

# Bristol and South Gloucestershire PCTs

Commissioning Issues for  
Maternity Services in Bristol and  
South Gloucestershire

**23 November 2004**

## Contents

<b>Purpose</b>	<i>Page 3</i>
<b>Background</b>	<i>Page 3</i>
<b>Are Population Health Needs Changing</b>	<i>Page 3</i>
<b>Outcomes: Mortality in Early Life</b>	<i>Page 4</i>
<b>Low Birthweight</b>	<i>Page 4</i>
<b>Stillbirths</b>	<i>Page 7</i>
<b>Perinatal Mortality</b>	<i>Page 8</i>
<b>Postneonatal Mortality</b>	<i>Page 8</i>
<b>Infant Mortality</b>	<i>Page 8</i>
<b>Maternal Mortality</b>	<i>Page 8</i>
<b>Breastfeeding</b>	<i>Page 9</i>
<b>Currents Issues for Service Providers</b>	<i>Page 10</i>
<b>Local Health Needs</b>	<i>Page 10</i>
<b>Changes in Services</b>	<i>Page 10</i>
<b>Choice</b>	<i>Page 11</i>
<b>Antenatal Screening</b>	<i>Page 11</i>
<b>Service Reconfiguration</b>	<i>Page 11</i>
<b>Quality Standards and Initiatives</b> <b>BNSSG – wide working</b> <b>Public Involvement</b> <b>GP Role in Maternity Services</b> <b>Risk Management</b>	<i>Page 12</i>  <i>Page 13</i>
<b>Caesarean Section Rates</b>	<i>Page 13</i>
<b>National Policy</b>	<i>Page 14</i>
<b>Information Sharing with Commissioners</b>	<i>Page 15</i>
<b>Conclusions</b>	<i>Page 15</i>

## **1 Purpose**

This is a report on a brief review of commissioning issues relating to maternity services. It concludes with key issues for maternity services in Bristol and South Gloucestershire.

## **2 Background**

A review of commissioning issues around neonates, maternity and gynaecology services was requested by the Bristol and South Gloucestershire Acute Commissioning Strategy Board. A comprehensive review of all aspects of all three specialties was not feasible. The review of maternity services had a narrower remit, aiming to identify key concerns amongst lead clinicians and managers of the services, and to assess the local situation for the topical issues of antenatal screening and Caesarean section rates. This report draws on information from:

- Interviews with lead clinicians and managers from services at St Michael's Hospital and Southmead Hospital.
- Published research
- Local health services data

It is therefore a partial view of maternity needs and services, in including only selected topics and informants. It is notable that users of the services have not been included in this preliminary review of issues.

## **3 Are Population Health Needs Changing?**

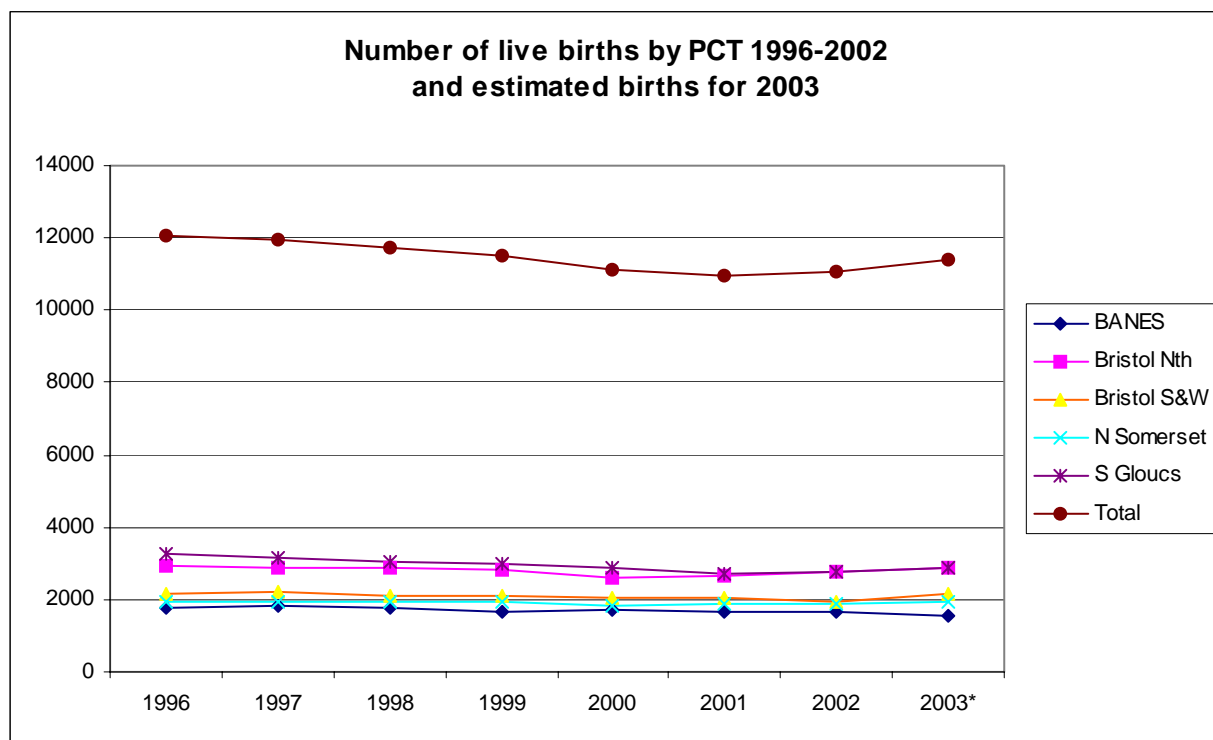
National interim 2001-based population projections suggest that the England and Wales population will continue to age over the next few decades. The number of people aged 30 – 59 is projected to fall from 42% to 37% in 2031, reflecting the low birth rates of the 1970's and recent low fertility<sup>2</sup>. Total fertility rates (the number of children a woman would bear if the current age specific fertility rates persisted throughout her childbearing years) have fallen but are expected to rise slightly during this decade, then remain relatively stable. Completed family size will continue to decline then level off at 1.75 children per woman.

General fertility rates fell in BNSSG during 1996-2000, reflecting the national trend. Both maternity units have seen a more recent upturn in the number of deliveries. Analysis of ONS and trust data suggests that total births in 2003 are likely to have returned to the levels seen in 1998 and 1999 (Graph 1). It is too soon to suggest that there is a sustained upward trend towards more births in BNNSG. Births might be expected to stay at around the current level given national predictions, but 2001 Census based population projections expected this autumn should be used to consider more specifically how local PCT populations are likely to change.

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<sup>2</sup> Hindess G. Population review of England and Wales 2001. Population Trends 112: summer 2003.

Graph 1



Source: Avon IM&T using trust and ONS data. \*2003 estimate based on trust data with additional 3.5% births added to allow for home deliveries. Comprehensive data awaited from ONS.

#### 4 Outcomes: Mortality in Early Life

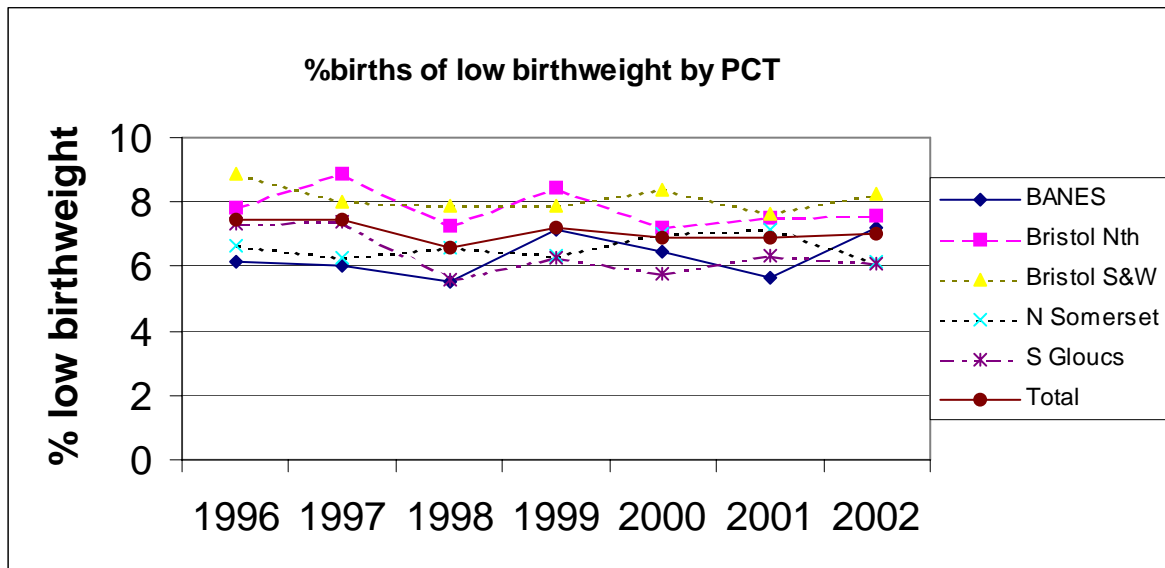
None of the following indicators show significant differences for local PCT populations compared with England. Data available here were mostly limited to only the most recent 3 year rates<sup>3</sup>. With this caveat, stillbirth and perinatal mortality rates (which most closely relate to quality of care) were satisfactory. The relatively high postneonatal and infant mortality rates observed particularly in North Somerset should be evaluated over a longer period.

#### 5 Low Birthweight

Low birthweight reflects premature birth and/or growth restriction in utero. The percentage of low birthweight babies (<2500g) increased nationally during the last quarter of the 20<sup>th</sup> century, reflecting the combination of demographic change (more women in later childbearing years) and a trend towards having children at a later age<sup>1</sup>. Bristol and South Gloucestershire data for 1996-2001 do not show an upward trend in low birthweight (graph 2). Rates were higher in Bristol, but not significantly different to the English rate.

<sup>3</sup> Sources were Avon Phnet, and the Clinical Compendium of Indicators via the South West Public Health Observatory at [www.swpho.org.uk](http://www.swpho.org.uk)

Graph 2

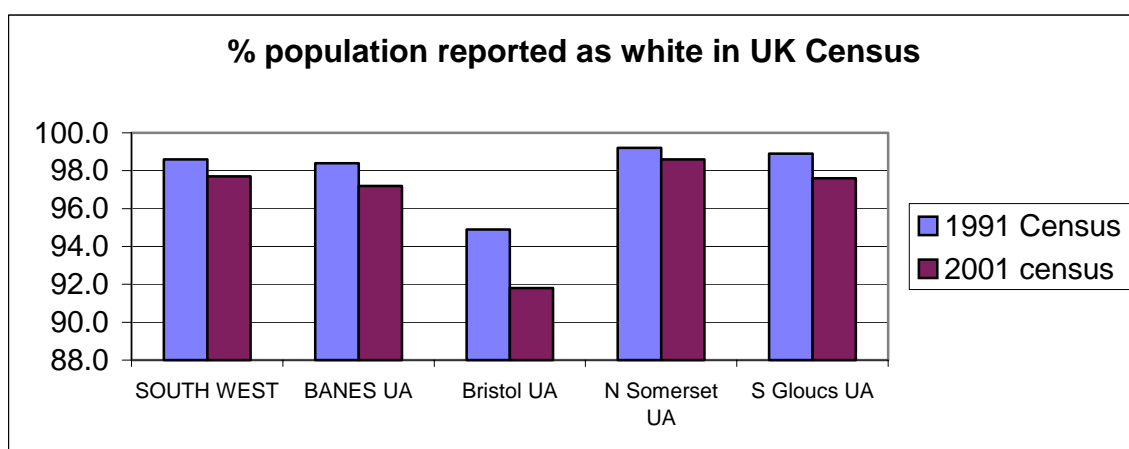


Source: Avon Phnet. <http://nww.avon.nhs.uk/phnet/> Low birthweight = births <2,500g as a percentage of total births

Factors associated with poorer health in babies, low birthweight and increased need for maternity and neonatal services include:

- Ethnicity. Somali women have been noted as a group with particularly high levels of need by services in Bristol particularly at UBHT. Low birthweight is commoner amongst many minority ethnic groups. Nationally very low birthweight (associated with high levels of need for neonatal care) was commonest for infants of mothers born in the Caribbean and West Africa during 1983-2001<sup>4</sup>. Results of the decennial national Census show an increase in the proportions of the population from ethnic minority backgrounds in all BNSSG PCTs in 2001 compared with 1991, and a corresponding fall in the proportion describing themselves as white (graph 3). Within this trend the number of people describing themselves as Black or Black British has grown.

Graph 3



Source: Avon Phnet. <http://nww.avon.nhs.uk/phnet/>

<sup>4</sup> Collingwood Bakeo A. Trends in live births by mother's country of birth and other factors affecting low birthweight in England and Wales 1983-2001. Health Statistics Quarterly 23; Autumn 2004.

- Drug dependency. There have been annual increases in reports of people with drug misuse to Regional Drug Misuse Databases<sup>5</sup>. 95% of users in a recent Regional Drug Misuse Database census were aged 15-44 yrs, with 50% in their 20's. Males outnumbered females by 3:1. With respect to neonatal services, there were 63 referrals to the maternity substance abuse service at St Michaels in 2003/04. One third of the babies recorded during Jan 03 – March 04 were of low birthweight (compared to the national rate of around 7%). At Southmead in 2003, 60 women were seen by the 'drugs in pregnancy' service.
- Smoking rates have been rising amongst girls aged 11-15 yrs. Just over a third of mothers (34%) in the United Kingdom smoked before or during pregnancy, whilst a fifth of all mothers (20%) continued smoking during their pregnancy. Among women smoking before their pregnancy, rates of stopping averaged 10% immediately before pregnancy and 18% during pregnancy. Smoking rates are highest amongst women who are most socio-economically disadvantaged. Low birthweight is twice as common amongst infants of mothers who smoke compared with non-smokers. There is research evidence showing smoking cessation interventions can be effective in pregnancy, but equally favourable results are not always achieved when implementing these in non-research settings<sup>6</sup>. Mandatory data requirements started in April 2003. Data quality is developing: local trend data should be available soon to further inform development of smoking cessation programmes being implemented by the maternity units and PCTs. These include employing 'Support to Stop' midwives.
- Teenage conception rates are above the E&W average in Bristol amongst women under 18yrs, and close to average in under 16's. There has been little change since 1998. S Gloucestershire has lower than average rates, with a recent fall in under 18's and a rise in under 16's. In N Somerset the under 18 rate rose between 1998 and 2001, and is close to the national average, whilst the rate in under 16's is low.
- Women who are in prison are a numerically small but high need group. NBT provides services for women in Eastwood Park Prison.
- Women from manual social classes are more likely to book late for antenatal care and/or make fewer antenatal visits than other women<sup>1</sup>. There is evidence of later booking of antenatal care by Asian women<sup>7</sup>. Graph 4 shows that low birth weight is commonest amongst the fifth of the population with the highest level of socio-economic disadvantage. The same pattern is seen for all other BNSSG PCTs except South Gloucestershire<sup>8</sup>.
- Multiple births have increased nationally over the past 20 years, associated with increased use of infertility treatment. The 2001 multiple maternity rate was 14.8 multiple maternities/1000 maternities compared with 12.1 in 1991<sup>1</sup>. In England in 1997-98 there were 280 deliveries of triplets or higher order multiple births out of approximately 585 000 deliveries – these are rare events. Eighty-nine percent of higher order multiple births were born preterm. This compares with 7% of singletons and 47% of twins. Prematurity, low birthweight, stillbirth and death are significantly commoner in multiple pregnancies.
- More 'higher risk' teenage and adult women survive childhood cancer and congenital heart disease, leading to new demands on services eg greater need for high dependency and intensive care.

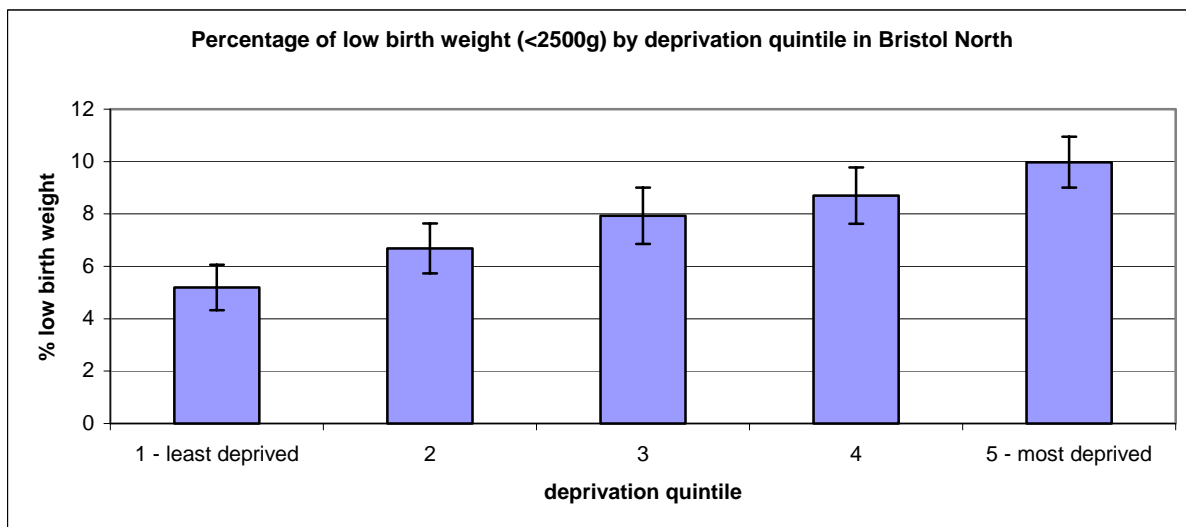
<sup>5</sup> South West Public Health Observatory. The impact of drug misuse on health in the South West, 1996-2001. <http://www.swpho.org.uk/drugsimpact/background.htm>

<sup>6</sup> Bull J et al. Prevention of low birthweight: assessing the effectiveness of smoking cessation and nutritional interventions. Health Development Agency 2003.

<sup>7</sup> Rowe R, Garcia J. Access to care for low income childbearing women. Evidence on access to maternity and infant care in England. March 2003. National Perinatal Epidemiology Unit, Oxford University.

<sup>8</sup> Graphs are available on the Avon Public Health webpage at <http://nwww.avon.nhs.uk/phnet/data2/births/graphs.xls>

**Graph 4**

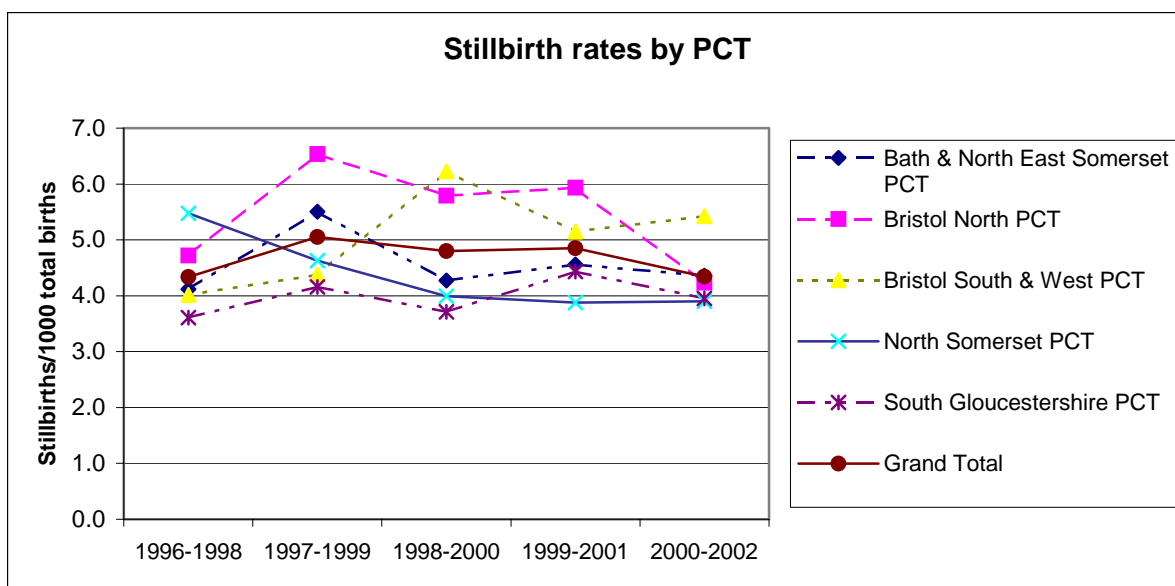


Source: Avon Phnet. <http://nww.avon.nhs.uk/phnet/><sup>6</sup>

## 6 Stillbirths

Numbers of stillbirths by PCT are small, in all but one year falling within the range of 6 – 16 stillbirths. Graph 5 shows that the total 3 yr rolling rate was stable between 1998 and 2002. Local PCT rates for 2002 were all below the English rate. The majority (70%) of stillbirths are for unexplained reasons, but risk factors for low birthweight are relevant to prevention of stillbirths. Congenital malformations are the next commonest cause accounting for just over one-fifth of stillbirths.

**Graph 5**



Source: Avon PHnet. Stillbirth rate = number of stillbirths (fetal deaths after 24 weeks) per 1000 total births.

## **7 Perinatal Mortality**

Perinatal deaths include stillbirths plus early neonatal deaths (at ages up to 6 completed days of life). The pooled perinatal mortality rate for 1999 – 2001 for England was 8 per 1000 thousand births. Local PCT rates were not significantly different from the English rate, being 8 or less. Immaturity is the recorded cause of death for about half of neonatal deaths (those in the first week of life), and congenital malformations account for a quarter of deaths.

## **8 Postneonatal Mortality**

Postneonatal mortality includes all deaths between 28 days and 1 yr old. The pooled rate for 1999 – 2001 for England was 1.8 per 1000 live births (95% confidence intervals 1.7 – 1.9). Higher rates are found for North Somerset at 2.8 (95% CI 1.7 – 4.6) and Bristol at 2.2 (95% CI 1.6 - 3.2), but these are not statistically significantly different from the English rate. Congenital malformations accounted for 28%, sudden infant death syndrome for 26% and infection 17% of postneonatal deaths nationally in 1998<sup>9</sup>.

## **9 Infant Mortality**

Infant mortality includes all deaths under 1 yr of age. The English rate in 2001 was 5.4 per 1000 live births (95% CI 5.2-5.6). Bristol, North Somerset and South Gloucestershire all had non-significantly higher rates, North Somerset being highest at 7.5 deaths per 1000 live births (95% CI 4.4–12.6).

## **10 Maternal Mortality**

Maternal deaths are very uncommon. Confidential enquires are conducted for all maternal deaths, as part of the national Confidential Enquiry into Maternal and Child Health (CEMACH).

The 1997-1999 Enquiry reported that women from the most disadvantaged groups of society were about 20 times more likely to die than women from the highest two social classes. Women from minority ethnic groups were twice as likely to die as women from white groups, and deaths amongst women from traveller groups are disproportionately more common<sup>10</sup>. Domestic violence was a feature in 12% of cases, and 20% of women who had died had booked for maternity care after 24 weeks, or had missed over four routine antenatal visits. There was concern about the numbers of women under 18yrs, increasing maternal age and parity, and possible overrepresentation of women with multiple pregnancies. Many women were obese.

Previous introduction of clinical guidelines was credited with the observed reduction in deaths from pulmonary embolism and sepsis, but women were still dying from preventable causes. Many cases were thought to have been missed in primary care or A&E. The leading cause of death overall was suicide. Deaths arising from causes directly related to pregnancy were lower than in any previously investigated triennium, but deaths from sepsis were slowly increasing.

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<sup>9</sup> Kinra S, Cooke H. Infant mortality in the South West of England. South West Public Health Observatory 2002.

<sup>10</sup> Executive summary and key recommendations. Confidential Enquiry in Maternal Deaths 1997 – 1999.

The report made recommendations around implementation of clinical guidelines (with a lead professional to develop and update them), staff training and many aspects of care. With respect to health services commissioning, it highlights the need for promoting early uptake of antenatal care, providing woman centred care particularly to enable easier access for women with greatest needs (by involving women in planning services) and ensuring there are appropriate responses to high risk pregnancies. Specialist support is recommended for mental health, and action to identify and respond to domestic violence.

The recent CEMACH report for 2000-2002 noted that thromboembolism remains the commonest cause of maternal deaths directly attributed to maternity (as opposed to indirect or coincidental causes). Psychiatric illness was the commonest cause of maternal deaths overall, followed by cardiac causes. The report reiterated the need for a perinatal psychiatry service. Difficulties in accessing services, particularly for the vulnerable and socially excluded were again highlighted<sup>11</sup>.

National data for 2001 and 2002 combined show no maternal deaths in Bristol or South Gloucestershire. There were 2 deaths in North Somerset, and 6 for the South West region as a whole.

## 11 Breastfeeding

Breastfeeding (exclusively for the first 6 months of life) is recommended by the Department of Health and World Health Organisation as the best diet for promoting infant and maternal health. Breast feeding rates are highest in the highest socio-economic groups.

*'Lack of breastfeeding contributes to the increased morbidity and mortality seen in the lowest socio-economic groups and research evidence suggests that at least two of the designated priority areas for action, namely cancers and coronary health, could be positively impacted by increasing breastfeeding rates'<sup>12</sup>.*

The national Priorities and Planning Framework target is to deliver an increase of 2 percentage points per year in breastfeeding initiation rate, focussing especially on women from disadvantaged groups. Table 1 provides information on breastfeeding rates at 6-9 weeks, but this has to be treated with caution. Definitions changed in 2002 to enable inclusion of babies being both breast and bottle fed, rather than just breastfed alone, therefore it is not appropriate to compare this data with rates recorded in 2001.

**Table 1 PCT breastfeeding rates 2002**

PCT	Number breastfed, 2002	% breastfed	95% CI
Bristol North PCT	1331	54.8	2.0
Bristol South & West PCT	716	42.5	2.4
North Somerset PCT	816	46.3	2.3
South Gloucestershire PCT	1043	43.8	2.0
<b>Total</b>	<b>3906</b>	<b>47.3</b>	<b>1.1</b>

Source: Avon Phnet. <http://nww.avon.nhs.uk/phnet/>

<sup>11</sup> Why Mothers Die 2000-2002 - Report on confidential enquiries into maternal deaths in the United Kingdom. Executive summary and key findings. RCOG London 2004. <http://www.cemach.org.uk/publications.htm>

<sup>12</sup> Fiona Dykes. A Report Evaluating the Breastfeeding Practice Projects 1999-2002. Department of Health. London. 2003.

## 12 Current Issues for Service Providers

The key themes arising from discussion with clinician and managers were:

- Local needs, particularly awareness and responses to women with high levels of need
- Changes in demand relating to the changing role of local neonates services, and through women exercising choice, and concern about reconfiguration
- Low levels of midwifery staffing
- Implementing antenatal screening for haemoglobinopathies and changes in Down's Syndrome screening
- Quality: continuing work on risk management and implementing clinical guidelines.

## 13 Local Health Needs

Health needs are discussed in the section on low birthweight above. Surestart was welcomed as a vehicle for innovation and raising standards of care, but there was frustration around it being limited to only specified neighbourhoods. Care of women from minority ethnic groups was a particular concern, in terms of logistics of ensuring interpreters are available as needed, and developing common understanding with women and their communities (particularly around use of Caesarean sections).

## 14 Changes in Services

The specialist role of the St Michael's and Southmead neonates services as level 3 services offering full intensive care within the Western Network has an impact on maternity services. Infants and mothers identified as high risk are best transferred to specialist services before delivery. This means that the demands on the receiving units are two-fold ie obstetric care for the mother and neonatal care of her infant. Local providers are concerned that national pricing of obstetric care does not recognize the complexity of the cases they receive, and that these referrals are consequently underfunded. Taking out of area referrals can also prevent the admission of a local woman even when her delivery was booked at the local unit. Changes in neonates services are discussed in a companion paper reviewing neonates services. The perspective for neonates services on this issue is different, as out of area referrals bring funding which is particularly appreciated in the light of perceived under funding for Avon babies.

Meeting the differing requirements of the European Working Time Directive, New Deal and the new consultant contract is challenging. Nationally new models for staffing are being piloted. At UBHT previous benchmarking showed the lowest provision of WTE consultants in obstetrics and gynaecology compared with other teaching hospitals, and that the service overall was cheaper.

Midwifery staffing is the major current concern, with UBHT levels being assessed as >30 wte below those proposed in 'Birthrate plus' (a national model for midwifery staffing). This compromises the capacity to provide one to one care: at UBHT a midwife may have to care for 3 women simultaneously during labour. High turnover leads to a relatively high workloads with respect to recruitment, induction and retraining. Community midwifery has the greatest shortages. These problems are due to lack of funded posts, rather than difficulty in recruiting.

NBT are working to improve obstetric service access to foetal medicine. Cover was agreed with visiting UBHT consultants but the sustainability of this is in doubt. A funded part time vacancy may not be adequate and further options to ensure adequate cover need to be identified.

## 15 Choice

The need to balance workload between the two maternity services was highlighted. This can be difficult to achieve where women exercise choices that lead to one trust having a higher workload than the other. One example is women living outside central Bristol choosing to book at St Michael's because they work in the city centre, and find this service more convenient for antenatal appointments. There was uncertainty about the implementation of choice for patients with respect to these services, and whether admitting rights for specified practices could be continued in future.

## 16 Antenatal Screening

Both trusts are working on implementation of developments in screening for Down's Syndrome and implementation of universal haemoglobinopathy screening. Local briefing papers are available<sup>13</sup>.

The major local developments needed to meet new national standards for Down's Syndrome are implementation of routine dating scans, and provision of a more complex combination of serum screening tests, in line with guidance from the National Screening Committee.

Both screening based on serum testing alone, and serum testing in combination with Nuchal Translucency (NT) screening are possible methods for meeting the 2007 performance targets. Local work is focusing on dating scans as a first priority, followed by development in serum screening to improve performance. However, the Regional Management Group for Antenatal Screening have recently recommended maternity units offer NT screening by 2007, and have asked units to consider development needs, to be discussed in October 2004.

Screening for haemoglobinopathies (sickle cell anaemia and thalassaemia) has been selective rather than universal. Central funding to support implementation of universal screening at St Michaels and Southmead is available for 2 years, following which PCTs will need to pick up costs. A costed implementation plan is being developed for the next Local Delivery Plan (LDP).

UBHT commented that these programmes will have a significant impact on midwifery workloads. Development of a technician provided dating scan service is being explored.

## 17 Service Reconfiguration

Clinicians and managers at NBT felt that the current configuration whereby NBT runs both hospital and community maternity services works well and achieves well-integrated care. Moving community services to PCTs would risk reducing this integration.

Transferring high risk babies in utero rather than post delivery (for safety reasons) means that accepting the transfer of a high risk baby increases workload for both obstetric and neonatal services. Whilst funding arrangements may be adequate for the costs of providing care for the baby, the mother often has above average health needs, and standard funding arrangements do not adequately cover these.

Women with greater health risks need access to high dependency and intensive care. This needs to be reflected in the location and development plans of services.

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<sup>13</sup> Antenatal screening. Dr V Harrison, Consultant in Public Health, BNSSG PCTs (based at BSW PCT)

Local and regional workloads relating to women with complex conditions need to be shared and appropriately balanced across the 2 trusts. Obstetric services need to retain access to adult services undergoing centralisation, to support care of women with medical conditions.

Proposals to change neonatal management and service configuration need to include careful assessment of the implications for obstetric services. There is concern that local women have to be turned away because of the impact of transfers on capacity.

Both units are large in terms of the number of deliveries per annum, compared to other units in England. Only 38 of 188 units reported in Department of Health Statistics exceed 4000 deliveries per annum. In 2002-03, Southmead had 4524 deliveries, and St Michael's 4376 deliveries, placing them in the top quintile of units by number of deliveries<sup>14</sup>.

Birth Centres are being discussed within the Bristol Health Services Plan. The following comments were made:

- Adding birth centres to current service provision would increase choice for women. Delivery in a 'low tech setting' might favourably reduce intervention rates. However practice and deliveries at the hospital might become even more focused on a more interventionist approach. Hence there is a danger of services becoming somewhat polarised.
- As an alternative setting for a home-style delivery, a birth centre might be more convenient for some women and staffing might be more achievable than the alternative of offering more home deliveries. However staffing would require additional posts: cover from existing services would not be feasible. There would also be implications for ambulance services.
- It would be vital for women choosing a birth centre delivery to understand that it is equivalent to a home delivery ie no specialist support services on site, even if the birth centre is located at a community hospital. Transfer would be needed for some women having significant problems during labour.

There is uncertainty about whether the development of Children's Centres will have any implications for midwifery services.

## **18 Quality standards and Initiatives**

### **18.1 BNSSG - wide working**

Providers in BNSSG have established a working group of representatives from local maternity and neonates services. This reflects a need for consistent working practices across local services, and concern about service reconfiguration, particularly the planned centralization of inpatient paediatric care.

The trusts have worked together to agree area-wide clinical protocols for early pregnancy services, and are doing further work to make GP referral choices easier.

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<sup>14</sup> table 32, Statistical Bulletin. NHS Maternity Statistics, England: 2002-03. Department of Health London. <http://www.publications.doh.gov.uk/public/sb0410.htm>

## **18.2 Public involvement**

Service development groups in both trusts aim to have lay members. The difficulty of recruiting sufficient numbers of lay members, particularly those representative of the population served ie mothers of young children, was noted. Most working groups at UBHT have lay members.

## **18.3 GP role in maternity services**

Concern was expressed about the intention of some GPs to stop providing postnatal examination of babies born at home, which will lead to mothers having to bring their babies to hospital instead. Some GPs are also declining the role in antenatal care envisaged in NICE guidelines.

## **18.4 Risk management**

NBT and UBHT participate in Clinical Negligence Standards for Trusts, a national voluntary scheme run by the NHS Litigation Authority. There are specific Maternity Clinical Risk Management Standards with a separate assessment process. Both trusts are at level 2 (level 1 is lowest, level 3 highest), and NBT is working towards achieving level 3 when reassessed during autumn 2004. The scheme was devised to enable trusts to fund clinical negligence costs, support effective reporting and management of claims, promote standards, implement risk management and policies aiming to minimise risk. Achievement of higher levels is linked to greater discounts on negligence costs. The scheme is endorsed by the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives.

There are eight core standards, and each core standard is comprised of several criteria. A wide range of organisational and clinical standards are covered. The workload in preparing for assessment increases according to the level being applied for, and is very substantial – but both trusts noted a benefit in helping them to be ‘on top’ of risk management. Each standard is fully referenced to source documents, which include published guidance from Royal Colleges, NICE and the National Screening Committee.

The substantial number of national clinical guidelines from NICE was noted; both trusts have systems in place for implementing these.

In interviews with neonates services, local obstetric care was described as ‘good quality’ with respect to the frequency with which they observed complications such as meconium aspiration and hypoxia amongst inborn babies.

Low midwifery staffing levels were a cause for concern about risk and governance. It is difficult to provide clinical updates when staff time is scarce. There were also concerns about ensuring sufficient access to high dependency and intensive care.

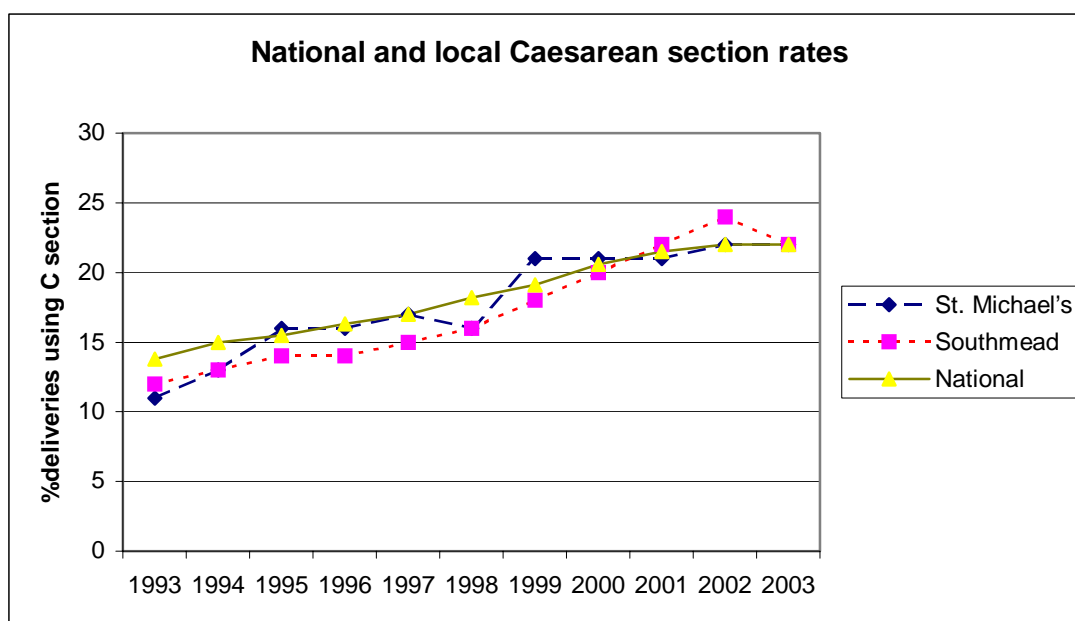
## **19 Caesarean section rates**

Caesarean section (CS rates) are the subject of a recent NICE guideline. Whilst both trusts currently show CS rates equivalent to that for England (22% in 2003), the English rate is high compared with other countries, and still on an upward trend having approximately doubled over the past 10 yrs (graph 6). Recently published research has shown a much

lower adjusted CS rate amongst women in the fifth (most disadvantaged) quintile for socio-economic deprivation, with equivalent rates in the other four quintiles<sup>15</sup>.

NBT are concerned that monthly monitoring of the CS rate shows a recent rise at Southmead (<27%). In response a midwife led service is being developed within the central delivery suite (CDS), and the All Wales Care Pathway is being adopted, with a view to supporting a less interventionist approach to childbirth. UBHT have also adapted the pathway for local use, and already have a midwife led service within CDS. There is concern that there is a continuing trend towards higher levels of intervention eg increased use of elective CS in twin pregnancies. Lower levels of midwifery staffing were a concern: UBHT noted evidence that one to one care could reduce intervention rates.

Graph 6



Source: Statistical Bulletin NHS Maternity Statistics, England: 2002-03. Department of Health March 2004  
<http://www.publications.doh.gov.uk/public/sb0410.htm>

## 20 National policy

The National Service Framework for Children, Young People and Maternity Services has just been published by the Department of Health (Sept 04). Standard 11 specifically refers to maternity services:

'Women have easy access to supportive, high quality maternity services designed around their individual needs and those of their babies.'

The NSF aims to 'ensure that pregnant women receive high-quality care throughout their pregnancy, have a normal childbirth wherever possible, are involved in decisions about what is best for them and their babies, and have choices about how and where they give birth.'

Implementation is anticipated over 10 years, involving further development of women-centred services; care pathways and managed care networks linking maternity and

<sup>15</sup> Dr Foster's case notes: Social class and elective caesareans in the English NHS. BMJ 2004;328:1399

neonatal services with a range of services and professionals to ensure access to high quality care; improved pre-conception care via pre-birth access to a midwife; access to midwives throughout pregnancy; antenatal and newborn screening; access to perinatal psychiatry services; choice of places to give birth; involvement of a consultant obstetrician in any decision to offer a Caesarean section; expert in neonatal resuscitation present at every delivery, postnatal examination and structured post-birth care; breastfeeding support and information<sup>16</sup>.

## 21 Information sharing with commissioners

There was agreement in principle with commissioners and trusts agreeing a more streamlined system for data sharing. Current central requirements for reporting on health indicators eg smoking, breastfeeding, are met through relatively ad hoc requests. Providing aggregated data only can limit potential for local analysis and interpretation. As both maternity units use the STORK system there is scope for an agreed data set and reporting system.

Implementation of new developments in antenatal screening for Down's Syndrome and universal screening for haemoglobinopathies in Bristol will require rigorous systems for monitoring the screening programmes, relating to both trust workloads and PCT populations.

Nationally, inadequacies of available data on infant health and services have been highlighted. The Maternity Care Data project attempted to address the problem of incomplete and variable approaches to providing maternity data for Hospital Episode Statistics. Whilst aiming for standardised and consistent data recording within the Electronic Patient Record, the fate of this initiative is unclear, the relevant webpage on the NHS Information Authority site not having been updated this year.

The NHS numbers for babies project has been implemented (Oct 2002), enabling each baby to have an NHS number from birth, an important step towards achieving a lifelong electronic patient record. In so doing, unexpected disruption has been reported, of systems for passing birthweight data from child health systems to local deaths registers and hence to ONS. Information supply to the National Congenital Anomalies System has also been affected.

## 22 Conclusions

The number of deliveries for Bristol and South Gloucestershire recently returned to the levels seen in 1998 and 1999, following a period of decline. National trends and predictions suggest that we should anticipate BNSSG PCT population deliveries staying around this level rather than declining further. Local population predictions based on the 2001 Census are expected this autumn.

Mortality indicators relating to maternity services for Bristol and South Gloucestershire are satisfactory on average, but more detailed analysis shows that babies of socio-economically disadvantaged mothers are at greater risk. Rates relating to older infants should be evaluated over longer time periods, notably for N Somerset where recent infant mortality rates are relatively high. National confidential enquiries into maternal and infant deaths highlight the importance of recognising the relationship between adverse outcomes

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<sup>16</sup> National Service Framework for Children, Young People and Maternity Services. Department of Health. London 2004.

[http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServicesInformation/ChildrenServicesInformationArticle/fs/en?CONTENT\\_ID=4089111&chk=U8Ecln](http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServicesInformation/ChildrenServicesInformationArticle/fs/en?CONTENT_ID=4089111&chk=U8Ecln)

and social and economic disadvantage. Implementation of clinical guidelines and other service improvements have made a difference, but national enquiries show women still die of preventable causes. Psychiatric illness is an important cause of maternal death. Infant deaths can be reduced by tackling risk factors such as smoking, and through increased access to effective health care (particularly for women at greatest risk of poor outcomes).

St Michael's and Southmead are high volume maternity units, working to meet high levels of health needs amongst minority groups eg provision of interpreters; specialist services for women with drug dependency. PCTs and primary care health professionals have an important supporting role eg to promote early uptake of antenatal care, and in continuing implementation of programmes underway to reduce smoking and promote breastfeeding. Women need to be directly involved in service planning. Most trust groups have lay members, but recruitment is challenging.

Midwifery shortages, service reconfiguration and changes in demand (reflecting neonates service developments and choice) are key operational issues. Work continues to ensure compliance with the European Working Time Directive and New Deal for junior doctor hours.

Implementation of changes to improve the performance of antenatal screening for Down's Syndrome, and universal screening for haemoglobinopathy have cost implications and will have an impact on midwifery workloads. Dating scan services need to be developed.

Demand on the two maternity units is affected by the changing role of local neonates services (particularly increased workload relating to out of area referrals), and through women exercising choice. There is concern about ensuring a balanced workload across the two units, and appropriate funding arrangements. A BNSSG working group has been established, and city-wide referral guidelines have been produced for GPs. GP and PCT involvement is needed in service planning.

Both trusts participate in the voluntary national Clinical Negligence Standards for Trusts scheme, working to the Maternity Clinical Risk Management Standards. NBT is due for reassessment and is aiming for the highest level in the scheme. Both trusts have structures for implementing clinical guidelines. Caesarean section rates may be rising higher than the English rate: both trusts have taken action to develop care pathways and midwifery-led care, but pro-intervention developments were also noted.

The newly-published National Service Framework for Children, Young People and Maternity Services sets an agenda for service development. Actions proposed are consistent with locally identified needs, but full implementation may exacerbate current pressures eg midwifery shortages and workloads. Some developments are already known to require additional funding eg antenatal screening developments.

It should be feasible to streamline current arrangements for sharing data on health programmes eg for smoking cessation and breastfeeding. PCT and trust representatives need to agree the dataset needed and an annual reporting cycle. New information needs eg relating to antenatal screening implementation should be included.

Dr CE Hine  
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