge and Malling)
3 areas reported informal links only (Folkestone, Gravesend and Sheppey)
6 areas had both informal and formal links established (Ashford, Canterbury, Maidstone & Tunbridge Wells Rural, Swanley, Thanet South & Whitstable

This evidence supports the recommendation previously identified:

Recommendation:

- For the Heads of Midwifery and Head of Kent Integrated Family Support Services to encourage Early Help Managers & Community Midwives to collaborate to discuss the findings of the Early Help Group Managers' Survey and review current links between local Children's Centres and midwifery and explore opportunities to improve communication and increase the delivery of maternity services within Children's Centres where appropriate.

o Benchmarking against Standards, Performance Indicators & PH Outcomes

As highlighted earlier in this section there is currently a lack of ownership of a robust system of performance and quality monitoring process by Kent Maternity Service Commissioners. Whilst individual providers use their own internal performance dashboards there is no Kentwide oversight of this data by Commissioners. The Kent and Medway Commissioning Support Unit and Kent & Medway Public Health Observatory have both been undertaking analysis of maternity service performance data and quality indicators in isolation. In addition the South East Coast Maternity, Children & Young People's Clinical Network is developing a regional Maternity Performance Dashboard to enable comparative analysis across the Clinical Network.

KMCS & KMPHO are now collaborating to develop a shared dashboard that incorporates indicators of performance, quality and public health outcomes.

- Service User Views

Resource and time constraints meant it was not possible to conduct a comprehensive analysis of service user views as part of this review. However the project lead did attend meetings of the Maternity Services Liaison Committees in each provider location to introduce the project and will return to present and discuss the findings of the review. They have also been invited to become a permanent Public Health Representative on each MSLC providing an ongoing opportunity to identify service user needs and concerns and feed these back to the Kent Public Health Team and other stakeholders.

Birth Voices, the MSLC for West Kent have recently undertaken their own audit of Parent Education Needs, the survey revealed that:

Of the 8 people that responded who had attended an NHS Parent Education Session in the last 2 years:

- 100% felt the sessions made them more confident about the upcoming birth.
- 75% felt more confident about feeding their baby
- Only 50% felt more confident about caring for their baby
- Over 85% of respondents felt that sessions should be offered both in the daytime and the evening.

Parents were asked to rank the subjects they felt would be most useful to include in sessions, these are the results in order of importance:

1) Self-help techniques for labour and birth
2) Active birth workshops
3) Breastfeeding
4) Baby care
5) Information on water birth
6) Medical pain relief options
7) Birth plans
8) Caesarean Birth

Specific comments on the Parent Education Sessions attended included:

- More group work rather than lecture style to improve concentration and recall.
- Better advertising of NHS classes to expectant parents.

West Kent MSLC members are currently undertaking a more detailed evaluation of the NHS Parent Education Classes to inform the improvement and development of class content and format.

NHS Family and Friends Test (NHS FFT)

This test was introduced in 2013 as a measure of patient satisfaction on the care and treatment they receive in hospital. Patients are asked *whether they would recommend the hospital services they have used to their friends and family if they needed similar care or treatment.*

Women are asked this question at 4 points during their maternity care:

1. Antenatal care – to be surveyed at the 36 week antenatal appointment
2. Birth
3. Care on the postnatal ward – to be surveyed at discharge from the ward/ birth unit/ following a home birth
4. Postnatal community care – to be surveyed at discharge from the care of the community midwifery team to the care of the health visitor/GP (usually at 10 days postnatal).

How likely are you to recommend your ANTENATAL CARE to friends and family?

Trust	Extremely Likely	Likely	Neither	Unlikely	Extremely Unlikely	Don't Know
DARTFORD AND GRAVESHAM NHS TRUST	83.33%	16.67%	0.00%	0.00%	0.00%	0.00%
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	80.00%	17.50%	0.00%	0.00%	0.00%	2.50%
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	72.73%	22.73%	0.00%	0.00%	0.00%	4.55%
MEDWAY NHS FOUNDATION TRUST	77.78%	18.52%	3.70%	0.00%	0.00%	0.00%
ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	76.60%	17.02%	2.13%	0.00%	0.00%	4.26%
EAST SUSSEX HEALTHCARE NHS TRUST	65.22%	30.43%	4.35%	0.00%	0.00%	0.00%
England	69.58%	24.35%	2.43%	0.76%	0.59%	2.28%

Source: NHS England

The vast majority of women were extremely likely to recommend their antenatal care and these services are generally rated more highly than hospitals in the rest of England

How likely are you to recommend the care you received DURING BIRTH to friends and family?

Trust	Extremely Likely	Likely	Neither	Unlikely	Extremely Unlikely	Don't Know
DARTFORD AND GRAVESHAM NHS TRUST	82.49%	15.82%	1.69%	0.00%	0.00%	0.00%
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	80.14%	13.01%	2.05%	0.00%	0.68%	4.11%
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	80.43%	8.70%	0.00%	0.00%	2.17%	8.70%
MEDWAY NHS FOUNDATION TRUST	70.73%	24.39%	2.44%	0.00%	2.44%	0.00%
ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	64.58%	12.50%	0.00%	0.00%	4.17%	18.75%
EAST SUSSEX HEALTHCARE NHS TRUST	60.19%	29.63%	3.70%	0.93%	1.85%	3.70%
England	77.43%	17.84%	1.34%	0.67%	0.56%	2.16%

Source: NHS England

Again the vast majority of women were also extremely likely to recommend the care they received during birth to friends and family. Hospitals in Kent were generally rated more highly than those in the rest of England, apart from Medway NHS Foundation Trust

How likely are you to recommend the care you received ON THE POSTNATAL WARD to friends and family?

Trust	Extremely Likely	Likely	Neither	Unlikely	Extremely Unlikely	Don't Know
DARTFORD AND GRAVESHAM NHS TRUST	82.70%	16.76%	0.54%	0.00%	0.00%	0.00%
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	70.29%	19.57%	5.07%	0.00%	0.00%	5.07%
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	73.91%	13.04%	0.00%	0.00%	0.00%	13.04%
MEDWAY NHS FOUNDATION TRUST	70.78%	24.68%	1.30%	0.65%	1.30%	1.30%
ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	66.28%	24.42%	2.33%	0.00%	0.00%	6.98%
EAST SUSSEX HEALTHCARE NHS TRUST	60.19%	29.63%	2.78%	1.85%	1.85%	3.70%
England	67.15%	25.01%	2.84%	1.20%	0.85%	2.95%

Source: NHS England

Again, the majority of respondents would be extremely likely or likely to recommend the postnatal care they received to friends or family

How likely are you to recommend the care you received POSTNATALLY IN THE COMMUNITY to friends and family?

Trust	Extremely Likely	Likely	Neither	Unlikely	Extremely Unlikely	Don't Know
DARTFORD AND GRAVESHAM NHS TRUST	75.33%	20.14%	1.62%	0.51%	0.41%	2.00%
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	*	*	*	*	*	*
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	82.05%	12.82%	0.00%	0.00%	0.00%	5.13%
MEDWAY NHS FOUNDATION TRUST	*	*	*	*	*	*
ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	73.24%	25.35%	1.41%	0.00%	0.00%	0.00%
EAST SUSSEX HEALTHCARE NHS TRUST	94.44%	0.00%	0.00%	0.00%	0.00%	5.56%
England	55.00%	42.50%	2.50%	0.00%	0.00%	0.00%

Source: NHS England

Unfortunately the numbers of people completing the postnatal community provision question was very low. The responses at EKHUFT and Medway NHS Foundation Trust have therefore been suppressed to protect confidentiality. The data available for other trusts indicate that respondents are extremely likely to recommend this element of postnatal care to their family and friends. It is worth noting that a number of people reported being unlikely or extremely unlikely to recommend the postnatal care in the community received from Dartford and Gravesham NHS Trust and this may warrant further investigation.

The Care Quality Commission also undertakes an Annual Survey of Women's Experience of Maternity Care. The results for 2013 for each maternity service provider can be found via the following web-links:

- DVH - http://www.cqc.org.uk/survey/maternity/RN7 http://www.nhssurveys.org/Filestore/MAT13/Benchmark_LB/Labour%20and%20Birth%20Reports/MAT13_LB_RN7.pdf
- East Kent - http://www.cqc.org.uk/survey/maternity/RVV http://www.nhssurveys.org/Filestore/MAT13/Benchmark_LB/Labour%20and%20Birth%20Reports/MAT13_LB_RVV.pdf
- Maidstone & Tunbridge Wells - http://www.cqc.org.uk/survey/maternity/RWF http://www.nhssurveys.org/Filestore/MAT13/Benchmark_LB/Labour%20and%20Birth%20Reports/MAT13_LB_RWF.pdf
- Medway - http://www.cqc.org.uk/survey/maternity/RPA http://www.nhssurveys.org/Filestore/MAT13/Benchmark_LB/Labour%20and%20Birth%20Reports/MAT13_LB_RPA.pdf

Conclusion

This review has highlighted a distinct variation in the delivery of the antenatal and postnatal elements of the Healthy Child Programme across Kent with areas of excellent practice and areas where significant development is required.

The review of the interfaces and interdependencies between organisations and professionals involved in the delivery of the Healthy Child Programme has revealed the complexity of the pathway of care for pregnant women and families. Despite the implementation of routine protocols for information sharing between professionals there is still concerning evidence of lapses in information sharing which need to be addressed.

A series of recommendations have been made to address these and other issues identified by this review. These are intended to assist service commissioners, providers and users in Kent to identify priorities for action to ensure full and equitable delivery of the Universal Healthy Child Programme to every pregnant woman and family across Kent and ultimately to improve public health outcomes for mother and child.

The Kent Children's Health and Wellbeing Board is asked to endorse these recommendations and oversee the development of action plans to implement them.

Recommendations

The recommendations are listed twice, firstly in the order they appear in the report, then grouped for Commissioners , Providers and Kent Public Health Team.

- **In order of appearance in the report:**

- For the Kent Children and Young People's Health and Wellbeing Board to receive & endorse the recommendations of this report and identify an appropriate forum to take on responsibility for monitoring and reporting on the implementation of the recommendations of this review. Options include:
    - The new Kent-wide project group for Collaborative Commissioning for Children's and Maternity Services
    - The new Local Maternity Service Quality Groups (currently proposed by South East Commissioning Support Unit) whose terms of reference could include monitoring and reporting on the implementation of the recommendations of this report.
    - Expanding the existing KCC led Early Help and Healthy Child Programme Task and Finish Group to become a more permanent Kent-wide multidisciplinary forum for Primary Care, Maternity Services, Early Help and Social Care providers to discuss issues relating to the delivery of the HCP in the early years and monitor the implementation of the recommendations of this review.

- The Kent Public Health Team should work in collaboration with KMCS and Maternity Services to undertake a Health Equity Audit of provision and access to specialist midwives, such as mental health, domestic violence and healthy weight. This should be undertaken as part of a comprehensive epidemiological Maternity Health Needs Assessment for Kent which also incorporates the findings of this Service Review. The findings of this Maternity Health Needs Assessment should inform the development of a Kent-wide Maternity Strategy and Maternity Service Specification.

- The new Kent-wide Maternity Service Specification should include comprehensive and universal delivery of the full -9months to 1week element of the HCP and reflect all relevant NICE Guidelines for maternity care. A robust process of performance monitoring and challenge should be agreed to ensure adherence to the specification and encourage continuous service improvement.

- Kent Public Health and the Maternity, Children and Young Peoples Team in KMCS should work together to establish a Kent-wide and CCG specific Maternity Services Information Dashboard. This should incorporate both clinical and public health activity and outcomes data, making use of data available from the new national maternity services dataset which is due to become available in late 2014/ early 2015. The local dashboard should also align with the South East Regional Maternity Dashboard currently being developed by the South East Coast Maternity, Children and Young Peoples Clinical Network.

- Commissioners and providers should collaborate to produce a Kent-wide perinatal mental health pathway with equitable access to perinatal mental health support at all levels of need, including prevention services, for pregnant women across Kent. The pathway should be developed with reference to the national Maternal Mental Health Pathway. (40)
  The pathway should incorporate the new role of District Health Visitor Perinatal Mental Health Leads & explore their capacity to provide training and support to midwives and other stakeholders on the pathway.

- Provider Trusts should analyse the demographics of women who present late for booking to identify those groups most likely to present late. Kent & Medway Public Health Observatory may be able to assist with this analysis. Commissioners and Providers should collaborate to identify and implement evidence-based interventions for these groups to facilitate early access and encourage continuous engagement with maternity care throughout pregnancy.

- Maternity Care, Early Help and Children's Service providers should meet to review the referral pathway for mothers requiring early help and support antenatally. The pathway should be analysed to identify the potential causes of existing delays in the acceptance of antenatal referrals to Children's Services and to develop an action plan to address these issues.

- Wherever practicable the paper-based information that is provided to parents across Kent on issues such as lifestyle, breastfeeding and preparation for parenthood should be standardised. All 3 maternity service providers should work together to review the contents of the leaflets currently provided antenatally and postnatally to identify the most appropriate sources of information.

- Midwives should ensure that contact details for local breastfeeding support groups are always provided antenatally.

- The Kent Public Health Team should collaborate with CCGs to review the commissioning, provision and uptake of "Making Every Contact Count" training for midwives and other health professionals on the maternity care pathway and create an action plan to ensure MECC training is available to all staff to increase their confidence in providing opportunistic brief interventions on lifestyle change.
  NB NHS England is due to publish a MECC Action Plan in March 2015 which will include a focus on implementing MECC in maternity services.

- Maternity care providers across Kent should collaborate to review the demand for information leaflets in alternative languages and opportunities to jointly commission them where appropriate.

- Heads of Midwifery should ensure that midwives have access to training on the specific health needs of recent migrants / asylum seekers / refugees, their social, religious and psychological needs and the most recent policies on access and entitlements to care as per NICE Guideline 110 Pregnancy & Complex Social Factors. (44)

- The 3 maternity service providers should work together to review the contents and delivery of antenatal education sessions, to share best practice, ensure the delivery of consistent messages to parents and equity of access to high quality education sessions for prospective parents across Kent. This work should be undertaken with reference to the Department of Health Guidelines: Preparation for Birth & Beyond: A Resource Pack for Leaders of Community Groups & Activities. (48)

- Commissioners and providers should clarify the role of midwives in the provision of parenting advice and assessing emotional attachment and the pathways for referral for additional support both antenatally and postnatally. Consideration should be given to the training needs of midwives to fulfil this role.

- Midwives should liaise with the Smoking Cessation Service to identify opportunities to receive automatic feedback on women who do not accept the initial referral for support.

- Heads of Midwifery should liaise with Dieticians and Service Commissioners to ensure that there is sufficient capacity to refer all women with a BMI >30 for dietetic support as per the NICE Guideline PH27. (47)

- Specialist Teenage Pregnancy midwives should liaise with local Children's Centres and other community venues to clarify what extra support is available to young parents in their area and share this information with their midwifery teams.

- Kent Public Health Team in collaboration with KCC Adult Learning Disabilities Service should identify the current numbers of parents with LD known to services in order to develop an accurate estimate of current and future need. This should inform the development of a Kent-wide commissioning strategy for antenatal and postnatal parenting support for PWLD.

- Heads of Midwifery should undertake a training needs analysis to determine midwives' competence and confidence in talking to and supporting women at risk of domestic violence.

- Heads of Midwifery should ensure that all women receive information on the Healthy Start Programme antenatally.

- Heads of Midwifery should ensure that all midwives facilitate discussion on the risks of sudden infant death syndrome and risk reduction strategies antenatally along with the provision of written information.

- Heads of Midwifery should collaborate to identify opportunities to provide breastfeeding information for fathers and to encourage them to provide breastfeeding support to their partners.

- The Head of Midwifery for MTW should review the postnatal provision of information on injury prevention and ensure midwives take the opportunity to review the safety of the home environment and provide appropriate safety advice on home visits.

- Commissioners and Maternity Services across Kent should undertake a needs assessment for tongue tie services and explore cost-effective models for delivery (such as the midwifery led service in MTW) in order to ensure equitable access to tongue-ties services for infants across Kent.

- Kent Commissioners, Commissioning Support Services, Providers and Public Health Team should identify and agree appropriate representatives to join the SEC Maternity Children and Young People's Clinical Network and initiate or support existing work to address the issues identified, acting as a conduit for sharing knowledge and learning with the clinical network and colleagues in Kent.

- It is recommended that each provider, in collaboration with GPs and HVs, undertake an audit into multi-disciplinary communication and information sharing using the audit tool developed by EKHUFT & KCHT

as a template. The audit cycle should be completed with the development of a local action plan to address the issues identified and an agreed timescale for re-audit.

    - EKHUFT should also complete the audit cycle by undertaking a re-audit which includes analysis of GP communication which was not included in the original audit.

- The East Kent Clinical Protocol for Antenatal & Postnatal Communication and Risk Assessment is now overdue for review. It is recommended that KCHT should use this opportunity to lead the development and agreement of a Kent-wide communication and risk assessment protocol to ensure consistent information sharing methods between Midwives, Health Visitors and GPs are agreed between and implemented across the county

- For stakeholders to consider the opportunity to expand the existing KCC led Early Help and Healthy Child Programme Task and Finish Group to become a more permanent Kent-wide multi-disciplinary forum for Primary Care Providers (incl. GPs & HVs), Maternity Service Providers, Early Help and Social Services, or identify an alternative forum. This group could take on the responsibility for overseeing the implementation of the recommendations of this review as well as continuing its work to review the maternity care pathway, to identify potential points of contact with each service along the pathway and to clarify the roles of each profession/service in the care of the family. This work should include the clarification of GPs role in preconception and antenatal care. This could start with a review of the national Maternity Service to HV Service Pathway. (46)

- For the Heads of Midwifery and Head of Kent Integrated Family Support Services to encourage Early Help Managers & Community Midwives to collaborate to discuss the findings of the Early Help Group Managers' Survey and review current links between local Children's Centres and midwifery and explore opportunities to improve communication and increase the delivery of maternity services within Children's Centres where appropriate.

- The Kent Health and Wellbeing Board should confirm the source of funding for the recurring costs of delivering the Babyclear smoking cessation initiative (including the establishing the additional Risk Perception element of the programme) Kent-wide as soon as possible.

- The Kent Public Health Team (KPHT) should continue to engage with maternity services to provide "6 Ways to Wellbeing" training" for staff and support midwives to incorporate this into their advice on lifestyle behaviours as part of their antenatal care. The KPHT should also explore opportunities to engage with other professionals involved in the delivery of the Healthy Child Programme (such as Health Visitors, GPs and Children's Centre Staff) and support them to incorporate the "6 Ways to Wellbeing" messages into their practice.

- CCGs should clarify if all providers of NHS Talking Therapies in Kent prioritise pregnant women accessing assessment and treatment. Maternity services should be encouraged to signpost these services to pregnant women with low level mental health issues.

- Kent Public Health Observatory should work with CCGs and Health Service Providers to increase knowledge of the size and location of the Roma population. Maternity Services need to improve their data capture systems to enable the easy identification of Roma women and families accessing their services.

- Kent Public Health Team should respond to the results of the Adult Weight Management Consultation and work with CCGs to agree commissioning responsibility for healthy weight services for pregnant women.
- Local Health & Wellbeing Boards should include a review of the provision of antenatal support to young parents as part of their action plan in response to the Teenage Pregnancy Strategy.

- **Recommendations grouped by stakeholder:**
  - Recommendations requiring collaboration between Commissioners, Providers and Public Health

- For the Kent Children and Young People's Health and Wellbeing Board to receive & endorse the recommendations of this report and identify an appropriate forum to take on responsibility for monitoring and reporting on the implementation of the recommendations of this review. Options include:
  - The new Kent-wide project group for Collaborative Commissioning for Children's and Maternity Services
  - The new Local Maternity Service Quality Groups (currently proposed by South East Commissioning Support Unit) whose terms of reference could include monitoring and reporting on the implementation of the recommendations of this report.
  - Expanding the existing KCC led Early Help and Healthy Child Programme Task and Finish Group to become a more permanent Kent-wide multidisciplinary forum for Primary Care, Maternity Services, Early Help and Social Care providers to discuss issues relating to the delivery of the HCP in the early years and monitor the implementation of the recommendations of this review.

- For Stakeholders to develop a new Kent-wide Maternity Service Specification to include comprehensive and universal delivery of the full -9months to 1week element of the HCP and reflect all relevant NICE Guidelines for maternity care. A robust process of performance monitoring and challenge should also be agreed to ensure adherence to the specification and encourage continuous service improvement.

- Kent Public Health and the Maternity, Children and Young Peoples Team in KMCS should work together to establish a Kent-wide and CCG specific Maternity Services Information Dashboard. This should incorporate both clinical and public health activity and outcomes data, making use of data available from the new national maternity services dataset which is due to become available in late 2014/ early 2015. The local dashboard should also align with the South East Regional Maternity Dashboard currently being developed by the South East Coast Maternity, Children and Young Peoples Clinical Network.

- The Kent Public Health Team should work in collaboration with KMCS and Maternity Service to undertake a Health Equity Audit of provision and access to specialist midwifery services such as mental health, domestic violence and healthy weight.. This should be undertaken as part of a comprehensive epidemiological Maternity Health Needs Assessment for Kent which also incorporates the findings of this Service Review. The findings of this Maternity Health Needs Assessment should inform the development of a Kent-wide Maternity Strategy and Maternity Service Specification.

- Commissioners and providers should collaborate to produce a Kent-wide perinatal mental health pathway with equitable access to perinatal mental health support at all levels of need, including prevention services, for pregnant women across Kent. The pathway should be developed with reference to the national Maternal Mental Health Pathway. (40)
  The pathway should incorporate the new role of District Health Visitor Perinatal Mental Health Leads & explore their capacity to provide training and support to midwives and other stakeholders on the pathway.

- .Provider Trusts should analyse the demographics of women who present late for booking to identify those groups most likely to present late. Kent & Medway Public Health Observatory may be able to assist with this analysis. Commissioners and Providers should collaborate to identify and implement evidence-based interventions for these groups to facilitate early access and encourage continuous engagement with maternity care throughout pregnancy.

- The Kent Public Health Team should collaborate with CCGs to review the commissioning, provision and uptake of "Making Every Contact Count" training for midwives and other health professionals on the maternity care pathway and create an action plan to ensure MECC training is available to all staff to increase their confidence in providing opportunistic brief interventions on lifestyle change.
  NB NHS England is due to publish a MECC Action Plan in March 2015 which will include a focus on implementing MECC in maternity services.

- Kent Public Health Observatory should work with CCGs and Health Service Providers to increase knowledge of the size and location of the Roma population. Maternity Services need to improve their data capture systems to enable the easy identification of Roma women and families accessing their services.

- Commissioners and providers should clarify the role of midwives in the provision of parenting advice and assessing emotional attachment and the pathways for referral for additional support both antenatally and postnatally. Consideration should be given to the training needs of midwives to fulfil this role.

- The Kent Health and Wellbeing Board should confirm the source of funding for the recurring costs of delivering the Babyclear smoking cessation initiative (including the establishing the additional Risk Perception element of the programme) Kent-wide as soon as possible.

- Local Health & Wellbeing Boards should include a review of the provision of antenatal support to young parents as part of their action plan in response to the Teenage Pregnancy Strategy.

    - Recommendations for Commissioners

- Commissioners and Maternity Services across Kent should undertake a needs assessment for tongue tie services and explore cost-effective models for delivery (such as the midwifery led service in MTW) in order to ensure equitable access to tongue-ties services for infants across Kent.

- Kent Commissioners, Commissioning Support Services, Providers and Public Health Team should identify and agree appropriate representatives to join the SEC Maternity Children and Young People's Clinical Network and initiate or support existing work to address the issues identified, acting as a conduit for sharing knowledge and learning with the clinical network and colleagues in Kent.

- CCGs should clarify if all providers of NHS Talking Therapies in Kent prioritise pregnant women accessing assessment and treatment. Maternity services should be encouraged to signpost these services to pregnant women with low level mental health issues.

- Recommendations for Providers

- Provider Trusts should analyse the demographics of women who present late for booking to identify those groups most likely to present late. Kent & Medway Public Health Observatory may be able to assist with this analysis. Commissioners and Providers should collaborate to identify and implement evidence-based interventions for these groups to facilitate early access and encourage continuous engagement with maternity care throughout pregnancy.

- Maternity Care, Early Help and Children's Service providers should meet to review the referral pathway for mothers requiring early help and support antenatally. The pathway should be analysed to identify the potential causes of existing delays in the acceptance of antenatal referrals to Children's Services and to develop an action plan to address these issues.

- Wherever practicable the paper-based information that is provided to parents across Kent on issues such as lifestyle, breastfeeding and preparation for parenthood should be standardised. All 3 maternity service providers should work together to review the contents of the leaflets currently provided antenatally and postnatally to identify the most appropriate sources of information.

- Maternity care providers across Kent should collaborate to review the demand for information leaflets in alternative languages and opportunities to jointly commission them where appropriate.

- Heads of Midwifery should ensure that midwives have access to training on the specific health needs of recent migrants / asylum seekers / refugees, their social, religious and psychological needs and the most recent policies on access and entitlements to care as per NICE Guideline 110 Pregnancy & Complex Social Factors. (44)

- The 3 maternity service providers should work together to review the contents and delivery of antenatal education sessions, to share best practice, ensure the delivery of consistent messages to parents and equity of access to high quality education sessions for prospective parents across Kent. This work should be undertaken with reference to the Department of Health Guidelines: Preparation for Birth & Beyond: A Resource Pack for Leaders of Community Groups & Activities. (48)

- Midwives should liaise with the Smoking Cessation Service to identify opportunities to receive automatic feedback on women who do not accept the initial referral for support.

- Heads of Midwifery should liaise with Dieticians and Service Commissioners to ensure that there is sufficient capacity to refer all women with a BMI >30 for dietetic support as per the NICE Guideline PH27. (47)

- Specialist Teenage Pregnancy midwives should liaise with local Children's Centres and other community venues to clarify what extra support is available to young parents in their area and share this information with their midwifery teams.

- Heads of Midwifery should undertake a training needs analysis to determine midwives' competence and confidence in talking to and supporting women at risk of domestic violence.

- Heads of Midwifery should ensure that all women receive information on the Healthy Start Programme and details of local breastfeeding support groups antenatally.

- Heads of Midwifery should ensure that all midwives facilitate discussion on the risks of sudden infant death syndrome and risk reduction strategies antenatally along with the provision of written information.

- Heads of Midwifery should collaborate to identify opportunities to provide breastfeeding information for fathers and to encourage them to provide breastfeeding support to their partners.

- The Head of Midwifery for MTW should review the postnatal provision of information on injury prevention and ensure midwives take the opportunity to review the safety of the home environment and provide appropriate safety advice on home visits.

- It is recommended that each provider, in collaboration with GPs and HVs, undertake an audit into multi-disciplinary communication and information sharing using the audit tool developed by EKHUFT & KCHT as a template. The audit cycle should be completed with the development of a local action plan to address the issues identified and an agreed timescale for re-audit.
    a. EKHUFT should also complete the audit cycle by undertaking a re-audit which includes analysis of GP communication which was not included in the original audit

- The East Kent Clinical Protocol for Antenatal & Postnatal Communication and Risk Assessment is now overdue for review. It is recommended that KCHT should use this opportunity to lead the development and agreement of a Kent-wide communication and risk assessment protocol to ensure consistent information sharing methods between Midwives, Health Visitors and GPs are agreed between and implemented across the county

- For the Heads of Midwifery and Head of Kent Integrated Family Support Services to encourage Early Help Managers & Community Midwives to collaborate to discuss the findings of the Early Help Group Managers' Survey and review current links between local Children's Centres and midwifery and explore opportunities to improve communication and increase the delivery of maternity services within Children's Centres where appropriate.

    - Recommendations for Kent Public Health Team

- Kent Public Health Team in collaboration with KCC Adult Learning Disabilities Service should identify the current numbers of parents with LD known to services in order to develop an accurate estimate of current and future need. This should inform the development of a Kent-wide commissioning strategy for antenatal and postnatal parenting support for PWLD.

- The Kent Public Health Team (KPHT) should continue to engage with maternity services to provide "6 Ways to Wellbeing" training" for staff and support midwives to incorporate this into their advice on lifestyle behaviours as part of their antenatal care. The KPHT should also explore opportunities to engage with other professionals involved in the delivery of the Healthy Child Programme (such as Health Visitors, GPs and Children's Centre Staff) and support them to incorporate the "6 Ways to Wellbeing" messages into their practice.

- Kent Public Health Team should respond to the results of the Adult Weight Management Consultation and work with CCGs to agree commissioning responsibility for healthy weight services for pregnant women.

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- Appendices:

APPENDIX 1 – Modifiable pregnancy risk factors and their potential impacts

Risk Factor	Evidence
Tobacco	Of all the harmful exposures in pregnancy, it is arguably smoking which causes the greatest harm. Not only does it cause impaired fetal growth, low birth weight and preterm birth, it is also associated with an increased risk of miscarriage, stillbirth, neonatal death and sudden infant death syndrome (SIDS). Furthermore, smoking prevalence during pregnancy remains unacceptably high in the UK. Evidence of causal effects on neurodevelopment remains unclear
Alcohol	Heavy alcohol consumption during pregnancy causes a birth defect called fetal alcohol syndrome. It may also damage the fetal brain without affecting other organs or tissues. Evidence that drinking at low-to-moderate levels causes harm during pregnancy is equivocal
Obesity	Apart from increased risks to the mother's health (e.g. through gestational diabetes) obesity is also associated with large-sized babies (macrosomia). Children of obese mothers are at an increased risk of later obesity themselves. The relative contributions of genetic factors, the effect of the obesity on the fetal environment (fetal programming) and of poor eating habits/ nutrition in childhood remain unclear but all are likely to be important.
Diet	Maternal under-nutrition in pregnancy is associated with the development of heart disease in the adult offspring. There may even be effects transmitted to future generations. This finding (another example of fetal programming) is a very active area of research at the moment.
Illicit Drugs	Particular concerns have been expressed about the effects of illicit drugs such as heroin, cocaine, cannabis and ecstasy on the fetus. Use of illicit drugs is associated with problems in child development. Where the mother is a regular drug user there will often be other complex social factors involved and it is therefore difficult to tease apart the toxic effects of the drugs from the effects of being brought up in the frequently chaotic life circumstances of a drug-using mother (and possibly her partner) and the effects caused by the mother's often poor physical and mental health. Studies in humans have shown that, when adjusted to take account of other risk factors, many of the effects seem more related to the environment the child is brought up in rather than direct toxicity from the drugs.
Mental Illness	Although the role and relative contributions of mental illness during pregnancy, drug treatment and the effects of postnatal continuation of mental illness remain unclear, a substantial body of research documents the adverse impact of maternal depression during pregnancy on birth outcomes, on continuing depression in the postnatal period and on infant development and later child outcomes. In addition to depression other less commonly occurring mental illnesses can have an impact on pregnancy and birth outcomes.
Low Socio-economic Status	Low socio-economic status is associated with poorer outcomes in children: data from the UK Millennium Cohort Study indicate that a significant socio-economic gradient in children's development is already evident by 3 years of age. Several adverse pregnancy outcomes including preterm birth and stillbirth are linked to lower socio-economic status. Preterm birth in particular is responsible for a high proportion of later neurodisability. A sizeable proportion of the effects of low socio-economic status on birth outcomes may be due to a greater smoking prevalence in poorer populations.
Psychosocial Stress	One area which has been of particular interest for child development is how maternal psychosocial stress could operate during pregnancy to influence pregnancy outcomes, the child's development and later risk of disease. Although a compelling idea with some supportive evidence from studies in humans, there seems to be a low correlation in some studies between reported stress symptoms and the assumed biological processes involved. Furthermore, there is no substantial evidence base yet on how or in what ways stress could be modified in this population of pregnant women. Further research on interventions is needed.

Reference: Chief Medical Officer's annual report 2012: Our Children Deserve Better: Prevention Pays, Department of Health, 2013

APPENDIX 2 – Key elements of the Healthy Child Programme: Early pregnancy to 1week post partum

Reference: Healthy Child Programme: Pregnancy and the first five years of life. Department of Health & Department for Children, Schools & Families, 2009

UNIVERSAL

- Health and development reviews
- Screening and physical examinations
- Immunisations
- Promotion of health & wellbeing,

e.g. smoking , diet and physical activity breastfeeding and healthy weaning, keeping safe, prevention of sudden infant death & maintaining infant health & dental health

- Promotion of sensitive parenting and child development
- Involvement of fathers
- Mental health needs assessed
- Preparation and support with transition to parenthood and family relationships
- Signposting to information and services

PROGRESSIVE

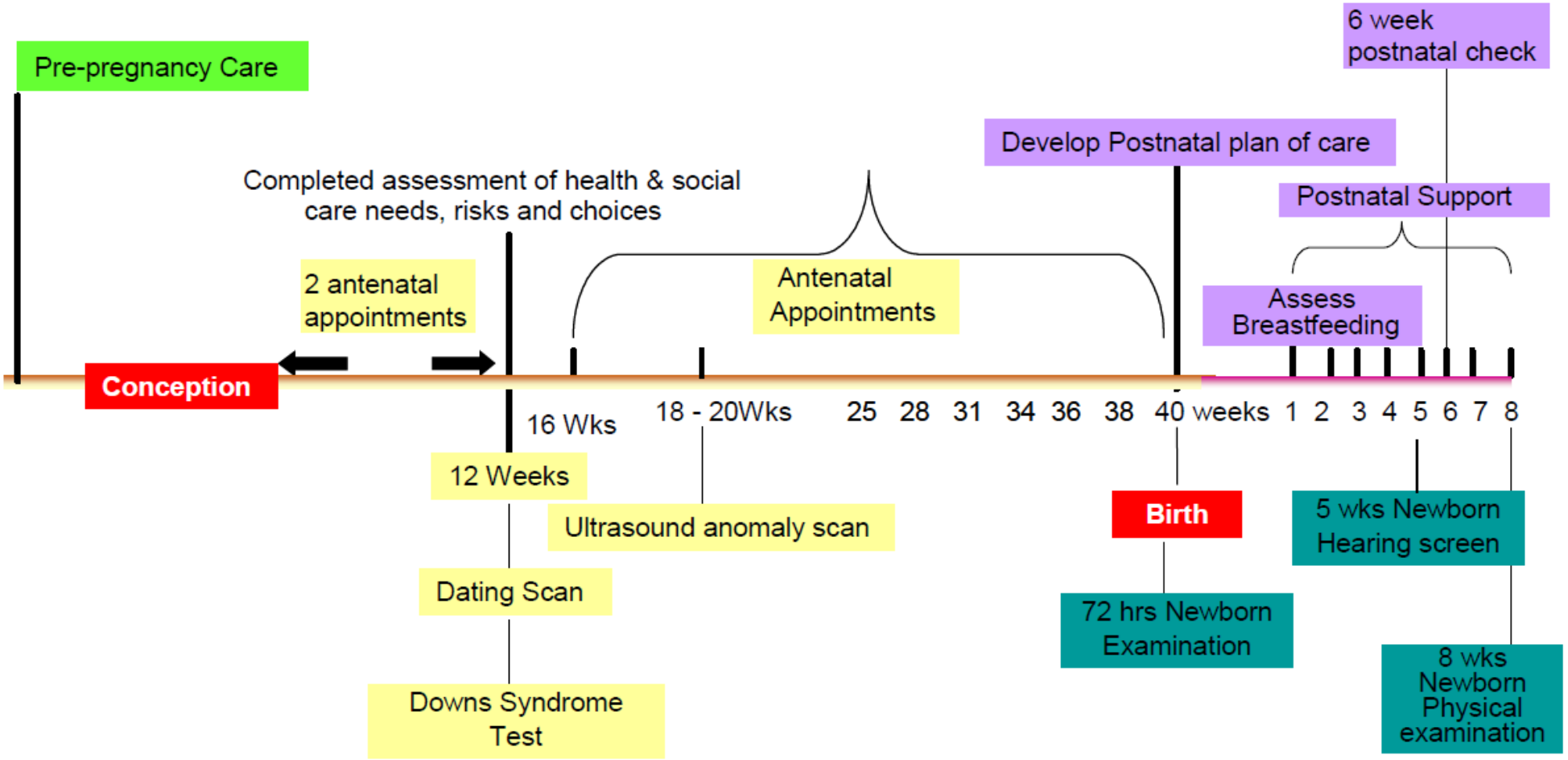
- Emotional and psychological problems addressed
- Promotion and extra support with breastfeeding
- Support with behaviour change (smoking, diet, keeping safe, SIDS, dental health)
- Parenting support programmes including assessment and promotion of parent-baby interaction
- Promoting child development including language
- Additional support and monitoring for infants with health or developmental problems
- Common Assessment Framework completed
- Topic-based groups and learning opportunities
- Help with accessing other services and sources of information and advice.

HIGHER RISK

- High-intensity-based intervention
- Intensive structured home visiting programmes by skilled practitioners
- Referral for specialist input
- Action to safeguard the child
- Contribution to care package led by specialist services

APPENDIX 3 – The Maternity Care Pathway in England

Reference: Commissioning Maternity Services: A Resource Pack to support Clinical Commissioning Groups, NHS Commissioning Board 2012



APPENDIX 4 –Key actions to be taken by midwives at the 3 levels of public health practice

Reference: Nursing and midwifery actions at the three levels of public health practice: Improving health and wellbeing at individual, community and population levels, Department of Health and Public Health England, 2013

Individual Level

- Individual obstetric, medical and social risk assessment by 12 completed week's gestation.
- Signposting and referral of individual women with medical risk factors and complex social needs to relevant professionals / agencies eg Obstetric care, smoking cessation services, Dietetic services, Safeguarding teams, CAMHs, Drug and alcohol services.
- One to one care in labour to support the promotion of normality and reduction in intervention such as caesarean section rates.
- Individualised support & encouragement of breastfeeding with referral to breastfeeding support services for those experiencing problems.
- Individualised care pathways to ensure improved maternal physical & mental health and wellbeing enabling strong early attachment and maternal and infant wellbeing.

Community Level

- Provision of local antenatal and newborn screening programmes meeting key performance indicators.
- Smoking cessation CO monitoring.
- Healthy start vitamin uptakes.
- Provision of specialist care pathways for vulnerable women – in conjunction with family nurse partnerships.
- Provision of parent education programmes in preparation for parenthood conveying clear and informative public health messages
- Promotion of breastfeeding in hospitals and at community level: – universal baby friendly standard reached by all care staff and breastfeeding welcome promoted in public places.

Population Level

- Provision of high quality , responsive maternity services in which women, their partners and families are supported to maintain & improve health and wellbeing throughout pregnancy, birth, the postnatal period and beyond through the transition to parenthood.
- Reduction in maternal and child mortality and morbidity rates resulting from medical, obstetric, social and psychological risk factors.
- Provision of regional antenatal & newborn screening programmes leading to early detection and where possible treatment of congenital abnormalities and disease.
- Increase in breastfeeding rates at population level, improved short and long term outcomes through improved nutrition leading to improved obesity rates and related illness in later life.

Appendix 5 - NICE Guidance relating to the public health aspects of Maternity Care

Name	Code	Year of Publication	Link to Guidance
Antenatal Care	CG62	2008	http://publications.nice.org.uk/antenatal-care-cg62/guidance
Postnatal Care	CG37	2006	http://publications.nice.org.uk/postnatal-care-cg37/guidance
Antenatal & Postnatal Mental Health (due to be updated in Dec 2014)	CG45	2007	http://www.nice.org.uk/guidance/CG45
Pregnancy & Complex Social Factors	CG110	2010	http://publications.nice.org.uk/pregnancy-and-complex-social-factors-cg110/guidance
Maternal & Child Nutrition	PH11	2008	http://publications.nice.org.uk/maternal-and-child-nutrition-ph11/recommendations
Quitting Smoking in Pregnancy & After Birth	PH26	2010	http://publications.nice.org.uk/quitting-smoking-in-pregnancy-and-following-childbirth-ph26/recommendati
Smoking Cessation in Secondary Care: Acute, Maternity & Mental Health Service	PH48	2013	http://www.nice.org.uk/Guidance/PH48
Weight Management Before, During & After Pregnancy	PH27	2010	http://publications.nice.org.uk/weight-management-before-during-and-after-pregnancy-ph27/recommenda
Diabetes in Pregnancy (due to be updated in Feb 2015)	CG63	2008	http://publications.nice.org.uk/diabetes-in-pregnancy-cg63/guidance
Hypertension in Pregancy	CG107	2010	http://publications.nice.org.uk/hypertension-in-pregnancy-cg107/guidance
Multiple Pregancy Rec 1.2.2.2 & 1.2.2.3 only	CG129	2011	http://publications.nice.org.uk/multiple-pregnancy-cg129/guidance
Antenatal Care Quality Standard	QS22	2012	http://publications.nice.org.uk/quality-standard-for-antenatal-care-qs22/list-of-quality-statements
Postnatal Care Quality Standard	QS37	2013	http://publications.nice.org.uk/postnatal-care-qs37
Hypertension in Pregancy Quality Standard	QS35	2013	http://publications.nice.org.uk/hypertension-in-pregnancy-qs35/list-of-quality-statements
Multiple Pregancy Quality Standard	QS46	2013	http://www.nice.org.uk/guidance/QS46

APPENDIX 6 – List of one to one interviewees and meetings attended

Interviewees:

Name	Job Title	Organisation
Dr Brighton Chireka	CCG Clinical Adviser for Children & Maternity	South Kent Coast CCG
Dr Chinni Chintakuntla	CCG Clinical Adviser for Children & Maternity	Ashford CCG
Rachel Grout	Commissioning Project Manager	Ashford CCG
Dr David Grice	CCG Clinical Adviser for CAMHS	Canterbury Coastal CCG
Margaret Mogentale	CCG Commissioning Lead for Children	Thanet CCG
Dr Catherine Handy	CCG GP Clinical Adviser	DGS CCG
Dr Su Xavier	Assistant Director of Partnerships and Health Inequalities	DGS & Swale CCGs
Dr Mark Ironmonger	CCG Clinical Adviser for paediatrics, maternity and dermatology	West Kent CCG
Maddie Harris	Consultant Midwife Lead for Public Health	EKUHFT
Gillian Duffey	Head of Midwifery	MTW NHS Trust
Alison Mendes	Consultant Midwife	MTW NHS Trust
Hilary Thomas	Consultant Midwife	MTW NHS Trust
Sarah Gregson	Consultant Midwife	MTW NHS Trust
Deborah McAllion	Head of Midwifery	Dartford & Gravesham NHS Trust
Ursula Marsh	Assistant Head of Midwifery	Dartford & Gravesham NHS Trust
Alison Corbett	Mother & Infant Mental Health Service Manager	KMPT
Alex Cheshire	Senior Associate for Acute Paediatrics and Maternity Services	KMCS
Beverley Lignum	Associate Acute Paediatrics & Maternity Services	KMCS
Marie Williams	Associate Acute Paediatrics & Maternity Services	KMCS
Sue Flynn	Head of Health Visiting & FNP	KCHT
Mary DeSantos Justo	Public Health Commissioning Manager	NHS England
John Rodriguez	Kent & Medway Screening & Immunisation Lead	NHS England
Nick Fenton	Head of 0-11 Kent Integrated Family Support Service	KCC
Hillary Wareing	Co-Director of the Tobacco Control Collaborating Centre & Babyclear Project Lead	Tobacco Control Collaborating Centre
Linda Smith	PH Specialist - Drugs & Alcohol Harm Reduction	KCC
Ivan Rudd	PH Specialist - Mental Health	KCC
Val Miller	PH Specialist - Obesity & Breastfeeding	KCC
Jo Tonkin	PH Specialist – Children and Young People	KCC
Del Herridge	Senior PH Information Analyst	KCC

Meetings attended:

Meeting Title	Date
East Kent Child Health and Maternity Strategy Group	28/05/2014
East Kent Maternity Services Liaison Committee	11/06/2014
North Kent Maternity Services Liaison Committee	16/06/2014
Birth Voices - West Kent Maternity Services Liaison Committee	09/09/2014
Kent & Medway Immunisations Board	02/09/2014

APPENDIX 7 – Details of the survey of Early Years Managers

A brief survey of Kent County Council Early Help Managers was undertaken, in September 2014, to ascertain the level of engagement between Maternity Services and Children's Centres and the amount of maternity service delivery taking place in Children's Centres across Kent.

The survey was designed by the report author and provided in a paper-based and online format The survey was distributed to Early Help Group Managers via email, with the endorsement of the Head of Kent Integrated Family Support Services. 11 responses were received and the results are summarised in the section; "System mapping – Service interdependencies and professional interfaces".
The following is a copy of the paper-based version of the survey:

SURVEY OF LINKS BETWEEN CHILDREN'S CENTRES AND MATERNITY SERVICES

Hello, my name is Helen Buttivant and I'm a Trainee Public Health Consultant working in the KCC Public Health Team.
I am currently undertaking a review of the relationship between Public Health and Maternity Services. As part of this review I am keen to gain an overview of the links between maternity services and children's centres across Kent.
The Head of Kent Integrated Family Support Services has authorised this brief survey and I would be very grateful if you could complete it and return it to me via email by ***Tues 9th September***

If you would prefer to complete an online version of the survey please follow go to this address:
https://www.surveymonkey.com[redacted]

Your name, job title and email address:
Name & address of Hub/Lead Children's Centre in your district:
Names of other Children's Centres in your district:

Do midwives provide any of the following services direct from your Childrens' Centre(s)?

Antenatal Clinics	YES / NO
Antenatal / Parentcraft Classes	YES / NO
Postnatal Clinics (aka Well Baby Clinics)	YES / NO
Other	YES / NO

Please provide any further details here:

Do Childrens' Centre Staff provide information for or participate in the provision of antenatal / parentcraft classes either within the Childrens' Centre(s) or elsewhere?

YES / NO

If "YES" please provide further details here:

Do you provide any other specific support for pregnant women and their partners in your Childrens' Centre(s) (e.g. healthy eating in pregnancy, smoking cessation, support to young parents to be etc)
YES
NO

If “YES” please provide further details here:

How do you liaise with the midwives working in your area:

Informally – ie as and when issues arise	YES / NO
Formally – ie regular face to face meetings	YES / NO
Other	YES / NO

Please provide details:

If you have any other comments on the links between maternity services and Children’s Centres in your area please add them here:

Thankyou for completing this survey. If you have any questions about this survey or my project please don’t hesitate to contact me: [redacted]