Croydon Joint Strategic Needs Assessment (JSNA) 2014/15

Key-Topic 1

Maternal Health

Lead author

Dawn Cox, Public Health Principal, Croydon Council

Co-author

Sarah Nicholls, Public Health Consultant, Croydon Council

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Fiona Assaly, Public Health Directorate PA
Caroline Boardman, Senior Commissioning Manager – Children, Integrated Commissioning Unit
Anita Brako, Public Health Knowledge Manager
Jimmy Burke, Senior Public Health Principal, Health Improvement Commissioner - Addictive Behaviours
Denise Clements, Transformation Manager, Children, Family, Family Intervention and Children's Social Care
Lisa Colledge, Public Health Intelligence Analyst
Sue Culling, Senior Joint Commissioner
Paula Doherty, Team Manager, Children, Family, Family Intervention and Children's Social Care
Dhanya Gardner, Public Health Intelligence Analyst
Sue Grose, Head of Integrated Commissioning - Mental Health and Substance Misuse Integrated Commissioning Unit - Croydon CCG & Croydon Council
Alan Hiscutt, Integrated Commissioning Unit and Adult Care Commissioning
Liz Hodgeman, Manager Woodlands Children's Centre
Shirley Johnstone, Adults Commissioning Manager; Resources
Ian Lewis, Director of Children Family Early Intervention Children's Social Care
Debby McCormack, Team Manager, Children, Family, Family Intervention and Children's Social Care
Dave Morris, Housing Strategy Manager
Kate Naish, Public Health Strategic Lead – Young People
David Osborne, Senior Public Health Information Analyst
Dwynwen Stepien, Head of Early Intervention and Family Support, Children Family Intervention and Children's Social Care
Julie Stubbs, Screening Support Sonographer
Sam Taylor, Head of Integrated Commissioning Children and Families Partnership
Elaine Trainor, Public Health Improvement Principal - Child Health

Partner organisations

NHS Croydon Clinical Commissioning Group
Yinka Ajayi-Obe, Clinical Lead Maternity Services and GP
Beth Kelly, FGM Project Consultant
Paula Swann, Chief Officer

Croydon Health Services NHS Trust
Alison Dalton, Health Visitor Implementation Lead
Bernie Dolan, Named Midwife for Safeguarding
Nancy Fraser, Health Visitor Lead
Jeanette Hennessy, Clinical Midwifery Manager

Tina Hickson, Assistant Director of Nursing
Rosie Jones, Specialist Perinatal Health Visitor
Margaret Leach, Health Visitor Lead
Nicola Lucas, IT Administrator for Maternity
Loretta McGurry, Family Nurse Partnership Manager
Ann Morling, Director of Midwifery
Lynn Ooi, Manager Neonatal Unit
Bernice Peters, Perinatal Mental Health and Safeguarding Lead Midwife
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Note on data cut off period

The majority of service data presented in this chapter cover the financial years 2013 – 2015. The data in this chapter was the most recent published data as at August 2015. Readers should note that more up-to-date data may have been subsequently published, and are advised to refer to the source shown under figures or listed in the appendices for the chapter for the latest information.

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1 Executive Summary

"Maternal Health" refers to the health of women during pregnancy, childbirth and the postpartum period. For most women, giving birth is a normal, healthy experience and a significant life event. The health and wellbeing of the mother pre-conception, during pregnancy and after the birth, has a significant impact on both maternal and infant health and wellbeing outcomes.

Strong and stable relationships have a key impact on a child's formative years.[1] Interventional strategies should support the building of secure attachments between baby and parents/caregivers. Providing the right support for this involves professionals working together effectively and efficiently.

There are a number of challenges facing service provision for mothers and infants. These include health inequalities, and increasing numbers of women with high risk and complex pregnancies, as well as social complexities. Additionally, the Home Office is located in Croydon, this brings the additional challenge of delivering an effective service to pregnant women and new mothers seeking asylum.

In 2014, 5,645 babies were born to Croydon residents; the majority of these births (in hospital or at home) took place within Croydon Health Services NHS Trust (CHS). However, one third of these births occurred in other locations outside Croydon borough. Just over half of Croydon's population are from black and minority ethnic groups and this is reflected in the ethnicity of women having their babies at CHS.

Challenges include:

In Croydon in 2014/2015:

- A quarter of pregnant women attend their first antenatal assessment after 12 weeks of pregnancy.
- The percentage of mothers smoking in pregnancy in Croydon and the proportion of babies born with low birth weight in Croydon are both higher than London.
- Whilst a high number of newborn babies are breastfed, there is a steep drop in the numbers continuing to breastfeed, at 6–8 weeks of age.

At Croydon Health Services NHS Trust (CHS) in 2014/2015

- an estimated 13% of women attending their first antenatal assessment had little or no understanding of English language
- over 60% of mothers were in the two most deprived quintiles.
- half of the mothers were overweight, obese and morbidly obese.
- 5% of pregnancies involved women who had diabetes.

[1] DCSF (2010) Support for all. The families and relationships green paper HMSO

The SWL 5 year strategy vision for maternity services[2] with the focus on delivering key initiatives is critical in driving change, meeting increased demands, and improving quality of maternity services, and outcomes for mother and babies. The strategy focuses on the whole pathway of care for individual women, taking into account that different pathways will be followed, from a normal pregnancy and birth, those with some complications, to those who have highly complex pregnancies and births.

Enabling good health in mothers before, during and after pregnancy is a critical factor in giving every child the best start in life. Giving every child the best start in life has been identified as a key priority both locally and nationally. Marmot[3] observed that disadvantage starts before birth and accumulates throughout life.

Supporting Marmot, to improve outcomes for mothers, infants, children, and their families, the new Croydon Best Start model consists of high quality, evidence-based, early intervention services, provided by multi-disciplinary, integrated locality teams of health, children's centre, early years and community practitioners. These services will deliver the 0-5's healthy child programme and targeted family support. These teams will be aligned with Croydon's midwifery service, and wrapped around GP clusters so that equality of opportunity is provided for all families. This will be further underpinned by a family partnership model approach in which parents are acknowledged and valued as experts both by themselves and their communities and by professionals.

This chapter focuses on the health and wider determinants of the clients (parents, caregivers and infants) accessing and serviced by maternal health services in Croydon. It aims to identify key areas for focus by examining the relationships that are developed between the professionals involved in providing support and the caregivers of the baby, as well as the professional relationships that are developed with those involved in the provision of support across health, social care and the voluntary sector. The chapter also looks at what is known about the determinants and risk factors impacting on maternal and infant health in Croydon and the outcomes that are seen as a result, with the intention of identifying recommendations to improve the service provision and outcomes for Croydon's population.

The literature review, carried out as part of the Joint Strategic Needs Assessment (JSNA) process, observes that the role of healthy relationships between and within professional teams and organisations and the impact of healthy relationships between parents and peers is evident. What is less clear, however, is the role of relationships between professionals and parents. The review also provides evidence of best practice in stakeholders' interactions and interrelationships, in respect of

[2] http://www.swlccgs.nhs.uk/wp-content/uploads/2014/06/SWL-5-year-strategic-plan.pdf accessed 12 November 2015
[3] Marmot M. Fair Society, Healthy Lives: A Strategic Review of Inequalities in England. London: University College London, 2010.

outcomes for mothers' and infants' health and well-being and supportive relationships between all stakeholders. Key areas of focus were early pregnancy, vulnerable groups, perinatal mental health, pre-conception and learning and physical disabilities.

An audit of services (see appendix 16.4 and 16.5) involved in maternal health provision was undertaken to gain an insight into the current activity and issues. Whilst it was evident that there is a great deal of excellent work is taking place, there are inconsistencies in services provision.

Some of the findings indicated the need for further development in:

- Communication and information provision between agencies and with services users
- Strengthening pathways for referrals, perinatal mental health, vulnerable groups, physical and learning difficulties and disabilities
- IT and data collection processes, reporting and sharing of information
- Multi-agency, cross-agency training
- Involvement of fathers
- Ensuring an appropriately skilled workforce

Improving maternal health and well-being is complex and needs engagement from all agencies involved in the journey including the mother. There are significant challenges for Croydon in ensuring provision of appropriate services to support maternal health and well-being. These include rising demand and increased expectations of service users set against capacity, improving performance, and the financial pressures placed on local health services, Croydon Council and the voluntary sector. Providing a supportive, integrated framework, "a whole systems approach", requires a co-ordinated approach by the commissioners and providers of services to ensure a seamless service with associated pathways.

Recommendations have been formulated after reviewing the data and audit.

2 Key Recommendations

2.1 For Commissioners

1. Best Start

It is recommended that commissioners ensure the provision of an integrated service and improve physical, social and psychological outcomes of families and young children through sustaining Best Start and the transformation of services ensuring that the elements of maternal health and the 5 year SWL maternity strategy are incorporated.

2. Vulnerable Women

It is recommended that commissioners ensure that all providers involved in the provision of support across health, social care and the voluntary sector provide a seamless pathway for vulnerable women and those with complex needs meeting the national standards as set out in the National Institute for Health and Care Excellence (NICE) guidance.

3. Perinatal Mental Health

It is recommended that commissioners ensure that all the providers involved in the provision of perinatal mental health services meet the national standards as set out in national guidance to strengthen mental health support to mothers and their families.

4. Vitamin D supplementation

It is recommended that commissioners consider provision of universal Vitamin D for infants and children under 5 years, and pregnant and breastfeeding women as recommended by national guidance.

5. Early access to maternity services and supporting women's choice

It is recommended that commissioners work with providers to improve the numbers of pregnant women accessing maternity services before 10 weeks and to support women's choice for place of birth.

2.2 For Providers

1 Pathways

It is recommended that providers work together to review the maternal health pathway, ensuring improved engagement with fathers and service users.

2 Communication

It is recommended that providers have an appropriate communication strategy in place relating to maternal health between agencies in and out of borough, and between service users and the wider public. It is important to ensure that information and advice to parents is consistent and streamlined across and within agencies.

3 Early Intervention

It is recommended that early identification, assessment, and early intervention are improved through increased use of Early Help Assessments to identify support for families.

4 Training and Development

It is recommended that providers evaluate current provision and work together to develop an effective cross-agency training programme ensuring training needs are identified and met.

5 Data and information sharing

It is recommended that providers work together to ensure robust and credible data and agree information sharing processes.

2.3 For Croydon Safeguarding Children Board

It is recommended that the Croydon Safeguarding Children Board review safeguarding processes for referrals and information sharing across agencies.

2.4 For the Children and Families Partnership Board

It is recommended that the prioritisation of teenage pregnancy by the Children and Families Partnership Board to prevent a further increase in teenage conceptions is re-considered.

2.5 For the Director of Public Health

1 It is recommended that the Director of Public Health has oversight of the high level population indicators: infant mortality and low birthweight and ensures that these are communicated strategically.

2 It is recommended that the Director of Public Health continues to ensure scrutiny of antenatal and newborn screening programmes.

3 Introduction

3.1 Background

This is the first key topic of the 2014/2015 Joint Strategic Needs Assessment (JSNA) in Croydon. From discussions with providers and other partnerships, this JSNA is timely to:

- Support the commissioners and providers to understand the needs of pregnant women and new mothers who require additional support over and above universal provision
- Support the South West London Five Year Commissioning Strategy, which covers eight clinical areas, one being maternity
- Support Croydon's Best Start Programme
- Support the development of the Family Mental Health Strategy

This JSNA will also inform commissioning intentions and decision-making for local service provision in the future.

For most women, giving birth is a normal healthy experience; becoming a parent particularly for the first time, is a significant life-event. The health and wellbeing of a mother at conception, during pregnancy and after the child is born is significant in the development of the child, providing the essential foundations for future learning, behaviour and health. This is the opportunity to give that child the best start in life.[4]

Strong and stable relationships are at the heart of family life. The quality of relationships at home makes a big difference to the whole family but they particularly affect children in their formative years[5]. The primary caregiver-child relationship and the parents' capacity to provide love, care and nurture are of major importance. At the heart of any strategy for intervention should be work to support the development of a secure attachment between baby and caregiver, strong family relationships and quality parenting.[6]

Also of importance are the healthy relationships developed between those involved in providing support and the parents/ carers of the baby. It is vital that effective professional relationships are developed with other professionals involved in the provision of support, including both health and social care services and the voluntary sector. This can make a real difference in delivering improved outcomes[7].

[4] Marmot M. Fair Society, Healthy Lives: A Strategic Review of Inequalities in England. London: University College London, 2010.
[5] DCSF (2010) Support for all. The families and relationships green paper HMSO
[6] Hogg, Sally (2013) Prevention in mind: All babies count: spotlight on perinatal mental health. London NSPCC
[7] Munro, Eileen (2011) The Munro Review of Child Protection: Final Report. A child-centred system London. DFE

Actions to reduce health inequalities should start before birth[8] and be followed throughout the life of the child to improve adult outcomes.

The mother and child bond is crucial to enabling the child to develop but factors that may impede this include maternal stress, maternal mental illness, domestic violence, drug and alcohol misuse, learning difficulties, and infant disability.

At varying times from pre-conception to after the baby is born, the mother, partner and baby develop links and relationships with various different agencies. Maternity care is just one element of a pathway that spans from contraception services, pre-conceptual care through pregnancy and birth to early years and mainstream and specialist children's health and social care services.

Co-ordinating these interdependencies to ensure pregnant women, new mothers, their babies, and families receive a seamless service is crucial.

3.2 Why improving Maternal and Infant Health is important

"Maternal Health" refers to the health of women during pregnancy, childbirth and the postpartum period. This includes family planning, preparation for birth, birth outcomes, recovery from birth, newborn care, nutrition, and breastfeeding. Risk factors for poor maternal health include obesity, alcohol, drug and substance misuse, smoking, homelessness, mental ill-health, teenage pregnancy, domestic violence, and Sexually Transmitted Infections. Women with low income, low level of education, previous illnesses, those with no recourse to public funds/asylum seekers, women born outside the UK and multiparous women are more at risk of developing complications during childbirth and after the birth of the baby.

Giving every child the best start in life was given the highest priority in the Marmot review and is also a priority for Croydon Council and its partners. Actions to reduce health inequalities should start before birth, continue after the birth of the child and throughout the child's life to ultimately improve their adult outcomes. Reducing the risk factors for poor pregnancy outcomes can significantly reduce infant death, disabilities and potential long term conditions that are related to prematurity and low birth weight.

Pregnancy and the first year are a critical stage in child development, providing the essential foundations for all future learning, behaviour and health. Adverse prenatal and postnatal experiences can have a profound effect on the course of health and development over a lifetime.[9]

[8] Marmot M. Fair Society, Healthy Lives: A Strategic Review of Inequalities in England. London: University College London, 2010.
[9] https://www.nspcc.org.uk/globalassets/documents/research-reports/all-babies-count-prevention-protection-vulnerable-babies-report.pdf accessed 12 November 2015

Risk factors for poor infant health outcomes include late booking for antenatal care, smoking and alcohol consumption in pregnancy, poor nutrition, infections, gestational diabetes, maternal obesity, low birthweight, multiple births, teenage pregnancy, and low socio-economic status.

Early attachment and good maternal mental health shapes a child's later emotional, behavioural, and intellectual developments.

3.3 Scale of the challenge

3.3.1 Demographics

- 27% of the population of Croydon is under the age of 19 years (97,200 persons) and it has been predicted that by 2021 this population will rise to an estimated 108,000
- Approximately 28,700 children aged under 5 are living in Croydon
- 81,000 women aged between 15 and 44 years are living in Croydon
- 52% of total resident population are from black and minority ethnic groups
- 1 in 4 children under 16 years are living in poverty

3.3.2 Activity

- In 2014, 5,645 babies were born to Croydon residents; the majority of these births (in hospital or at home) took place within Croydon Health Services NHS Trust (CHS), however, one third of these births occurred in other locations outside Croydon borough
- A quarter of pregnant women resident in Croydon, attend their first antenatal assessment after 12 weeks of pregnancy
- The average maternal age for having a baby is increasing
- The conception rate for 15-17 year old women increased in 2013
- Whilst a high number of newborn babies are breastfed, there is a steep drop in the numbers continuing to breastfeed at 6–8 weeks of age.

3.3.3 Challenges

- Nearly two-thirds of mothers receiving antenatal care at CHS are in the two most deprived quintiles
- Just over half of Croydon's population are from black and minority ethnic groups and this is reflected in the ethnicity of women having their babies at CHS
- Half of the women receiving their first antenatal assessment at CHS were overweight, obese, or morbidly obese and 5% of pregnancies involved women who had diabetes. Nationally, 2-5% of pregnancies involve women with diabetes
- The percentage of mothers smoking in pregnancy is higher than London
- Infant mortality rates (IMR) are similar to the London and England average

- The Home Office is located in Croydon and with it comes the subsequent challenges of pregnant women and new mothers who are asylum seekers
- There is an increasing number of women with pre-existing medical conditions, high risk and complex pregnancies as well as social complexities
- There is increasing social and ethnic diversity leading to communication difficulties, social and clinical challenges. An estimated 13% of women attending their first antenatal assessment at CHS had little or no understanding of English language
- The proportion of babies born with low birth weight is higher than in London
- Evidence estimates that 20% of women in Croydon could be affected by Perinatal Mental Illness

3.4 Aims of the needs assessment

The aim of this chapter is to provide an overview of:

- the current relationships between mothers and their families with the different agencies that they come into contact with for care and support during their journey from early pregnancy until the end of the post natal period
- the current relationship that each agency has with each other to be able to provide a seamless pathway for the mother and her family.

Gaps in the ability to achieve healthy relationships within current service provision will be identified, and recommendations for future developments will be made.

4 Commissioning

Births have increased by almost a quarter in the last decade and are at their highest in 40 years. As a consequence of this, the cost of maternity services is rising. Increased demand, together with increasing high risk and complex pregnancies, require careful monitoring, robust intervention, and support. This means commissioners will need to work closely with their local maternity providers.

A wealth of evidence-based guidance on clinically effective and cost efficient care is produced by National Institute for Health and Care Excellence (NICE), professional bodies for general practice, obstetrics and midwifery, academia, and other independent sources and is available to inform local commissioning arrangements.

4.1 SWL Strategic Commissioning Strategy

In response to National Health Service England's (NHSE) 'Call to Action"[10], the SWL Strategic Commissioning Strategy (2014)[11] identified that SWL maternity services have not consistently delivered the best outcomes for mothers and infants as there are large variations in delivery of care across the four units in SWL.

The SWL 5 year strategy (2014/2015-2018/2019), vision for maternity services, and focus on delivering key initiatives are critical in driving change and improving outcomes for mother and baby. The overarching vision is to strengthen the whole maternity pathway service model through improving the quality of maternity services and ensuring that the provision of these services is timely and robust. Existing guidance reinforces the need to deliver high quality care but variations in outcomes locally and against international benchmarks, led to the development of London Quality Standards (LQS)[12]. They are based on clinical evidence, national recommendations and best practice, and detail the minimum safety standards that should be achieved by all providers. The SWL Clinical Commissioning Groups (CCGs) have made a firm commitment to achieving these standards and Croydon CCG are monitoring the local maternity services to ensure that they are meeting LQS, that women with increased complexities and risks of complications have timely support, normal healthy women are supported, and all women are enabled to have a positive experience of maternity care.

Key challenges to improving maternal health are pre-conceptual health, birth rate, maternal age, perinatal mental health, increased complexities associated with pregnancy and social factors, and integration with the Early Years agenda.

[10] https://www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf accessed 12 November 2015
[11] http://www.swlccgs.nhs.uk/wp-content/uploads/2014/06/SWL-5-year-strategic-plan.pdf accessed 12 November 2015
[12] http://www.londonhp.nhs.uk/wp-content/uploads/2013/06/London-Quality-Standards-Acute-Emergency-and-Maternity-Services-February-2013-FINALv2.pdf accessed 4 January 2016

The strategy responds to the challenges facing maternity services affecting demand and service provision, and the expected future needs of the local population.

These are highlighted in the report and include:

- The variation of outcomes across the four maternity units
- Increased presentation of obstetric and medical complexities
- Maternity services being organisation focussed rather than women centred
- The challenge to improving continuity of carer for women in labour
- Poor postnatal care experiences for women, both in hospital and community settings
- The consistency, quality, and quantity of antenatal care provided by GPs
- Screening programmes not being fully integrated into normal pathways and variations in uptake and follow-up

To support this strategy, the SWL Maternity Network formed in 2013, and includes clinical leads from the local providers, commissioners, service users and public health representatives. The network programme is closely aligned with the SWL strategy and by working collaboratively, aims to improve the overall quality and outcomes for maternity services.

Maternity services are commissioned for Croydon mothers by the Clinical Commissioning Group (CCG) partially through the Integrated Commissioning Unit (ICU) for services provided by CHS and through host CCG arrangements for other Trusts' maternity services. At present, a separate service specification for maternity services does not exist although service performance is being monitored and managed through contracting and quality processes. A SWL maternity service specification has been developed which will be in place for all SWL providers for 2016/2017. The specification supports local commissioning of maternity services based on best practice and evidence to reduce unwarranted variation and improve access whilst improving quality and outcomes across South West London.

The Department of Health (DH 2009) Healthy Child Programme (HCP)[13] is a national programme of preventative and early intervention services that works with mothers, families, children and young people to maximise their health and well-being. This programme spans from pregnancy until the child is 19 years of age. Delivery of the programmes is by midwives and commissioned by the CCG; 0-5 years is led by health visitors with school nurses leading on 5 – 19 years. From October 2015, the commissioning for health visitors, the Family Nurse Partnership (FNP) and the HCP for under 5s, transferred to the Local Authority, however, the antenatal and newborn screening programmes, childhood immunisations and the Child Health Information Systems will continue to be commissioned by NHS England (NHSE) / Public Health England (PHE) until at least 2020.

13 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf accessed 12 November 2015

Development of the HCP (0-5 years) delivery has been supported by a national programme to increase HV numbers and develop an evidence based model of HV practice (DH 2015).[14] This has been complemented by the introduction of the FNP in Croydon in 2010 which has been expanded to offer a total of 150 family nurse places for young parents.

GPs, who are commissioned by NHSE, provide antenatal care and are key referrers to maternity services.

Mental Health services are commissioned by Croydon CCG, through the Integrated Commissioning Unit (ICU).

The wider determinants of environmental, social, cultural, and educational factors all impact on the health of mothers and families and are influential on health and well-being. Therefore, the health of the children in Croydon, are similarly influenced by the provision of social services, early years providers, education, housing, and children's centres commissioned by Croydon Council.

A programme of work to reduce child poverty is being delivered through Croydon's Child Poverty Strategy.[15]

4.2 Family Nurse Partnership

While for some young women, having a child when young can represent a positive turning point in their lives, for many teenagers bringing up a child is incredibly difficult. Teenage pregnancy can result in poorer outcomes for baby's health including low birth weight, increased likelihood of abuse and neglect, mother's mental health and well-being, living in poverty, school readiness, and poor life outcomes.

The rationale for investing in supporting teenage mothers and fathers is strong and the FNP has a robust evidence base. The FNP uses an intensive home visiting programme that is delivered by highly skilled nurses to first time teenage parents from early pregnancy until the baby reaches the age of two years. The proven outcomes include improved maternal and child health, reduced child maltreatment, improved school readiness, and better life course outcomes.[16] The FNP is a preventative programme which implements strengths based, solution focussed strategies and motivational interviewing skills to enable families to develop behaviour change strategies. Based only on the outcomes monetised so far in the United

[14] https://vivbennett.blog.gov.uk/wp-content/uploads/sites/90/2015/03/4-5-6-Model.pdf accessed 12 November 2015
[15] https://secure.croydon.gov.uk/akscroydon/images/att2015.pdf accessed 15 November 2015
[16] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215542/dh_128008.pdf accessed 15 November 2015

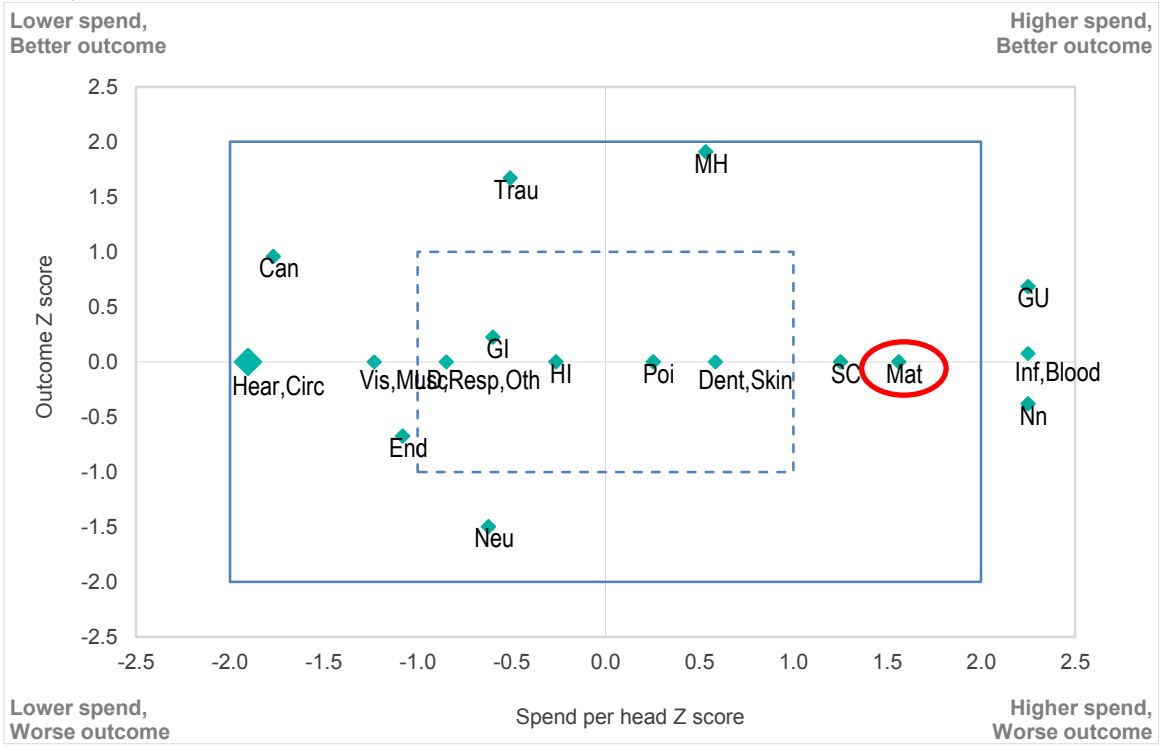
Kingdom (UK), for each £1 put in the programme, society obtains £1.94 at an annual rate of 6% return on investment.

Data from the FNP in Croydon, has shown considerable improvements in the outcomes of young parents and children that the FNP supports; for example, the programme is seeing high rates of breastfeeding and significant reductions in the percentage of mothers smoking in pregnancy. The programme also supports reducing repeat conceptions to teenage mothers. FNP offers a service to vulnerable and often hard to reach and disadvantaged clients. Engagement of the young people requires tenacity and persistence from the nurses who strive to offer consistency and acceptance to their clients; two behaviours many of them will not have previously experienced.

4.3 Expenditure

Figure 1 shows the relationship between expenditure and outcome for maternity and reproductive health services. Programme budgeting data indicates that whilst Croydon lies towards a higher spend, the outcomes are not significantly different to England. For 2014, Croydon CCG has a maternity spend per weighted head of population of £88 which is higher than the current average spend in England (£66) and just below London's spend (£92).

Figure 1: NHS Spend and Outcome Tool: quadrant chart for Croydon CCG data, 2014



Source: PHE Spend and Outcome Tool [17]

[17] http://www.yhpho.org.uk/default.aspx?RID=49488 accessed 15 November 2015

The higher, current average spend per head in Croydon compared with England, may be explained by market forces factor and by increased complex pregnancies.

5 Methodology

The JSNA process for this chapter has been informed by a reference group of stakeholders from across different organisations that provided data and expert opinion (see acknowledgments on page 2). Other key partnership groups in Croydon have also fed information into the process and commented on drafts. As this is a rapid JSNA, it was agreed by our reference group to consult stakeholders comprised largely of representation from the NHS, Local Authority, and Voluntary Sector. In addition, views were sought from service users.

As effective and co-ordinated universal services and interventions help support parenting and attachment, views were sought to:

- gain insights into, and identify the extent of healthy relationships with and between those who support the pregnant woman, new mother, infant, partner, and family in the health, social care and the voluntary sectors where they should be at the heart of the system
- understand the journey of engagement, and to identify gaps in the support given to achieve the best outcomes for maternal and infant health
- better understand the additional support required to improve outcomes for mothers and infants, areas identified by the reference group

A range of evidence from a variety of sources has been gathered to understand the complexity of healthy maternal relationships in Croydon and to make recommendations.

5.1 Audit

5.1.1 Commissioners and Providers

The audit identified six key areas to seek an understanding from commissioners and providers. These were:

- Strategic
- Data
- Communication
- Workforce
- Universal Provision and Early Help
- Risk Factors and Complex Needs

A number of key questions were asked including:

- Are there identified accountable leads for maternal health?
- Does your organisation have a policy/policies relating to maternal health?
- What data is collected, and do you have data sharing arrangements?

- How does this data inform service provision, activity, outcomes, and monitoring?
- What are the gaps, difficulties and barriers to provision?
- What provision is there to communicate effectively with targeted groups?
- How is information disseminated and shared with associated partners and organisations, service users, and families?
- What training provision is there specifically for topics relating to maternal health?
- What services proactively and positively encourage mothers-to-be to book early and continue to use antenatal services throughout their pregnancy?
- How is your organisation or service involved and contribute to the development and delivery of a pregnant woman's maternal care plan?
- What support and information does your service / organisation provide to pregnant women and their families with complex needs and/ or additional risk factors?

5.1.2 From the service users:

A number of questions were asked of the service users using key five key areas. These were:

- Access to service, needs, information
- Communication
- Relationships
- Environment
- Other

Following the audit, qualitative analysis was undertaken which identified a number of common and consistent emerging themes.

5.2 Data

National, regional and local statistics support the understanding on what the data tells us about the scale of the challenges to improve maternal and infant health outcomes in Croydon.

5.3 Literature review

A literature review was conducted to understand what evidence is available to inform best practice and effective approaches relating to healthy maternal relationships.

5.4 Limitations

5.4.1 Data

This was limited by availability and specificity of up-to-date data from a range of associated national and local datasets.

5.4.2 Analysis

In terms of qualitative analysis, time and resources were limited but considerable effort was made to gather the views of various agencies and views from mothers and fathers.

Twenty-six agency audits were completed; the majority being from health and the local authority. Five of these audits were completed with the voluntary sector agencies, six with commissioners and one with the Metropolitan Police. Unfortunately, it was only possible to complete the audit with 3 new mothers and one father. Ideally, had more capacity been available, more mothers, fathers, and voluntary sectors views would have been sought. However, despite small numbers, the views of the mothers and father were helpful in providing a snap shot as a basis to identify need.

Table 1: Agencies who completed the audit tool

Maternity	Head of Midwifery	Clinical Midwifery Manager	Manager Special Care Baby Unit	Perinatal Mental Health and Safeguarding lead midwife	Named Midwife for safeguarding	
Health Visiting	Head of HV/School Nursing	HVs CTLs HV implementation lead	Perinatal Mental Health Lead	Family Nurse Partnership		
CCG	Chief Accountable Officer	Maternity Clinical Lead/ General Practitioner				
Local Authority	Project manager Children, Family, Family Intervention and Children's Social Care	Team Manager Children, Family, Family Intervention and Children's Social Care	Locality Early Help Strategic Manager	Children's Centre Manager	Head of Social Care Services	
Commissioners	Head of integrated commissioning Adult Substance misuse	Adult Learning disabilities	Senior PH Principal Health Improvement, Addictive Behaviours	Team Manager Children, Family, Family Intervention and Children's Social Care	Senior Commissioning Manager ICU Children's and Maternity	Housing Strategy Manager
Voluntary Sector	Lifeline	National Childbirth Trust	Real Nappy	Homestart	Jubilee parenting	
Other	Metropolitan Police					

6 Maternal health: building healthy family relationships. Literature review

See Appendix 16.2 for review of evidence and references.

The over-riding ethos of the NHS Constitution (2012)[18] and the supporting NICE guideline on patient experience[19] bring the patient to the fore with their emphasis on patient-centred care, respect for the patient, and a well-informed and consenting patient.

The role of healthy relationships between and within professional teams and organisations, and the impact of healthy relationships between parents and their peers are evident in the literature. The role of relationships between professionals and parents is less well drawn out; some studies make explicit both its importance and how to foster good relationships, in others it may be assumed to be implicit, or alternatively has not been included in the studies' considerations.

The following review draws on evidence from searches of databases and of the 'grey' literature (reports published by national bodies). For the sake of completeness the outcomes of case studies published by NICE in support of their guidelines are included.

6.1 Healthy organisational relationships

Inter- and intra-organisational relationship forming is explored in several studies, some of which acknowledge barriers that may exist on the personal or organisational level. The M(ums)-Power project (Health Foundation 2013) was a partnership of providers, commissioners and users. Studies of successful development of relationship working found that success involved a sharing of vision, aims and goals, effective pathways and guides, building trust, role clarity, training and education, and ongoing support (Myors 2013; Pow 2013). Vision building may have to take into account differences in desired outcome between service users and policy or practice imperatives (Cameron 2012).

An initiative for women with medical or obstetric complications in a US based hospital showed that communication and patient satisfaction were improved by

[18] http://webarchive.nationalarchives.gov.uk/20130107105354/http://dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_132961 accessed November 2015
[19] https://www.nice.org.uk/guidance/cg138 accessed November 2015

initiating Perinatal Patient Care Conferences. In this process, the patients and their families were able to discuss diagnosis, treatment, and prognosis in a non-clinical environment prior to admission. A collaborative written plan of care that accommodated the woman's needs and wishes was developed as a result and then disseminated among the healthcare team. This process decreased women's and caregivers' anxiety and supported a culture of trust and safety across the continuum of care (Gordon et al. 2015).

A King's Fund report shows that better outcomes are achieved when patients are involved in their own healthcare (Foot 2014) and several reports show how effective community collaboration can be at all stages in the planning cycle (South 2014; PHE 2015; Waithe 2009). Garrod (2012) gives a specific instance of how a maternity service users group was set up. Another King's Fund report demonstrates how NHS care can be improved by engaging staff and devolving decision-making (Ham 2014). NICE guidelines show how shared decision-making can be embedded in professional teams and how they can be supported in delivering a high quality patient experience (NICE Shared Learning in: CG138, 2012; QS15, 2012; QS4, 2010).

NICE guidelines also emphasise the importance of a properly structured project management approach, including evaluation, monitoring, and training (NICE Shared Learning in: CG10, 2014).

Voluntary organisations are active at the national level, as opinion formers (WAVE Trust) and in developing, researching and evaluating parent and child development and well-being programmes (NSPCC: Baby Steps, Mind the Baby). Others include Health Foundation (Closing the Gap), BIG Lottery (Fulfilling Lives: A better start), and Early Intervention Foundation - it reports on parent-child interactions (Axford 2015) and its own Early Years programme.[20]

They also partner or support government initiatives: NCT support to Department of Health's initiative, Preparation for Pregnancy and Beyond and Department of Education initiative, CANparent. National voluntary agencies also act at ground level, including NCT Perinatal courses, NCT support to Baby Cafes, Health Foundation-sponsored trial M(ums)-power, and the Against Violence and Abuse projects (NICE PH50, 2014).

Individual volunteers also participate in user groups as peer supporters, as befrienders, and are part of community-centred approaches (South 2014; Public Health England 2015; Public Health England 2013; Chief Medical Officer 2013; Waithe 2009; Garrod 2012).

[20] http://www.eif.org.uk/early-years-2/ accessed November 2015

The difficulties in overcoming lack of trust and willingness to collaborate between professionals and services is acknowledged in several studies (Cameron 2014; Mangan 2014; NICE Shared learning in QS46 2013; PH55 2014). The overall assessment of the Closing the Gap project found that organisational relationship change was challenging to achieve and may not translate from one level to another (Chin Hoong Sin 2014).

6.2 Healthy relationships in pre-conception

An Early Learning Foundation report provides practical advice for local areas on how they can improve services for families and young children (Early Learning Foundation 2014). One study suggests an innovative approach to delivering health and wellbeing and tackling health inequalities by facilitating micro-enterprises (Lockwood 2013).

6.3 Healthy relationships in early pregnancy

The importance of enabling parents to start to form relationships and friendships with their peers from the early stages of their pregnancy is reflected in a number of studies that have looked at different ways of achieving this; exploring the dynamics of different group numbers, timing, professional input, sharing of information and experience, and attracting 'hard to reach' parents. The King's College project (Mashta 2011) favoured small groups where women could share their experience and freely voice concerns with the support of two professional midwives. The M(ums)-Power study, (Health Foundation 2013) part of the Closing the Gap initiative, tested different timings for the group meetings but also developed a range of online and social media tools for mothers to interact. The value of home visits, with the creation of a strong relational bond of trust between the parent(s) and the practitioner, and parents' wish to be involved in the decision making process, is outlined by initiatives such as the Family Nurse Partnership (Smyth 2014; Family Nurse Partnership 2015; Owen-Jones 2013) and the NSPCC programme Baby Steps (Hogg 2015).

Several studies have shown how parents are willing and able to directly influence and improve service delivery (Winters 2007, Cheyne 2012). A Department for Education trial called Canparent, explored approaches to normalising and de-stigmatizing parenting classes for parents of children 0-5 (Lindsay 2014). A Department of Health sponsored initiative, Preparation for Birth and Beyond, has developed a model for antenatal education which encourages active learning by parents. The Foundation Years website provides resources for early learning, fathers' involvement, and effective professional-parent relationship building.

A very recent (March 2015) report from the Early Learning Foundation analyses programmes that improve the quality of parent-child interactions, from conception to age 5; it looks in particular at the themes of attachment and parental sensitivity, social and emotional development, and language and communication (Axford 2015).

A study on partner relationships emphasises the contribution to father-child relationships that can be made by programmes that teach and support healthy co-parenting. A Swedish study on fathers' use of the internet shows how fathers can support and inform each other, and that professionals can also play a role in this media.

NICE guidelines look at the importance of information sharing to inform decision-making (NICE Shared Learning in: CG132, 2011; QS32, 2013). NICE guidelines attest to the value of specialist stop smoking advisers in maternity settings as an effective way of helping pregnant women to quit smoking (NICE Shared Learning in: PH48, 2013; PH26, 2010).

6.4 Review of the Healthy Child Programme - Organisational Relationships

The importance of partnership working is highlighted in a 2015 evidence review update of the Healthy Child Programme 0-5 published by Public Health England.[21] This report highlights the relationship that programme staff are able to establish with the participating families as one of the key factors in facilitating behaviour change through the evidence based interventions highlighted (PHE, 2015).[22]

In addition to partnership working, the evidence suggests the importance of continuity in terms of the extent to which pregnant women and new mothers/parents are provided with the opportunity to establish a small number of key relationships. Ideally, women would be allocated: one midwife who stays with them from booking to delivery; one health visitor (or a nurse if the woman has been enrolled in the Family Nurse Partnership) who oversees the Healthy Child Programme for that child and establishes contact at 28 weeks antenatal and continues through three years; programme facilitators who deliver entire programmes; and, where necessary, just one social worker and one family support worker (PHE, 2015).

The continuity of relationships between practitioners and families is important, particularly with families experiencing problems. A review of the evidence on intimate partner violence found that partnerships to address domestic violence are effective at increasing referrals, reducing further violence, or supporting victims of domestic

[21] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/429740/150520RapidReviewHealthyChildProg_UPDATE_poisons_final.pdf accessed 12 November 2015

[22] Public Health England. Rapid Review to Update Evidence for the Healthy Child Programme 0–5. March 2015

violence. These partnerships typically involve agencies such as social services / child welfare, the police, and those focused on domestic violence or substance misuse (PHE, 2015).

The review also concluded that various enabling factors are associated with effective partnership working, including: leadership and management, active membership, community involvement, strong relationships and communication, training, and resources (PHE, 2015). Conversely, the barriers and challenges to effective partnership working in domestic violence include: lack of resources (financial and human), differences in the culture of agencies/ organizations, leadership and management issues, lack of commitment, limited monitoring, and addressing diverse populations (PHE, 2015).

6.5 Breastfeeding

Many studies support the value of peer support in establishing and maintaining breastfeeding; the role and organisational relationships with voluntary agencies is also considered (Public Health England 2013; NICE Shared Learning in CG37 2014; QS37 2013). Adoption of the UNICEF Baby Friendly Initiative is seen as being a powerful tool for organisational change with a beneficial outcome (Cleminson 2013; NICE Shared Learning in CG37 2014). Other initiatives include Baby Cafés, Be A Star campaign and Smartphone apps (Public Health England 2013).

6.6 Healthy relationships in perinatal mental health

The recent report on the first 1001 days (All Party Parliamentary Group for Conception to Age 2, 2015) calls on local authorities to adopt a ‘1001’ days strategy to promote the development of socially and emotionally capable children at age 2. It recommends that Children’s Centres should become the focus of multi-agency teams and services. More examples of these kinds of multi-agency approaches are given in the All Babies Count report (Hogg 2012) and the CMO report for 2012 supports the development of resilience from antenatal through to middle childhood. An Australian report found that interagency collaboration improved services for mothers with psychiatric illnesses (van der Hamm 2013). NICE guidelines give an example of a birth plan for use with pregnant women with mental health problems and show that user-led training can be productive (NICE Shared Learning in : CG192, 2014; CG136, 2011).

A comprehensive and cost effective parent infant mental health service, jointly run by two NHS Trusts, the Tameside and Glossop Early Attachment Service (EAS) aims to meet the mental health needs of all parents from those with high need levels through to the universal provision. This service has been developed through building links and close working partnerships with midwifery and health visiting to raise awareness

and skills in parent infant mental health and enable proficiency in early problem identification and the use of a range of universal interventions. The working principle is that staff of partner agencies deal with universal interventions and families with less severe problems, while the core EAS team works with those who have serious parent-infant mental health concerns (Lee & Mee 2015).

6.7 Health relationships with vulnerable groups

The Family Nurse Partnership works effectively (Smyth 2014; Family Nurse Partnership 2015; Owen-Jones 2013; NICE Shared Learning in: CG110 2010) with young mothers identified as at risk; one author suggests it should be included within Universal Services (Smyth 2014). Studies on working with mothers from vulnerable groups; immigrant (Fisher 2013), socially disadvantaged groups (Docherty 2012; Ebert 2014), and highly vulnerable women (Barlow 2015) suggest that communication, acknowledgement of cultural background, early identification, and engagement are important. The NSPCC-sponsored programme 'Baby Steps' (Hogg 2015) found that early and frequent meetings, including both home visits and group meetings, were effective with hard to reach families, and with minority ethnic groups, and for parents in prison.

Mellow Parenting is another initiative designed as an attachment-based early intervention programme that strengthens parent-child relationships and good parenting. Several studies report the effectiveness of well-structured early intervention programmes to help parents at risk of becoming abusive, (Shapiro 2012; McConnell 2012) or mothers in abusive relationships (Howell 2015) to develop good parenting skills. A recent WAVE Trust report summarises programmes that have proved effective in supporting vulnerable parents and enabling the health and wellbeing of their children, including Sure Start, Healthy Child Programme and the Big Lottery project: Fulfilling lives, a better start. The Early Intervention Foundation has assessed the effectiveness of early intervention in preventing domestic violence and abuse. (Guy 2014).

A NICE guideline suggests that inter-organisational relationships, and personal inter-team relationships, are vital in supporting initiatives to counter domestic violence and abuse (NICE Shared Learning in: PH50 2014). One systematic review (Smith 2012) has found little evidence of studies on the role of fathers in primary prevention programmes for child maltreatment.

Studies on promoting engagement with young parents suggest that staff characteristics and programme content are important but that attention must also be paid to personal issues such as reliance on public transport, lack of money, and unemployment (Taylor 2012). Crowther (2012) suggested that a skills framework

could be developed to assist professionals in developing effective relationships with vulnerable parents.

Two studies look specifically at how to support young or teen fathers. Kirven (2014) has summarised programmes that have proved to be effective, including specially trained 'father-facilitators' in child education, peer support, individualised case management, and utilising community assets. An American programme (Brito 2014) supporting teen fathers in prison, emphasised the importance of helping fathers to build relationships with their children, rather than abstract parenting knowledge.

Several NICE guidelines consider how to increase uptake of Healthy Start vitamins among disadvantaged groups (NICE Shared Learning in: PH11, 2009; PH56 2014) and how to support women with weight management problems during and after pregnancy (NICE Shared Learning in PH27, 2010).

6.8 Healthy relationships with parents with learning and mental disabilities

One study looked at the suitability of the Triple P programme for parents with intellectual disabilities and found that it, and other evidence-based interventions, could be suitably adapted. A small study based in Scotland found that parents with learning disabilities could engage effectively with open perinatal education groups, with account taken of their individual learning needs.

Findings from a study showed that training workshops delivered to midwives in local hospitals in Nottinghamshire resulted in an increase in referrals for parents with a learning disability to the learning disability services by midwives and midwives were more aware of supporting the additional needs of parents with a learning disability, including the referral process for the learning disability teams. Information was also provided to parents with a learning disability using improved methods of communication, thus preparing them throughout the pregnancy continuum, during labour and birth, and also for parenthood (Harrison & Willis 2015).

7 Health Outcomes

The NHS Health Outcomes framework[23] sits alongside the Public Health Outcomes[24] and Adult Social Care outcomes frameworks providing a national overview of performance.

The outcomes frameworks include a number of indicators relating to pregnancy, birth and infancy as well as general ones relating to mental health, safeguarding and integrated care (DH 2014).

These include:

NHS

- Neonatal mortality and stillbirths
- Infant mortality
- Improving women and their families' experience of maternity services

Public Health

- Low Birth Weight(LBWT)
- Breastfeeding initiation and at 6-8 weeks
- Smoking status at time of delivery
- Under 18 conceptions
- Antenatal and newborn screening
- Infant mortality

Local data on a number of these indicators are presented in the next section.

[23] https://www.gov.uk/government/publications/nhs-outcomes-framework-2015-to-2016 Accessed 15 November 2015
[24] https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency accessed 15 November 2015

8 Data Findings

8.1 Birth rate

In Croydon, there has been an increase in births from 4869 in 2004 to 5642 in 2014; a birth rate of 15 per 1000 residents. This is similar to London but higher than England. It is predicted that there will be little variation in the birth rate in Croydon between 2015 and 2025.[25]

In 2014, Croydon had the second highest number of births out of the 32 London Boroughs, Newham being the highest with 6000 births. In 2013 – 2014, there were 3752 births at CHS (hospital and home births); this suggests that one-third of Croydon babies are being born at other locations outside Croydon borough.

Choice is an important consideration for women and they should be supported in their choice of where to have their baby. They should have the opportunity to make informed decisions about their care and treatment, and to feel in control of what is happening. The number of women having their babies outside of the borough for example King's College Hospital, Princess Royal University Hospital and St George's Hospital, maybe due to these hospitals being geographically closer to home than Croydon or in relation to King's College Hospital and St George's Hospital, the women's need to be seen in a specialist setting because of their complex needs.

8.2 Total Fertility rate

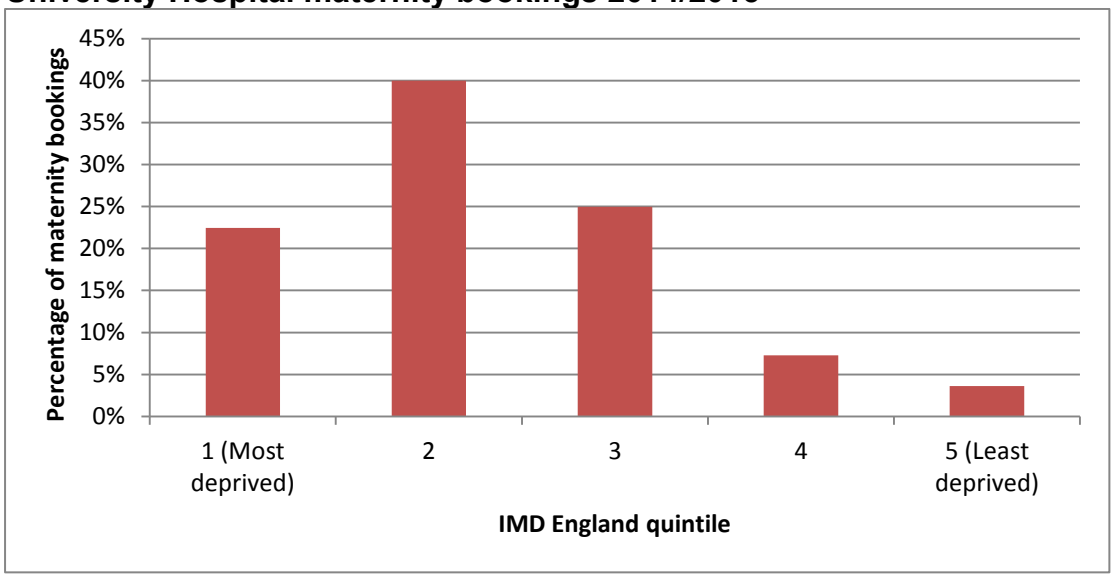
The Total fertility rate (TFR) represents the number of children that would be born to a woman if she were to live to the end of her childbearing years and bear children in accordance with current age specific fertility rates. Croydon's TFR in 2014 was 2.01; this is slightly higher than both London and England average rates (1.71, 1.83).

8.3 Deprivation

Croydon has high levels of deprivation and was ranked 107th (out of 326 local authorities) most deprived local authority in England, and the 19th most deprived London borough (out of 32 London boroughs). Two Lower Super Output Areas (LSOAs) fall within the 5% of most deprived areas in England.

[25] http://data.london.gov.uk/dataset/ons-2014-mid-year-population-estimates--london-analysis/resource/c2041c37-5fd4-434c-82a4-dd643097d326 accessed 4 January 2016

Figure 2: Index of Multiple Deprivation England quintiles (%) for Croydon University Hospital maternity bookings 2014/2015



Source: Croydon University Hospital data

This level of deprivation is reflected in the women who are receiving their antenatal maternity care at CHS where over 60 % of them are in the two most deprived quintiles with only 10% in the two least deprived quintiles. Babies born into poor families are more likely to be born prematurely and have low birth weights and are **2 times** more likely to die within one year of birth than those born to affluent families.

8.4 Ethnicity and Language

Over 50% of Croydon's population are from Black and Minority Ethnic (BME) groups compared with 15% in England and 40% in London. With the expectation that the population will increase, it is predicted that by 2025 the general BME population will be 56.6%. Croydon's ethnicity is reflected in the ethnicity of women having their babies at CHS.

Ethnicity of pregnant mothers influences the provision of services to support need. This is because certain conditions are known to be more common in certain ethnic groups such as diabetes, mothers or their families who have recently moved to the UK may have difficulty in understanding the language, and there are variations in cultural norms. In England, over a quarter of births (27.0%) in 2014 were to mothers born outside the UK and this percentage is rising year on year. Poland remains the most common country of birth for non-UK born mothers between 2010 and 2014, followed by Pakistan and India. The number of non-UK born women of childbearing age has continued to increase mainly due to increased immigration.

The CHS maternity unit reported that 6% of mothers required an interpreter, however this probably does not reflect the true number needing interpreters. Using the 2011 Census where women between 15 and 44 years reported having little or no English, it is estimated that in 2014-2015 potentially 13% of women booking for antenatal care at CHS had little or no English. This equates to 14 women per week that might require interpreters and extra support in pregnancy.

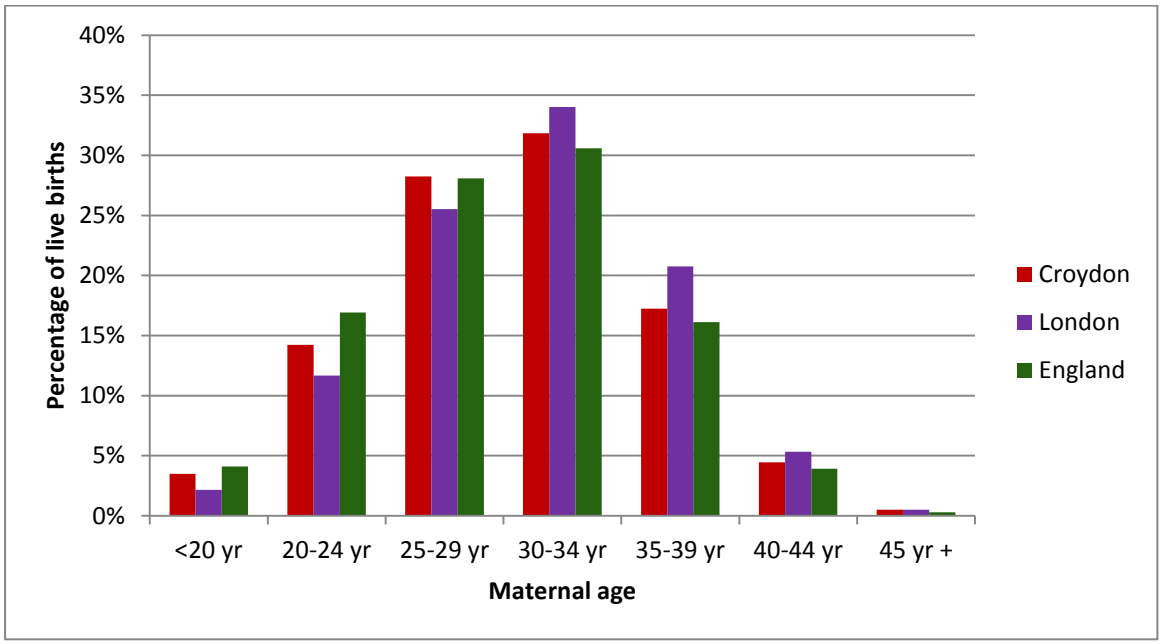
A joint initiative between CHS and Croydon Adult Learning and Training (CALAT) for English speakers of other languages (ESOL) started in 2010 to support the reduction of infant mortality rates in Croydon in non-native speaking communities. With this, a small-scale qualitative research study[26] was conducted to explore the role of language in pregnancy and the potential impact on experience and outcomes. Focus group interviews were held with migrant women who had had babies born in Croydon. Linguistic difficulties were identified as one of the many contributory factors to poorer outcomes, despite the availability of interpreters. A significant barrier to a successful outcome for mother and child appears to be the hesitancy with which patients accessed healthcare. In addition, it was revealed that there were clear patterns in participant experience; women routinely encountered communication difficulties with medical staff, interpreter provision was inconsistent, and complex written information compromised patient understanding.

Supported by this evidence, bespoke antenatal/ESOL classes, facilitated by a midwife and ESOL tutor, are held for women at Croydon University Hospital (CUH) who are native speakers of languages other than English. Vital information is given to mothers in accessible formats along with English language input to facilitate understanding.

[26] Brooks E (2010)‘ How do you feel?’ Is language a barrier to positive health?

8.5 Maternal Age

Figure 3: Maternal age category (%) for live births in Croydon, London and England in 2013



Source: Office of National Statistics: Vital Statistics 2 tables

In 2013, the highest proportion of deliveries (32%) were to women aged 30 to 34 years old; 22% of deliveries were to women aged 35 years and over. 3.5%of deliveries were to mothers under 20 years, compared with 2.2% for London and 4.1% for England. Since 2011, in Croydon, there has been a 4% rise in women having babies over the age of 30 years.

The age of the mother is a factor that influences the health, well-being and life chances of the child. Mothers aged 19 years and under and mothers aged over 35 years, and their babies, are at increased risk of poorer outcomes. Overall teenage mothers and their children have a higher risk of poorer health and well-being, poorer educational outcomes and employment prospects leading to increased risk of poverty. Higher complications in pregnancy may be due to later access to antenatal care, lifestyle, and diet, and they are also less likely to breastfeed. Older mothers have greater risks of developing medical disorders such as diabetes and high blood pressure. In addition the likelihood of stillbirths and multiple births increase with mother's age.

8.6 Antenatal

8.6.1 Antenatal Care

A mother's health at the time of conception is critical in the development of the fetus. Factors at conception that can influence fetal development are nutritional status, diet, drug and alcohol use, pre-existing medical conditions, medication, and exposure to chemicals. Pre-conception care can ensure that women are as healthy as possible in preparation for pregnancy.

Early pregnancy is a key time in the baby's development and promoting mother's health, and evidence is clear that women who access maternity services early, preferably before ten weeks, and receive a full health and social care assessment are more likely to receive appropriate care and achieve better health, emotional and psychological outcomes.

The purpose of antenatal care is to prevent or identify, and treat any conditions that may affect the health of the fetus/newborn and/or the mother, help to promote good pregnancy, reduce health inequalities and improve birth outcomes for both the mother and infant. This in turn can lead to positive experiences and contribute to giving the infant the best start in life.

8.6.2 Booking assessment

Early access to maternity care is an important opportunity for healthcare professionals to interact and build relationships with women and families, to monitor the pregnancy, the baby's growth and development, and focus on the mother's health and wellbeing. Early access to services is also a useful indicator to promote service accessibility.

General Practitioners (GPs) provide antenatal care and are often the first healthcare professional that women see once they know they are pregnant; GPs are the key referrers to the maternity services. Women should have the choice to receive shared antenatal care that is provided by the midwife and by their GP, but it is apparent that the majority of the maternity care pathway is undertaken by midwives and the variation in the quality and quantity of care offered by General Practice means that choice is limited. It is recognised that support and training for GPs is required.

Pregnant women should be supported to access antenatal care ideally by 10 weeks. Risk factors for late booking are teenagers under 20 years of age, women who have high parity (5 or more live births), mothers from black and minority ethnic groups and those living in temporary accommodation. Late booking and poor attendance for antenatal care are strongly associated with poorer outcomes for mothers and babies.

In Croydon 2014/2015, 69% of antenatal assessments were before 13 weeks gestation. This means that one-third of antenatal assessments were later than recommended. Late access to antenatal care is a significant public health issue as the risks of maternal and perinatal deaths are increased. Reducing the percentage of women who access maternity services late will help to reduce the health inequalities these groups face and improve maternal and infant outcomes.

8.6.3 Screening

Screening is the process of identifying apparently healthy people who may be at increased risk of a disease or condition, and all pregnant women are offered antenatal screening. Screening for disease in pregnancy and childhood enables early intervention and treatment. All programmes have been proven as cost effective.

The Antenatal and Newborn Screening programmes[27] encompass six specific programmes. These are:

- Infectious Diseases in Pregnancy Screening Progamme
- Fetal Anomaly Screening Programme (FASP)
- Newborn and Infant Physical Examination Screening Programme
- Newborn Bloodspot Screening Programme
- Newborn Hearing Screening Programme
- Sickle Cell and Thalassaemia Screening Programme

Rates of screening uptake are monitored nationally through key performance indicators

Table 2: Key Performance Indicators by Maternity Service (CHS) and CCG 2014/2015

	Q1 (%)	Q2 (%)	Q3 (%)	Q4 (%)
FA1 Downs Syndrome Screening	99.2	98.3	98.8	98.8
ID1 HIV coverage	98.9	99.6	99.8	100.0
ID2 Timely referral of Hepatitis B positive women for specialist assessment	100.0	8.3	46.7	16.7
ST1 Antenatal Sickle Cell and Thalassaemia screening-Coverage	98.4	99.1	99.8	100.0
ST2 Antenatal Sickle Cell and Thalassaemia screening - Timeliness of test	46.8	49.2	46.5	55.6
ST3 Antenatal Sickle Cell and Thalassaemia screening - Completion of FOQ	No return	No return	No return	No return
NB1 Newborn Blood Spot - Coverage	99.8	96.8	97.0	97.1
NB2 Newborn Blood Spot - Avoidable repeats	1.1	1.7	4.7	0.9
NB3 Newborn Blood Spot - Timeliness of result available	100.0	100.0	100.0	100.0

Source: PHE 2015[28]

[27] https://www.gov.uk/topic/population-screening-programmes accessed 15 November 2015

Table 3: Performance Thresholds

KPI	FA1	ID1	ID2	ST1	ST2	ST3	NB1	NB2	NB3
	≤97%	≤90%	≤70%	≤95%	≤50%	≤90%	≥94.9%	≥2.0%	≥94.9%
	≥97 – 99.9%		≥70-90%	≥95-99%	≥50-75%	≥90-95%	≥95.0%	≥1.9-0.6%	≥95%
	100%	≥90%	≥90%	≥99%	≥75%	≥95%	≥99.9%	≤0.5%	≥98.0%

Pregnant women in the UK are also offered the influenza vaccine and whooping cough vaccine in response to the risk of increased complications for pregnant women in the case of flu, and infants in whooping cough, should the mother or infant fall ill with one of these diseases.

PHE research indicates that babies born to women who were vaccinated at least a week before birth had a 91% reduced risk of becoming ill with whooping cough in their first weeks of life, compared to babies whose mothers had not been vaccinated.

8.6.4 Smoking in pregnancy

Smoking is the UK's single greatest cause of preventable illness and early death; eradicating smoking during pregnancy will improve mother and infant outcomes. Smoking in pregnancy is a major risk factor for both mother and baby and increases the risk of miscarriage, premature birth, stillbirths, low birth weight, and sudden unexpected death in infancy. Children may also suffer from on-going health risks such as asthma if growing up in the home where there are smokers. Smoking in pregnancy increases infant mortality by about 40%. In Croydon in 2014/2015, levels of women smoking recorded at the time of delivery was 6.9%; this is significantly higher than London (4.9%) but significantly lower than England (11.4%) This equates to 351 women smoking during pregnancy in Croydon.

Smoking in pregnancy accounts for 5-8% of preterm births. The wider societal cost of smoking in pregnancy in London contributing to preterm births is estimated between £24 million and £38 million[29].

In Croydon, a specialist smoking cessation service is available to help pregnant women to stop smoking and midwives are trained in brief intervention and carbon monoxide screening.[30] Supporting women and families of childbearing age and pregnant women to never smoke and to stop smoking should remain a high priority for commissioners.

[28] https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2014-to-2015 accessed 4 January 2016
[29] Annual Report of the Chief Medical Officer 2012 (2013) Our children deserve better. Prevention Pays
[30] http://www.ash.org.uk/pregnancy2013 accessed 4 January 2016

8.6.5 Healthy Start

Healthy Start (HS) is a statutory UK wide Department of Health (DH) scheme to improve the health of low-income pregnant women and families with young children on benefits and tax credits[31]. This scheme provides a nutritional safety net and encourages breastfeeding and healthy eating for pregnant women and children under 4 years in low income and disadvantaged families. Communication with DH suggests that whilst a high proportion of eligible families in Croydon are on the scheme, the uptake of Vitamins is very low.

One of the components of the HS vitamins is Vitamin D. Recent NICE PH guidance (PH56)[32] recommends increasing access to vitamin D supplements, raising awareness of the health problems associated with lack of it, and addressing those who may be at risk.

Vitamin D is important for keeping bones and teeth healthy. A lack of the vitamin can lead to deformities such as rickets in children, and a condition known as osteomalacia in adults, which causes pain and tenderness.

In England, around a fifth of adults and a sixth of children – approximately 10 million people –may have low vitamin D status. This is partly because the main source for vitamin D is from natural sunlight, and for 6 months of the year, mid-October to the beginning of April, there is no sunlight at the correct wavelength for skin to create vitamin D; also dietary sources are limited.

Certain groups of people in the UK are also more likely to have lack of vitamin D. These include pregnant women, children and older adults. People with darker skin are also at risk of having low vitamin D levels.

While people from these at risk groups are advised to take a vitamin supplements, they do not always receive the information and support they need. This is evident by the low uptake of the Healthy Start Scheme.

8.6.6 Obesity

Maternal obesity is now considered one of the most commonly occurring risk factors seen in obstetric practice and is associated with significant risks of maternal and perinatal mortality. Women who are obese, are grouped as high risk during pregnancy and require additional antenatal screening, intervention and monitoring and additional healthcare resources are essential due to pregnancy complications and increased use of neonatal intensive care facilities. If the mother is overweight, the baby will have an increased risk of obesity and diabetes in later life.[33]

[31] http://www.healthystart.nhs.uk/ accessed 4 January 2016
[32] https://www.nice.org.uk/guidance/ph56 accessed 4 January 2016
[33] https://www.nice.org.uk/guidance/cmg36 accessed 4 January 2016

In 2014/15, 1 in 5 pregnant women in CHS had a BMI of 30 or above at the first antenatal assessment booking assessment.

Table 4 shows that half of the women having a baby at CHS in 2014/2015 were overweight, obese or morbidly obese. This presents a critical clinical challenge to local maternity services.

Table 4: Prevalence of obesity in women at booking assessment at Croydon University Hospital 2014 – 2015

BMI classification	%
Underweight : <18.5 kg/m ^{2}	3.3
Normal weight : 18.5 – 24.9 kg/m ^{2}	46.1
Overweight : 25 – 29.9 kg/m ^{2}	29.3
Obese : 30 – 39.9 kg/m ^{2}	18.6
Morbidly obese : ≥ 40 kg/m ^{2}	2.8

Source: CHS: Cerner

Excess weight and obesity amongst children and adults is identified as a local priority for action in the joint health and wellbeing strategy 2013-18.[34]

The Croydon Healthy Weight action plan is Croydon's local response to national strategy, [35] and to build upon the aspirations in the public health White paper: Healthy Lives, Healthy People.[36]

The refresh of the Healthy Weight action plan takes forward the recommendations from the Healthy Weight JSNA (2013/14)[37] and sets the context for joint work between the Council, the CCG and other stakeholders such as local community services, to:

- Co-ordinate efforts in Croydon to reduce the burden of death, disability, and distress caused by excess weight
- To halt the rise in the prevalence of obesity in adults and children by 2020 and then maintain this level through a focus on both prevention and management

Various initiatives have been implemented in the Croydon to tackle obesity in adults and children.

[34] https://www.croydon.gov.uk/sites/default/files/articles/downloads/hwbb20121031strategy.pdf accessed 4 January 2016
[35] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213720/dh_130487.pdf accessed 4 January 2016
[36] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216096/dh_127424.pdf accessed 4 January 2016
[37] http://www.croydonobservatory.org/2013-2014_JSNA accessed 4 January 2016

8.6.7 Food Flag Ship Borough

Growing food, learning to cook healthier food, and understanding the importance of a balanced, nutritious diet in preventing obesity are the principal aims of Croydon becoming a Food Flagship Borough. The programme in Croydon aims to transform the local food environment by raising awareness about the importance of eating nutritious meals to tackle obesity and reduce health inequalities in the borough.

A whole-system transformation will take place which, in the long term, will reduce childhood obesity, increase school attainment and reduce the numbers of new cases of type-2 diabetes. The local outcomes will be that, after two years, children will eat more healthily in and out of school, and children and their families will know how to grow and cook fresh food. Activities to support achieving these outcomes range from improving food provision in schools, and working with businesses, to piloting innovative approaches. All of the Food Flagship projects are open to all, however, currently there are no specific projects targeting pregnant women.

8.6.8 Weight watchers®

In June 2014, Croydon Council commissioned Weight Watchers® to work with adults who can access free weekly meetings and access online support. Attendees are supported and motivated by trained leaders at various stages of their weight loss journey; there are 10 Weight Watchers® venues situated either across or within easy access of the Borough.

Having been referred from the NHS Health Check programme and general practices, attendees learn how easy it is to follow low carb, gluten free or higher carb options, whichever suits their body best as Weight Watchers® have an approach to suit every need. A high quality, community based, weight management service is provided to support obese adults in Croydon at risk of developing cardiovascular disease and / or diabetes, to lose 5% of their initial body weight and to lead healthier lifestyles.

Whilst weight management is important in pregnancy to help pregnant women to achieve healthy weight before, during, and after pregnancy by eating healthily, and being physically active, weight loss during pregnancy is not recommended as it may harm the health of the unborn baby (NICE).[38]

8.6.9 Alcohol and substance misuse

Alcohol and substance misuse before and during pregnancy are major risk factors for miscarriage, premature birth or low birth weight baby, baby suffering from

[38] http://www.nice.org.uk/guidance/ph27/chapter/1-Recommendations#recommendation-1-preparing-for-pregnancy-women-with-a-bmi-of-30-or-more accessed 4 January 2016

symptoms of withdrawal from drugs used by the mother during pregnancy, stillbirth, physical and neurological damage to baby before birth, particularly if violence accompanies parental use of drugs or alcohol, Fetal Alcohol Syndrome, maternal and infant death, and health inequalities[39].

The NICE costing statement: Pregnancy and Complex Social Factors[40], suggests that approximately 1% of deliveries were to women with drug misuse problems and a similar number to problem alcohol users. Another report, the National Household Survey on Drug Abuse[41] suggests the number of deliveries to women who are problem alcohol users may be as high as 12% but NICE assumes a more realistic figure should be around 4.5%. However, it is acknowledged that there is an underestimation of alcohol consumption among young pregnant women because data on rates of alcohol consumption during pregnancy are commonly based on self-reporting and as such, is unreliable because of poor estimation, poor recollection, and the social stigma associated with heavy drinking during pregnancy. This situation is further compounded by variations in the alcoholic concentration of different types of alcoholic drinks.

Applying these percentages to women having their babies at CHS, in 2014/2015, 169 deliveries at CHS were potentially to women with drug misuse problems and a similar number for those with alcohol problems.

The limited CHS data indicates that the number of women who drink in pregnancy was 5 and those with a drug abuse history was approximately 37 (this number includes drugs where is multiple use). This indicates that there is significant under-reporting.

For alcohol and substance misuse, early intervention is key to improving outcomes.

8.6.10 Dental Health in pregnancy

Oral health is important for general health and well-being and pregnancy offers the opportunity to promote the importance of good oral health to mothers and encourage attitudes and behaviours that will help them protect the oral health of their children. [42]

Rates of oral disease increase with levels of social deprivation and poor oral health in the mother is associated with preterm birth and low birth weight, and dental caries in the child.

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[39] http://www.nofas-uk.org/documents/2011.331%20NOFAS%20Factsheet%20PregnantFinal.pdf accessed 4 January 2016
[40] https://www.nice.org.uk/guidance/cg110/resources/costing-statement-136146061 accessed 4 January 2016
[41] http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf accessed 4 January 2016
[42] http://www.maternal-and-early-years.org.uk/topic/pregnancy/oral-health-in-pregnancy accessed 4 January 2016

Pregnant women are entitled to free dental care during pregnancy, and up to one year after the baby is born, however maternal dental health data locally and nationally is not collected. The Dental Quality and Outcomes Framework (2011)[43] is still at the pilot stage and it is apparent that maternal health indicators are not included.

NICE guidance on approaches for local authorities[44] makes recommendations on undertaking oral health needs assessments, developing strategy, and delivering community based interventions whilst focussing on the more vulnerable in society; this could be applied to pregnant women in Croydon.

8.6.11 Domestic violence

British Crime Survey data showed that nationally, 7.3% of all women and 5.0% of men experienced domestic violence and abuse in 2011/2012. Croydon has the largest number of domestic violence offences by volume in London ranking 19th out of 32 London boroughs.

For Croydon, it is estimated that the prevalence of domestic violence and abuse is around 13,700 women and 8,800 men have experienced at least one incident of domestic violence and abuse during 2011/2012. It is also likely that during the same period around 12,600 women experienced four or more incidents of domestic violence and abuse (with a mean average of 20 incidents) and just fewer than 1,000 men experienced four or more incidents (with a mean average of 7 incidents). However, during the 12 month period from July 2011 to June 2012, there were 5,960 recorded allegations of domestic violence and abuse. A single person can be involved in more than one allegation. This indicates massive underreporting of domestic violence and abuse in Croydon.

Increasing evidence indicates that there are distinct links between domestic and sexual violence with inequalities, mental ill-health, health and wellbeing, homelessness, alcohol and substance misuse, child poverty, and children in care.

Transition to parenthood is a major life change and can place considerable stress on a couple's relationship. It is during pregnancy and immediately after childbirth that many women first experience domestic abuse and this has serious consequences for maternal and infant health. Evidence also suggests that around 30% of domestic violence and abuse starts or worsens during pregnancy and is higher in the immediate months following the birth of the baby. In the UK in 2011 more than 14% of maternal deaths occurred in women who had told their health professional they

[43] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216300/dh_126627.pdf Accessed 4 January 2016
[44] https://www.nice.org.uk/guidance/ph55 accessed 4 January 2016

were in an abusive relationship and in over 50% of known domestic violence cases, children are directly abused.[45]

8.6.12 Teenage pregnancy

Tackling teenage pregnancy (TP) is crucial to improving health and well-being of the population and is a key national priority.[46] There are disproportionate health, social and educational outcomes for young parents and their children.

- 63% higher risk of child poverty for children born to women under 20.[47]
- 21% of the estimated number of female adolescents not in education, employment or training (NEET) aged 16-18 are teenage mothers.[48]
- The infant mortality rate for babies born to teenage mothers is 44% higher than mothers aged 20-30.[49]
- 25% higher risk of low birth weight at term for babies born to women under 20.[50]
- Mothers under 20 are twice as likely to smoke before and during pregnancy and three times more likely to smoke throughout pregnancy.[51]
- Mothers under 20 are third less likely to initiate breastfeeding and half as likely to be breastfeeding at 6-8 weeks.[52]
- Mothers under 20 suffer from poorer mental health in the three years after birth compared with older mothers - with a 30% higher level of mental illness two years after the birth.[53]

The 2013 under-18 conception rates released in March 2015 showed that Croydon saw an increase in rates rising from a rate of 28.6 conceptions per 1000 in 15-17 year old women during 2012 to 32.5 per 1000 during 2013. This equates to 232 conceptions during 2013, showing a rise of 26 conceptions. The overall percentage of conceptions leading to termination was 62%, a 6% increase from the 2012 figure.

As a consequence Croydon's under-18 conception rate rose by 14% from the 2012 rate, with a higher rate than both averages for England and London.

The under-18 maternity rate is 12.4 per 1000 in 15-17 year old girls, being seen in 2013. The number of under-18 conceptions which subsequently led to a birth during

[45] http://www.croydonobservatory.org/2013-2014_JSNA accessed 4 January 2016
[46] http://www.local.gov.uk/c/document_library/get_file?uuid=9f5ef790-eee2-422d-851c-6eb5c3562990&groupId=10180 accessed 4 January 2016
[47] Mayhew E and Bradshaw J. Mothers, babies and the risks of poverty, Poverty, 121 (2005). Consultation on Child Poverty Strategy 2014-2017. HM Government (2014)
[48] National Client Caseload Information System (NCCIS), DfE 2014
[49] Childhood, Infant and Perinatal Mortality in England and Wales, 2012. ONS 2014
[50] Botting B, Rosato M and Wood R (1998) Teenage mothers and the health of their children. Population Trends 93
[51] Infant Feeding Survey 2010
[52] Infant Feeding Survey 2010
[53] Long term consequences of teenage births for parents and their children. Teenage Pregnancy Research Programme Briefing. Teenage Pregnancy Unit, DH 2004

2013 was just 89, and reflected an annual drop of 78 births in comparison to 1998 levels.

Evidence demonstrates that spending on reducing TP is cost effective. For every £1 spent on contraception, £11 is saved in other healthcare costs (PHE).

There is a consensus of expert opinion that there are 10 key steps to reducing teenage pregnancy. Croydon has implemented all of them and the decreasing rates year on year, have been presumed to be due to this.

Croydon must continue to prioritise the delivery of high quality sex and relationship education in schools and colleges, maintain young people's access to sexual health services, prioritise targeted provision to at risk groups of young people and ensure workforce development within all our service and team plans.

Engagement of all the key mainstream delivery partners; health, education, social services, youth support services, and the voluntary sector, is essential to reduce teenage conceptions and improve support services for teenage parents. Long-term, raising the aspirations of teenage girls will help contribute to a sustainable reduction in teenage pregnancy.

8.6.13 FGM

Female Genital Mutilation (FGM) also known as female circumcision or female cutting, comprises of all procedures involving the partial or total removal of the external female genitalia or any other injury to the female genital organs for non-medical reasons. FGM has no health benefits for girls or women and can have serious consequences for a woman's health both short and long term and in some instances can lead to death. FGM causes significant harm and constitutes physical and emotional abuse. Considered as child abuse, FGM is illegal in the UK either to perform or arrange for a girl to be taken abroad to have it performed. However, it is estimated that over 20,000 girls under the age of 15 years are at risk of FGM in the UK each year, and 66,000 women in the UK are living with the consequences of FGM[54].

8.6.13.1 Scale of the problem

There are estimated to be:

- 3,480 females in Croydon who have been affected by FGM at some point in their lives, which is equivalent to 1 in 104 people in Croydon.
- 180 females aged under 16, 2,250 females aged 16 to 49 and 1,050 females aged over 50 in Croydon are affected by FGM .

[54] https://www.gov.uk/government/publications/2010-to-2015-government-policy-violence-against-women-and-girls/2010-to-2015-government-policy-violence-against-women-and-girls accessed 4 January 2016

- 3% of maternities in Croydon are for women affected by FGM, which is equivalent to 180 births per year, equivalent to 1 in 2020 people in Croydon

However, due to the hidden nature of this crime the full extent is unknown[55].

Reducing FGM requires a whole systems approach and already significant partnership work has been undertaken in Croydon to address the multi-faceted complexities of FGM. Recognising the need to develop an overarching Croydon–wide strategic plan, Croydon CCG has recruited a project consultant for one year to:

- Scope and map the prevalence of FGM in Croydon
- Improve outcomes for women and children affected by FGM
- Reduce and prevent FGM prevalence in Croydon
- Improve multi agency response to FGM in Croydon

Over the course of the year, the FGM project will strengthen awareness of existing support services for women affected by FGM during pregnancy, such as the perineal clinic run through Croydon Health Services, offering, advice, de-infibulation procedures and follow up to women across Croydon. In addition, the FGM project will implement new services for women so that they are supported within the community beyond pregnancy and birth, such as through an FGM support group running within a Children's Centre, and Champions trained to provide support within the community for men and women affected by FGM.

Girls at risk of FGM will be safeguarded through a roll out of professionals training, education sessions in schools, and a Borough wide awareness raising campaign.

Professionals will be supported through the training offer, as well as via the overarching strategy, action plan, and referral pathways for FGM – providing clarity on how to respond to cases where FGM may be present or has already occurred in Croydon.

A mid-year FGM Conference will pull together Local Authority, Health and Voluntary sector partners to share information on the different work streams under way and gather commitment to ensure that there is future sustainability going forward beyond the project. A final evaluation of the project will provide long-term recommendations.

8.7 Labour and Postnatal care

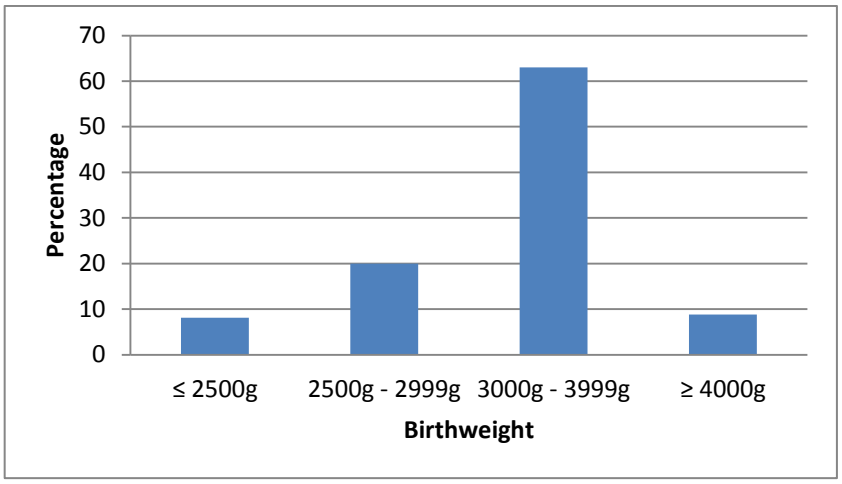
Two-thirds of Croydon babies are born at CHS. In 2014/2015 just under 60% of mothers giving birth at CHS had normal births. 27.1% of the babies were born by caesarean section; of these 18.5% were emergency caesareans and 8.6% were elective caesarean sections. Comparing Croydon with the other maternity units in

[55] http://www.nhs.uk/conditions/female-genital-mutilation/Pages/Introduction.aspx accessed 4 January 2016

South West London, CHS Caesarean section rates are second lowest in the SWL Maternity Network but slightly higher than the SWL Maternity Network average of 26.6%.

8.8 Birthweight

Figure 4: Birthweight of live-born infants (%) in Croydon, London and England in 2013



Source: birth registration data

Birthweight is a good measure of long term health and low birth weight (LBW) is used as an important predictor of future health and mortality since a child with LBW is more likely to die or have poorer life outcomes. Having a LBW baby (less that 2500 grams) is strongly associated with deprivation, poor maternal health, late access to antenatal care, belonging to a black and ethnic minority group, lone mothers, smoking in pregnancy, multiple births, alcohol abuse, low socio-economic status and age. LBW babies are **27 times** more likely to die in their first year than heavier babies, are at greater risk of disability and **over 5 times** more likely to die suddenly and unexpectedly than those of a normal birth weight. Teenagers have a 25% higher risk of having a LBW baby at term[56]. LBW can affect life chances, educational performance and in turn impact on adult outcomes. LBW babies are more likely to require intensive medical support at birth and throughout childhood which has implications for the child, the family and increases the demand on services required to support the child.

This has commissioning implications for health, social care, education and continuing care services. Compared with the national and regional profile, Croydon has a higher level of LBW babies; 8% of Croydon babies were below 2500 grams in 2013; this equates to 450 babies; this is higher than the London and England (7.6%, 7.1%) averages. Of the 8%, just over 1% of the babies weighed less than 1500

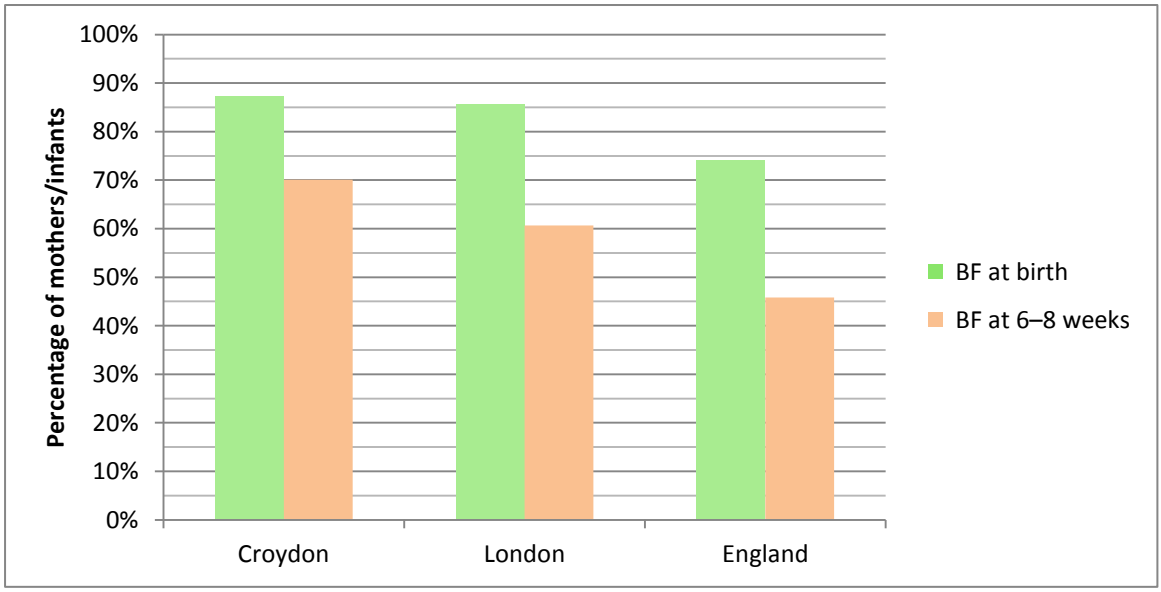
[56] PHE (2015) Reducing infant mortality in London: an evidence-based resource

grams. However, children from ethnic minority backgrounds are more likely to be born as LBW than those from white backgrounds[57] [58]. As Croydon has a high BME population compared to the London & England averages, it is feasible that some of the variation in LBW could be attributed to ethnicity. More analysis would be needed to look at the ethnic breakdown of LBW babies in Croydon which falls outside the remit of this chapter.

The optimal birthweight is between 3500grams and 4000grams but with the increase in adult and adolescent obesity and diabetes in the general population, birthweights have also increased significantly. This increases the risk of neonatal morbidity and injury, maternal injury, and caesarean section. In 2013, 8.8% of Croydon babies weighed more than 4000grams at birth.

8.8.1 Breastfeeding

Figure 5: Breastfeeding at birth* and at 6–8 weeks (%) in Croydon, London and England in 2014**



Source: NHS England
*Breastfeeding initiated by mother at birth, shown as a percentage of all mothers
**Infant receiving any breastfeeding at 6– 8 weeks, shown as a percentage of all infants
BF = breastfeeding

Breastfeeding is a key intervention that improves both the mother's and infant's health and encouraging the mother to breastfeed can also improve the child's life chances.[59] Exclusive breastfeeding is recommended for the first six months of an infant's life. Evidence demonstrates that improving breastfeeding rates not only

[57] http://jpubhealth.oxfordjournals.org/content/31/1/131.full accessed 4 January 2016
[58] http://www.ons.gov.uk/ons/rel/hsq/health-statistics-quarterly/no--39--autumn-2008/birthweight-and-gestational-age-by-ethnic-group--england-and-wales-2005.pdf accessed 4 January 2016

[59] PHE (2015) Reducing infant mortality in London: an evidence-based resource

improves longer term health for children and reduces the risks of future diseases but can also impact on the financial return on investment to the health service through reducing hospital admissions and attendances in primary care[60] .Breastfeeding rates are lower in white British mothers, those under 20 years of age, and in the least or most deprived areas.

In 2014 more Croydon mothers are feeding their babies in the first 48 hours (87%), than London or England (86%, 74%) and the drop off rate is less in Croydon (16.9%) than London and England. Over a quarter of infants in Croydon are partially or exclusively breastfeeding at 6 – 8 weeks after birth.

Increasing breastfeeding rates requires a multifaceted approach and interventions in place in Croydon, include Mum to Mum Peer support, Baby Cafes® and working towards achieving full UNICEF Baby Friendly Accreditation. This is a three stage evidence-based award to ensure that within the organisation, there is a culture of breastfeeding, the staff are confident, competent and consistent in supporting women. Stage 2 has already been achieved by CHS and it anticipates that Stage 3, the final stage, will be completed in 2016. All midwifery and health visiting staff are trained to offer support with breastfeeding from the antenatal period.

8.8.2 Infant Mortality

Infant mortality is defined as the death of a child in the first year of life and is an internationally recognised measure of the health in a society and a significant factor in overall life expectancy and health inequalities. The infant mortality rate (IMR) is the number of babies born alive who die in the first year of life per 1000 live births.

In England and Wales

- 61% of deaths in children (0-18) are of infants
- 1 in 250 infants die in their first year of life (4.1 infant deaths per 1,000 live births)[61]
- IMR for babies born to teenage mothers is 44% higher than mothers aged 20-39 years.
- LBW babies are **27x** more likely to die before the age of 1 year than babies of normal weight
- Babies born to mothers in the routine and manual group have a **4x** higher infant mortality rate than those born to mothers in higher managerial and professional groups[62].

IMRs are worse in disadvantaged groups and areas and are often linked to social factors such as education, employment, income and the environment. Lifestyle

[60] http://adc.bmj.com/content/early/2014/11/12/archdischild-2014-306701.full.pdf+html accessed 4 January 2016
[61] http://www.chimat.org.uk/resource/view.aspx?RID=222265 accessed 4 January 2016

[62] PHE (2015) Reducing infant mortality in London: an evidence-based resource

choices, and the quality, availability, and accessibility of services are also important. Risk factors for infant mortality include smoking during pregnancy, low birth weight, prematurity, mothers from black ethnic groups, mothers born outside the UK, teenage mothers, single mothers and mothers who register their baby alone, births among those who are in routine and manual jobs, deprivation, multiple births and obesity.

Table 5: Infant mortality rates 2011–2013

Indicator	Croydon	London	England
Infant mortality rate (per 1000 live births)	4.0 [3.1–5.0]	3.9 [3.7–4.1]	4.1 [4.0–4.2]
Stillbirth rate (per 1000 live and still births)	5.4 [4.4–6.6]	5.5 [5.3–5.8]	4.9 [4.8–5.0]
Perinatal mortality rate (per 1000 live and still births)	7.2 [6.1–8.6]	7.6 [7.4–7.9]	7.1 [7.0–7.2]
Neonatal mortality rate (per 1000 live births)	2.4 [1.8–3.2]	2.7 [2.6–2.9]	2.9 [2.8–2.9]
Post-neonatal mortality rate (per 1000 live births)	1.6 [1.1–2.3]	1.2 [1.1–1.3]	1.3 [1.2–1.3]

Source: Indicator Portal, Health & Social Care Information Centre 2015 (Numbers in brackets indicate 95% confidence intervals)

Table 6: Infant mortality numbers and rates, Croydon and England 2011 to 2013

Year	Croydon					England
	Infant deaths	Neonatal deaths	Post-neonatal deaths	Live births	Infant mortality rate*	Infant mortality rate*
2011	23	13	10	5720	4.0 [2.7–6.0]	4.3 [4.2–4.5]
2012	22	13	9	5884	3.7 [2.5–5.7]	4.1 [4.0–4.3]
2013	23	15	8	5605	4.1 [2.7–6.2]	3.9 [3.8–4.1]
2011–2013	68	41	27	17209	4.0 [3.1–5.0]	4.1 [4.0–4.2]

*Per 1000 live births Source: Health & Social Care Information Centre. Numbers in brackets indicate 95% confidence intervals

As numbers are small, using three-year rolling averages provides a more reliable guide to underlying trends. For 2011 to 2013, Croydon IMRs were lower than England but slightly higher than London. Whilst the numbers are small, infant deaths have fallen from 30 in 2006 to 23 in 2013: the IMR from 6.0 per 1000 live births to 4.0 per 1000 live births. Reducing the variation in IMR requires initiatives to improve

maternal health, child health and the wider determinants of health such as education and housing. The reduction in Croydon reflects the actions and initiatives that have been put in place in an attempt to reduce infant mortality over recent years.

Neonatal mortality rates are especially sensitive to events during pregnancy, delivery and the neonatal period, and to the care given to mothers and their babies. Post neonatal mortality rates are thought to be influenced to a greater extent by parental circumstances including socio economic position and the care they provide their infant.

8.8.3 Perinatal mortality (stillbirths and deaths of babies under 7 days)

In Croydon, the perinatal mortality rate was 7.2 per 1000 births in 2011 – 2013. This is a reduction from 2006 – 2008 where the rate was 9.2 per 1000 births.

8.8.4 Stillbirths

In 2011-2013, the stillbirth rate (SBR) in Croydon was 5.4 per 1000 births, being higher than England (4.9 per 1000) but marginally lower than London (5.5 per 1000) The SBR in Croydon has decreased from 6.4 per 1000 births in 2006 – 2008 to 5.4 in 2011-2013.

Stillbirths are strongly associated with deprivation, smoking in pregnancy, ethnicity, and teenage mothers which may account for some of the variation seen in Croydon but to understand this more, an analysis of the associated risk factors would need to be undertaken.

9 Women's experience of birth

Maternity care has a profound effect on women's physical, emotional and psychological health throughout life. Women's experience of their care during pregnancy, during labour and the birth of their baby and in the days and weeks following the birth, affects the way that they care for themselves and the relationship with their baby, the father of the baby, and subsequent care-givers and other professionals and agencies. It is a window of opportunity for intervention as many women and their partners are accessing the services

9.1 Care Quality Commission

In 2013, the Care Quality Commission (CQC) undertook a review of women's experiences of maternity care in CUH which showed that:

"most women and family members were happy with the maternity services and we saw evidence that they were both safe and caring. The unit was well-led and positive changes were being made and sustained. Women were offered choices and most found doctors and midwives caring, with some exceptions at night. Systems were in place to recognise and respond to emergencies quickly. The hospital cares for a relatively high number of high-risk pregnancies and the midwives we spoke to were passionate about ensuring women got the right care and support. The staff team included a range of specialists to meet the diverse needs of local women. Staffing levels were improving and staff were positive about the service they offered. Some women mentioned delays in the antenatal clinic."

The CQC visit to CUH in September 2015[63] recognised that there had been continued and sustained improvements to maternity services. Women who had previously given birth at the hospital commented positively on the improvements to maternity services and stated that staff, were caring, responsive and knowledgeable. This report acknowledges the commitment to improving maternity services in Croydon.

9.2 Local Supervising Authority Inspection

An inspection in June this year was carried out by the 'Local Supervising Authority' (LSA) for the inspection of midwives, a body that draws from a range of experienced midwifery staff and educators based in London that audits midwifery care on behalf of NHS England. The LSA looks at a number of aspects of how 'Supervisors of Midwives'(SoMs), a term used to describe midwives who have undergone further training to support practising midwives, ensure that maternity services are safe, supportive and well-run.

[63] http://www.cqc.org.uk/location/RJ611 accessed 4 January 2016

This inspection highlighted the progress that has been made in improving the quality of the CUH maternity services.

The expert 'peer review' of the midwifery leadership at the maternity department at Croydon Health Services has found that 'Supervisors of Midwives' (SoMs) provide 'excellent care' to the women who choose to deliver at Croydon. This leadership, they found, demonstrated that SOMs worked to a 'high standard', encouraged 'good team working' and that they 'worked extremely hard' to improve women's experience of the service.

The report also found that even when clinical guidance discouraged the type of birth women had planned, they still had 'positive experiences' thanks to the 'excellent care' and planning provided by the Trust's 'Supervisors of Midwives' and the Trust's Crocus team, a community midwifery team which supports mums to deliver at home which was also identified as providing 'an exceptional service'.

The report confirmed that the Trust's SoMs are meeting all required standards, including working with the women who use CHS services, supporting teamwork and leadership, management of midwives, and ensuring the department is safe and accountable through good 'clinical governance'.

9.3 National Maternity Review

Following concerns about poor maternity care in a number of hospitals in the UK, a review of all current maternity services is being led by NHS England. The review is on safe and efficient models of maternity services, to ensure women can make safe and appropriate choices of maternity care for themselves and the babies and also to support NHS staff including midwives to provide responsive care. During the consultation period, women who have been pregnant and supported by the NHS, their husbands or partners, friends, and family members as well as healthcare professionals, charities and representative organisations and commissioners of maternity services were invited to tell NHSE what they thought was good about maternity services and what could be done to improve them.[64]

9.4 Friends and Family Test

The Friends and Family Test (FFT) aims to provide a simple, headline metric which, when combined with follow-up questions, can be used across the maternity pathway

[64] https://www.england.nhs.uk/2015/12/14/julia-cumberlege-8/ accessed 4 January 2016

to drive a culture change of continuous recognition of good practice and potential improvements in the quality of the care received by service users.

Women are surveyed at three touch points:

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

Table 7: FFT scores CUH April – July 2015

2015	April		May		June		July	
Clinical Area	**response (n)**	**(%)**	**response (n)**	**(%)**	**response (n)**	**(%)**	**response (n)**	**(%)**
36 weeks	42	95	48	89	23	100	29	97
Labour and birth	43	100	57	94	85	96	67	100
Postnatal Ward	105	96	180	86	240	93	234	95
Postnatal Community	50	100	44	95	42	95	36	100

Source: CUH Maternity Unit

Whilst the response rate for the different clinical areas except the postnatal ward, was not high, and the percentage of those who would recommend their family and friends fluctuated month on month, there has been an improvement in July 2015 where more than 95% of service users would recommend their family and friends to the maternity service.

The response from FFT is key to assessing patient experiences and provides the opportunity to improve services where responses have been poor.

9.5 Walk the Patch

Maternity Services Liaison Committees (MSLCs) play a significant role in influencing and guiding the development of maternity services and are a vehicle for change and improvement. With their commitment to improving the overall quality of care women and their families receive, Walk the Patch, facilitated by the User representatives of the MSLC, provides one- to-one, face-to-face contact with women and their partners from all backgrounds, giving them the opportunity to have their say about their experiences with the maternity services and the care that they received. Having visited the clinical areas one hour before the MSLC meeting, the findings are presented to the committee. Feedback includes a range of compliments, complaints,

concerns, and suggestions about improving women's experiences and these are discussed at the meeting and actioned as appropriate.

10 Croydon Best Start

Croydon Council, Croydon Health Services and voluntary, community, and faith organisations are working together to deliver a wide range of services for families with young children (from conception to when the child starts school at five years).

As part of the transformation programme, from 2015, the council and its partners have been working together to redesign how these services are planned and delivered to enable better access to services and identify needs earlier to improve outcomes and reduce costs.

The new Croydon Best Start model consists of high quality, evidence-based, early intervention services, using a whole systems approach, provided by multi-disciplinary, integrated locality teams of health, children's centre, early years, and community practitioners, who will deliver the 0-5's healthy child programme and targeted family support. These teams will be aligned with the midwifery service and wrapped around GP clusters so that equality of opportunity is provided for all families[65]. This will be further underpinned by a family partnership model approach in which parents are acknowledged and valued as experts both by themselves and their communities and by professionals.

The outcomes for this model are that:

- Babies and children are safe and protected from harm, physically and mentally well, and ready and prepared for school.
- Parents and families are physically and mentally well and able to manage their own lives and deal with problems as they happen.

Evidenced based family assessments - Best Start Promotional Guides, have been developed to promote partnership working between professional and parent in identifying and assessing family needs and will be used by all Best Start practitioners for early identification of needs and support family engagement with services. With Best Start, all practitioners will be able to offer advice and signpost support across the whole Best Start offer, ensuring that 'every contact counts' and that parents know what support there is and how to access it. Within the new model, additional services have been included to capitalise on the integrated approach, maximise financial savings and increase benefits to children and families.

Developing and implementing this new model is already underway and in April 2016 "Croydon Best Start" goes live.

[65] http://news.croydon.gov.uk/beststart/ accessed 4 January 2016

10.1 Family Partnership Model

The Family Partnership Model[66] is an innovative, evidence based approach where parents are acknowledged and valued as experts by themselves, their community and by professionals. Through specific helper qualities and skills, the parents are supported to overcome their difficulties, build strengths and resilience, and fulfil their goals more effectively.

Evidence based antenatal and postnatal promotional guides provide a structured but flexible approach to promoting partnership working between professionals and parents to identify and assess family needs and help support:

- The early development of babies
- The transition of mothers and fathers to parenthood
- Making well-informed decisions about the needs of the baby and the family

As this model is being developed, these promotional guides are now being used effectively by midwives and heath visitors, with joint visits with the families being established.

10.2 Early Intervention

Early childhood development including physical, social/emotional, and language elements, has a determining influence on subsequent life chances and health through skills development, education and occupational opportunities. Early childhood influences have a direct impact on the subsequent risks of obesity, malnutrition, mental health problems, heart disease and criminality.

Experiences in early childhood, from antenatal development until eight years of age lay critical foundations for the entire life course. Early intervention gives the opportunity to make lasting improvements in the lives of children, to anticipate persistent social problems, and to reduce health inequalities[67].

Croydon is committed to supporting all children, young people and families to provide equality of opportunity and for them to realise their full potential, therefore, a range of services to support families in Croydon have been commissioned. Through Early Help assessments, a process of staged intervention is used to identify, assess, and support the needs of children and young people. This is an inclusive process that involves parents/carers, children and young people, relevant staff, and support services. Being solution-focussed, this approach meets the needs at the earliest opportunity.

[66] http://www.cpcs.org.uk/index.php?page=about-family-partnership-model accessed 4 January 2016
[67] http://www.eif.org.uk/ accessed 4 January 2016

The National Health Visitor service model further supports this by offering a framework of support for all families which includes contact with the Health Visiting service at five key points in a child's first 2 years of life and a differentiated level of intervention depending on need.

11 Need in Croydon

This section outlines areas acknowledged by the scoping group as requiring a greater understanding of need.

11.1 Perinatal Mental Health

A strong predictor of well-being in the child's early years is the mental health and well-being of the mother and other care givers. During pregnancy and in the year after birth, women can be affected by a range of mental health problems, including anxiety, depression, and postnatal psychotic disorders. These are collectively called perinatal mental illnesses. Not forgetting fathers, interestingly, a study in 2010 (Dave S et al)[68] found that the prevalence of paternal depression is around 4% during the first year of life.

When mothers suffer from these illnesses it increases the likelihood of problems in childhood, including pre-term birth, emotional problems, conduct disorder, special educational needs, and poor school performance. The onset and escalation of perinatal mental illnesses can often be prevented through early identification and expert management of a woman's condition, and prompt and informed choices about treatment. Even if the illness itself is not preventable, it is possible to prevent many of the negative effects of perinatal mental illness on families. It is suggested that about half of all cases of perinatal depression and anxiety go undetected and many of those which are detected, fail to receive evidence based forms of treatment.

Evidence suggests that perinatal mental illnesses affect up to 20% of women and if untreated, can have a devastating impact on them and their families. This would equate to about 1200 women in Croydon per year with 13 new mothers in Croydon experiencing postpartum psychosis and chronic serious mental illness, about 180 new mothers experiencing severe depressive illness, and up to 1800 mothers per year experiencing adjustment disorders and distress.[69] In 2014-2015, 30 women were referred by midwives, for mental health issues; these are usually the severe illnesses e.g. Bi-polar effective disorders, personality disorders, suicidal ideation and schizophrenia. On average, a further 30 women were referred to the perinatal mental health team with depression and low mood.

Due to the prevalence of mental health conditions in this group and the need to access and refer to mental health services, it is important that there is a strategic approach to secure sufficient, high quality, integrated services.

[68] Incidence of Maternal and Paternal Depression in Primary Care A Cohort Study Using a Primary Care Database Dave´ S et al 2010 , http://www.fyiliving.com/wp-content/uploads/2010/09/momdaddepression.pdf accessed 14 January 2016
[69] Hogg, Sally (2013) Prevention in mind: All babies count: spotlight on perinatal mental health. London. NSPCC

Local strategies should set out plans for developing the knowledge, skills and resources necessary for the detection and prompt and effective treatment of perinatal mental illnesses across the local area. A concerted effort will need to be made by all partners in order to co-ordinate support for women.

The Centre for Mental Health and the London School of Economics (2014) have published an analysis of the estimated costs of mental health conditions in children and young people which are linked to their mothers' emotional problems in early parenthood. It is estimated that annual costs of perinatal mental health problems are £8.07 billion, of which 72% relate to impacts on children and young people. The cost to the public sector of perinatal mental health problems is 5 times the cost of improving services[70]

Table 8: National total costs per case

	Total cost to mother	Total cost to child	Total cost to mother and child
Perinatal depression	23,000	51,000	74,000
Perinatal anxiety	21,000,	14,000	35,000
Perinatal Psychosis	47,000	6,000	53,000

Effective prevention, detection and treatment of perinatal mental illnesses could have a positive impact on the lives of families, improve the wellbeing, health, and achievement of children and generate long-term savings through improved outcomes for mothers and babies.

There is good availability of Perinatal mental Health services in Croydon and further investment for 2015/2016 has been made.

To support maternal mental health and bonding and attachment for mothers and their children, work is underway to develop a Parent Infant Partnership[71] as part of the 1001 Critical Days review and recommendations[72]. PIPUK® supports organisations to set up "an infant mental health service" offering psychotherapeutic services to parents, carers and their under two's.

Provision of support for women with chronic low-level mental health problems remains patchy and there is often confused responsibility between primary care, mental health and maternity services.

11.2 Learning and physical disabilities

It has been estimated that 9.4% of women giving birth in the UK have one or more limiting longstanding illnesses which may cause disability, affecting pregnancy, birth

[70] Bauer et al (2014) The costs of perinatal mental health problems. LSE PSSRU
[71] http://www.pipuk.org.uk/ accessed 4 January 2016
[72] www.1001criticaldays.co.uk accessed 4 January 2016

and early parenting.[73] Disabled women and their partners are often anxious about pregnancy, delivery and parenting. Fear of the unknown is even more likely than for other first time parents. Many physically disabled women successfully become mothers and give birth to healthy babies[74]. Babies of mothers with learning disabilities are at increased risk of poor birth outcomes. Some mothers with learning difficulties are likely to have difficulty accessing good quality antenatal care that meets their needs and others may just avoid maternity care. 30-50% of children whose mothers have a learning disability are at risk of poorer development, compared to children from similar socio-economic groups. Whilst they are no more likely to be born with a learning disability, they are more likely to have developmental delays, lower IQ and behavioural problems.

11.3 Vulnerable groups

Pregnant women with complex social factors e.g. poverty, substance misuse, asylum seeker, and under 20 years of age, may have additional needs and early identification of these vulnerable groups of women will ensure that the mother's needs are assessed aiming to improve mother and infant outcomes[75]. Complex social factors may vary, in both type and prevalence and across different local populations.

11.4 Safeguarding

Keeping children from harm is a demanding task requiring very high levels of professional dedication and skill. Getting safeguarding practice right needs a clear focus and to be central to children's services overall.

The care that parents receive in pregnancy, at the time of birth and in the months following has a huge impact on their mental health and well-being, and their ability to cope. Laming (2009)[76] highlighted the importance of good practice in communication and information sharing within and between each local service to keep children safe.

A recent Croydon Safeguarding Children Board multi-agency audit (2015) reviewed 12 randomly sampled cases, pre-birth and under one year, who had been referred to social care and early help during 2014, and who had also been exposed to domestic violence. The audit identified areas of concern with communication and information sharing between the agencies involved, follow-up of referrals, early identification, and engagement with fathers. To address these concerns a robust action plan has been developed and implemented.

[73] Sumilo D, Kurinczuk JJ, Redshaw ME, Gray R: Prevalence and impact of disability in women who had recently given birth in the UK. BMC Pregnancy Childbirth 2012, 12:31–37.
[74] Smeltzer CS: Pregnancy in women with physical disabilities. J Obstet Gynecol Neonatal Nurs 2007, 36:88–96.
[75] https://www.nice.org.uk/guidance/cg110 accessed 4 January 2016
[76] Department for Children Schools and Families (2009) The Protection of Children in England: A Progress Report. London:The Stationary Office)

11.5 Housing

Poor housing conditions such as overcrowding and living in temporary accommodation can have a devastating impact on families and their health and well-being. Homelessness is increasing and the impact of this increase has been felt in Croydon harder than other areas of the country due to the size of the borough population, its housing tenure mix, and its low earnings compared to the London average.

Nationally, 65% of homeless households accepted as in priority need, have children. This is 11% lower than in Croydon (76%). In 2013/14 this represented 582 families and more than 1,000 children living in temporary accommodation. Of the 582 families, 8% (76) were pregnant women. Nearly half of all homeless households accepted by the Council are single women with children and the age of the main applicant is typically between 25 and 44 years. Reasons for being homeless are varied but may include low-income and a background of abuse.[77] [78]

11.6 Fathers

There is a strong evidence base[79] identifying that:

- father-child relationships have a profound impact on children that last a life-time
- high-levels of involvement are associated with positive outcomes for children including better physical and mental health, higher educational achievement and lower criminality and substance misuse
- mothers who feel supported by their children's fathers suffer less parenting stress and parent more positively

However, despite the evidence of positive outcomes, fathers are not universally invited to be involved across the maternal/infant health pathway.

An example of engaging fathers more, Working with Men[80], a specialist charity supporting positive male activity, engagement and involvement, are facilitating men-only preparation for birth parent education classes at Croydon University Hospital.

[77] http://www.crisis.org.uk/data/files/publications/YoungWomenPregnancy.pdf accessed 4 January 2016
[78] http://www.croydonobservatory.org/2013-2014_JSNA accessed 4 January 2016
[79] http://www.fatherhoodinstitute.org/uploads/publications/460.pdf accessed 4 January 2016
[80] http://workingwithmen.org/ accessed 4 January 2016

12 What the agencies said

It was apparent from the audit that a tremendous amount of good work is on-going to improve maternal and infant outcomes in Croydon; however, this section highlights the gaps that were noted during the course of the audit.

From analysis of the notes made during discussions with the various the agencies /providers and it was possible to identify a number of emerging themes that were common to all. These have been categorised under the following headings:

- Communication
- Pathways
- Data
- Universal services
- Workforce development
- Risk factors and vulnerable groups
- Commissioning
- Other

12.1 Communication

- A number of agencies do not have a specific maternal health communication strategy and for those who do, it is unclear how this strategy is evaluated
- No specific protocol on maternal health for homeless families with dependants and suitability of placements
- Inconsistent /poor communication between agencies e.g. referrals
- Challenge to communicate with different population groups
- Communication with service users and their families could be improved; feedback from service users on provision of services is not always formalised
- Information overload for pregnant women, new mothers, and families
- Poor communication systems and processes with out of area hospitals to alert midwives when new mothers and babies return to their home.
- Lack of whole systems approach through some programmes

12.2 Pathways

- Need to improve referral processes between and within all agencies across the maternal health pathway
- A number of agencies have not developed/implemented appropriate guidelines and pathways e.g. referral pathways, provision for women identified with pre-existing mental health issues
- Not all agencies are familiar with different local agency systems and processes

- Roles and responsibilities within agencies are not clear

12.3 Data

- Improved technology investment required so that communication through smart phones/free apps and other means could be utilised
- Limited available local and national data. e.g. learning disabilities
- Duplication of data collection systems, reporting and documentation
- Considerable constraints around using electronic records, difficulties in completing reports; no interface between IT systems
- Limited data sharing processes and local sharing agreements not fully in place across whole pathway
- Data collection not always specific to maternal health. e.g. learning disabilities
- Data collected is not used effectively to identify outcomes and gaps
- Qualitative data not routinely collected
- Inconsistent monitoring of those with complex or additional needs at local level

12.4 Universal Services

- Services are not fully utilised and in some areas of the universal pathway, provision is targeted
- Lack of capacity for provision of services
- Variations in involvement of care where not all agencies are involved in the care and care plans of women accessing their services

12.5 Workforce development

- Training needs assessments are not consistent across agencies and needs identified are not always current
- Limited or no specific training around maternal health and multi-agency training in relation to under 5's in various agencies
- Limited reporting of training undertaken in agencies to ensure quality, maintenance and development of associated competences to ensure sustainability
- Information about courses and training availability not consistently cascaded to appropriate agencies
- Lack of training around specific skills such as listening skills and disparity in skills set
- Lack of provision for the public to develop as volunteers
- Comprehensive safeguarding training is required for all associated partners

12.6 Risk factors and vulnerable groups

- Lack of clarity about what advice and information is given out to vulnerable/targeted groups and the specific support that is given to them e.g. those with learning disabilities
- Concerns around the interface between primary and secondary care in vulnerable populations
- Need to be proactive to promote services and engage with those who are less likely to access services
- Interpreters not always accessed as appropriate
- Need to strengthen links with Community Psychiatric Nurses to collectively find approaches that work with for the families
- Lack of engagement with voluntary sector as a whole but especially when complex needs are identified
- Mental ill-health puts added stress upon services and is not included as a key performance indicator
- Need for a holistic assessment looking at the needs of women and children in respect of domestic violence, and this plan should be adjusted to be specific for them
- Croydon does not commission specific services for those with learning difficulties and those with learning disabilities
- Provision of appropriate information and support when complex issues are identified pre- and post-birth
- Opportunities missed to support vulnerable mothers
- Lack of provision for childcare to attend specialist appointments i.e. those attending specialist therapeutic sessions
- Improve involvement of fathers – seen as invisible but they can identify risk factors and be supportive. Need to be persistent when engaging with fathers and improve involvement with families

12.7 Commissioning

There are a number of organisations involved in the commissioning of maternity services and there needs to be closer working arrangements between these organisations to ensure intensive scrutiny of services

12.8 Other

- Lack of consistency across the agencies having accountable leads and champions for communication, data, and workforce development

12.9 Examples given by the voluntary sector to show support given to pregnant women and new mothers

- Whilst the voluntary sector agency does not provide a specific service for pregnant women, support is provided through their core service: a single mother with a learning disability was supported to join a small family peer support group and was introduced to other universal services in her area
- A pregnant mum with a complicated pregnancy was socially isolated and was supported through her pregnancy
- Mothers having previously experienced post-natal depression (PND) were supported and given reassurance during their pregnancies and post natal periods

13 What the service users said

Absolutely fantastic; fab!

However, the audit uncovered various issues that were felt pertinent to improving the services.

13.1 Relationships

- Not always involved in decisions/ felt pressured to make a decision
- Limited or no contact with GP
- Capacity of staff on postnatal wards affected relationships
- Would like to see same midwife throughout pathway
- Difficult to build relationships as time for antenatal and postnatal visits limited and rushed; there was not always enough time to ask questions or have discussions
- Inconsistency with how fathers/partner were involved

13.2 Communication

- Different agencies did not communicate with each other to fully support new mothers and infants after birth
- Information overload; but sometimes specific information was required tailored to individual needs
- Inconsistency of handover records from hospital to community midwives, HVs and GPs
- Conflicting advice
- Attended pregnancy parenting class for couples, but felt uncomfortable as partner could not be there and everyone else there were a couple
- Not asked about additional needs – i.e. hearing impairment
- Unaware of importance of early access to maternity care (this was a mother having her 2nd baby)
- Whilst it was the mother's choice to have her baby at an out of borough hospital, the GP did not discuss alternative options for place of birth prior to her making a decision

14 Recommendations

Commissioners of services in these recommendations include:

- Croydon Clinical Commissioning Groups
- Croydon Council
- NHSE

Agencies/Providers in these recommendations include:

- Croydon Council
- Croydon Health Services
- South London and Maudsley NHS Trust
- Voluntary Sector

14.1 For Commissioners

1. Best Start

It is recommended that commissioners ensure the provision of an integrated service and improve physical, social and psychological outcomes of families and young children through sustaining Best Start and the transformation of services ensuring that the elements of maternal health and the 5 year SWL maternity strategy are incorporated.

2. Vulnerable Women

It is recommended that commissioners ensure that all providers involved in the provision of support across health, social care and the voluntary sector provide a seamless pathway for vulnerable women and those with complex needs meeting the national standards as set out in national NICE guidance.

3. Perinatal Mental Health

It is recommended that commissioners ensure that all the providers involved in the provision of perinatal mental health services meet the national standards as set out in national guidance to strengthen mental health support to mothers and their families.

4. Vitamin D supplementation

It is recommended that commissioners consider provision of universal Vitamin D for infants and children under 5 years, and pregnant and breastfeeding women as recommended by national guidance.

5. Early access to maternity services and supporting women's choice

It is recommended that commissioners work with providers to improve the numbers of pregnant women accessing maternity services before 10 weeks and to support women's choice for place of birth.

14.2 For Providers

1. Pathways

It is recommended that providers work together to review the maternal health pathway, ensuring improved engagement with fathers and service users.

2. Communication

Have an appropriate communication strategy in place relating to maternal health between agencies in and out of borough, and between service users and the wider public. It is important to ensure that information and advice to parents is consistent and streamlined across and within agencies.

3. Early Intervention

It is recommended that early identification, assessment and early intervention are improved through increased use of Early Help Assessments to identify support for families.

4. Training and Development

It is recommended that providers evaluate current provision and work together to develop an effective cross-agency training programme ensuring training needs are identified and met.

5. Data and information sharing

It is recommended that providers work together to ensure robust and credible data and agree information sharing processes.

14.3 For Croydon Safeguarding Children Board

It is recommended that the Croydon Safeguarding Children Board review safeguarding processes for referrals and information sharing across agencies.

14.4 For the Children and Families Partnership Board

It is recommended that the prioritisation of teenage pregnancy by the Children and Families Partnership Board to prevent a further increase in teenage conceptions is re-considered.

14.5 For the Director of Public Health

1 It is recommended that the Director of Public Health has oversight of the high level population indicators: infant mortality and low birthweight and ensures that these are communicated strategically.

2 It is recommended that the Director of Public Health continues to ensure scrutiny of antenatal and newborn screening programmes.

15 Conclusions

It is widely accepted that the physical health and mental well-being of the mother in pregnancy, during labour and after the birth of the baby has a lifelong impact on both the mother and infant.

To improve outcomes for the mother and give each child the best start in life, early intervention and access to maternity services are key. This early access allows for the development of relationships between not only the mother and the professionals she comes in contact with, but also between those who care for her.

Despite many positive comments, feedback from the audit highlighted the lack of an integrated model of working, areas of concern with pathways, poor communication, issues with IT and data, and cross-agency training.

Improving maternal health and well-being is multi-factorial and needs engagement from all agencies involved in the journey including the mother.

Challenges for Croydon in providing services for maternal health and well-being are enormous given the rising demand and increased expectations of service users set against capacity issues, improving performance, and the financial pressures placed on the NHS, Croydon Council and the voluntary sector.

To provide a supportive, integrated framework, requires a co-ordinated approach by the commissioners and providers of services to develop a seamless service with associated pathways and improve outcomes for both mothers, infants, children and their families.

16 APPENDICES

16.1 Glossary

Infant mortality

Infant mortality is the death of a child less than one year of age. It is measured as infant mortality rate (IMR), which is the number of deaths of children under one year of age per 1000 live births.

Lower Super Output Areas

A LSOA is a geographical area designed for the collection and publication of small area statistics. They give an improved basis for comparison throughout the country because the units are more similar in size of population.

Neonatal death

This is the death of a live born baby up to 27 completed days of life. This is a more sensitive measure for deaths which occur in the early weeks of life. The neonatal mortality rate is the number of neonatal deaths per 1,000 live births.

Post neonatal deaths

Post neonatal deaths are those which occur between 28 days and one year of age. The post neonatal mortality rate is the number of post neonatal deaths per 1,000 live births.

Premature birth

A premature birth is a birth that takes place more than three weeks before the baby is due; occurring before the start of the 37th week of pregnancy.

Rickets/Osteomalacia

The softening and weakening of bones in children usually because of extreme, and prolonged vitamin D deficiency.

Stillbirth

Stillbirth is the death of a child born after the 24th week of gestation with no sign of life. The stillbirth rate is defined as the number of stillbirths per 1,000 total births.

Sudden Unexpected death in infancy

'Sudden Infant Death' is the term used to describe the sudden and unexpected death of a baby under 1 year of age that is initially unexplained. Stillbirths are usually measured separately from data on infant mortality but they are included in perinatal death rates.

16.2 Review of evidence

Maternal health: building healthy family relationships (Literature search)

Key area	Conversation	Case study	Findings /evidence	Learning
Early Pregnancy; Vulnerable Groups	Access to maternity services, Antenatal screening, Perinatal mental health, Vaccinations, Breast feeding, Choices, Information, Partners' involvement, Single mothers	This initiative is called: Centering Pregnancy. It is based on a US model, the Centering Pregnancy programme has been used in Canada, Australia and Scandinavia. This pilot ran at King's College Hospital from 2010-2011 (Mashta, 2011)	Pregnant women are in groups of 10-12, with two midwives, and receive traditional antenatal services, in a group setting. Group discussions allow and encourage the women to share knowledge, ideas, concerns and issues about pregnancy and parenting.	Enabled the women to share knowledge and to create friendships and encouraged women to be active partners in their care.
Early Pregnancy; Vulnerable Groups	Access to maternity services, Antenatal screening, Perinatal mental health, Vaccinations, Breast feeding, Choices, Information, Partners' involvement, Single mothers	M(ums)-Power: putting women at the centre of antenatal care. This project was part of the Health Foundation programme: Closing the Gap: changing relationships[81], reporting in 2013 (Health Foundation, 2013)	Three London antenatal clinics (with differing demographics) tested group consultations during the 16-week appointment. The project team also developed a range of online and social media tools for use by women receiving antenatal care. The partners in the project team included health authorities, commercial providers, social media organizations and included local user groups, GPs, midwives, obstetricians and commissioners. Results: the women reported very positive perceptions of the	The women were able to form relationships with each other and to participate more fully in their antenatal care

[81] http://www.health.org.uk/areas-of-work/programmes/closing-the-gap-through-changing-relationships/related-projects/putting-women-at-the-centre-of-antenatal-care/

Key area	Conversation	Case study	Findings /evidence	Learning
			care they received during the 16-week session; Well-designed online information and tools improved women's experience of care by helping them to feel better informed, more prepared for their appointments and more in control of their pregnancy. There were efficiency gains by reducing the average amount of midwife contact time (average time saving of 25 minutes per contact.)	
Early Pregnancy; Vulnerable Groups	Access to maternity services, Antenatal screening, Choices, Information	Overall evaluation of the Closing the gap through changing relationships[82]. (Chih Hoong Sin, 2014) and the Improvement Stories [83](Chih Hoong Sin, Closing the gap through changing relationships: evaluation. Supplement: Improvement Stories, 2014)	Seven interventions were carried out under this programme, covering CAMHS, homeless healthcare, antenatal care, adult mental health, online medical records, haemodialysis, complaints handling. The evaluation summarised the conceptual background of relationship change management, and identified barriers and enablers.	Relationships are generally easier to change on the individual clinician–patient level. Healthcare professionals and service users/patients generally value the concept of changing relationships Within the wider communities of healthcare professionals and service users/patients, the task of changing relationships becomes significantly more challenging. Successful relationship change at one level may not translate into wider changes

[82] http://www.health.org.uk/publications/closing-the-gap-through-changing-relationships-evaluation/
[83] http://www.health.org.uk/public/cms/75/76/313/4877/Closing%20the%20Gap%20through%20Changing%20Relationships%20evaluation%20supplement.pdf?realName=vmIDy4.pdf

Key area	Conversation	Case study	Findings /evidence	Learning
Early Pregnancy; Vulnerable Groups	Access to maternity services, Antenatal screening, Perinatal mental health, Vaccinations, Breast feeding, Choices, Information, Partners' involvement, Single mothers, Communications with other services, Commissioning	Family nurse partnerships, quoted as a case study in a report on how public services can be transformed by the relational state (Muir, 2014)	The report presents support for the development of a relational state, that would create public service systems that are more interconnected, allowing problems to be addressed holistically, forging deeper relationships at the frontline, which allows for more intensive and personalised engagement, and meeting the public's wish for services to provide deeper relationships, rather than shallow transactions.	Survey participants preferred services delivered in community settings that strengthen support networks, and they supported initiatives that allowed families to be included much more in the decision-making process and in care itself
Perinatal mental health	Access to maternity services, Perinatal mental health, Choices, Information, Communications with other services, Commissioning	A community-based perinatal and infant mental health day program for mothers with psychiatric illness, in Queensland Australia (van der Hamm, 2013)	The program was initiated through interagency collaboration between adult mental health, infant mental health and community child health services. Improvements were seen in maternal mental health and in mother-infant relationships	Interagency collaboration delivered improved services
Perinatal mental health	Access to maternity services, Perinatal mental health, Choices, Information, Communications with other services, Commissioning	A literature review of the research related to professionals' perceptions and experiences of working in collaborative and integrated models of perinatal care for women with mental health problems (Myors, 2013)	The overarching theme of the literature review related to 'making it happen'	Eight key elements were identified as central components of this process of 'making it happen': funding and resources for collaboration; shared vision, aims and goals; pathways and guidelines; continuity of care; building relationships and trust; role clarity; training and education of staff and support to work in new ways

Key area	Conversation	Case study	Findings /evidence	Learning
Early pregnancy	Access to maternity services, Choices, Information	A case study of the transformation of a failing maternity unit (Winters, 2007)	The barriers to accepting user involvement and the necessity of changing service providers 'mindset' are discussed	Perseverance and tact from the service users (mothers) enabled the service providers (midwives) to improve perinatal care
Perinatal mental health	Perinatal mental health'; Choice, Information, Communications with other services, Commissioning	SCIE guide and briefing on the implications of integration for people who use services, practitioners, organisations and researchers (Cameron, 2012)	The research briefing looks at UK-based evaluations of jointly-organised services (to older people and people with mental health problems.) Studies identify several models of joint working. It identifies factors that promote and hinder joint working, and the implications for service users	Outcomes defined by people who use services may differ from policy and practice imperatives, and are a crucial aspect of understanding the effectiveness of integrated services. Integrated services work best when they promote user involvement, choice and control. Involving staff, particularly health professionals in the development of initial plans for joint ventures is crucial to future working relationships
Vulnerable groups	Choice, Information, Communications with other services, Commissioning	Reviewed the views of staff on the conditions needed for effective partnership working (within a sexual health service, in Scotland) (Pow, 2013)	Strength of partnership was indirectly associated with working more effectively with service users and this relationship depended on clear communication, trust, established professional roles and shared resources. Effective partnership working depends on a number of interdependent relationships between organizations.	Effective partnership working led to improved service delivery
Early pregnancy, Vulnerable Groups,	Access to maternity services, Antenatal screening, Continuity of care, Teenage pregnancy; poverty, Vaccinations, Perinatal	This paper examines the Family Nurse Partnership as a public health initiative in supporting young women and	Preliminary data from the UK shows a positive influence on smoking cessation, breastfeeding rates and	The partnership between the FNP practitioner and the young person is one of the most reported factors by participants

Key area	Conversation	Case study	Findings /evidence	Learning
	mental health, Breast feeding, Choices, Information, Partners' involvement, Single mothers	improving the outcomes of themselves and their child(ren). It explores evidence of effectiveness, cost benefit and resource implications and discusses the role of the midwife within the context of public health initiatives and specifically to the delivery of the Family Nurse Partnership (Smyth, 2014)	educational attainment and employment status rates. The articles discusses the impact on health visiting and midwifery workforce and suggests a potential for integration of FNP within universal services	about the programme's success
Early pregnancy, Perinatal mental health, Vulnerable groups,	Access to maternity services, Antenatal screening, Teenage pregnancy, Perinatal mental health, Breast feeding, Choices, Information, Partners' involvement, Single mothers	The Preparation for Birth and Beyond programme was co-developed by the Department of Health and the NCT. The programme was designed as a model for antenatal education and information for mothers and their partners[84]	Preparation for Birth and Beyond courses and activities are intended to help and inspire parents to learn, acquire skills and make changes The emphasis should shift from 'teaching' to adult-learning and group methods, in which new mothers and fathers are active participants rather than passive recipients	Two case studies are presented (but not evaluated) on the NCT website [85]
Pre-conception, Early pregnancy, Perinatal mental health, Learning and physical disabilities, Vulnerable groups	Potentially all conversations	Kings Fund report on patient involvement in their own healthcare (Foot, 2014)	The evidence shows that when patients are involved in decisions about their own health and care, decisions are better, health and health outcomes improves and resources are allocated more efficiently. The report discusses reasons for lack of progress	
Early	Potentially all conversations	PHE report: A guide to	Includes collaboration and	Examples of collaborative

[84] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215386/dh_134728.pdf
[85] http://www.nct.org.uk/professional/antenatal-services/nct-preparation-birth-and-beyond-antenatal-education-programme

Key area	Conversation	Case study	Findings /evidence	Learning
pregnancy, Perinatal mental health, Learning and physical disabilities, Vulnerable groups		community-centred approaches for health and wellbeing (South, 2014)[86]	partnerships, which involve communities and local services working together at any stage of the planning cycle, and volunteer and peer roles, where members of the community use their own experience and knowledge	approaches peer support (e.g. Breastfeeding peer support), befriending, participatory budgeting
Early pregnancy, Perinatal mental health, Learning and physical disabilities, Vulnerable groups	Potentially all conversations	Kings Fund report on improving NHS care by engaging staff and devolving decision making (Ham, 2014)[87]	The report found that organisations with higher levels of staff engagement delivered better care: lower mortality rates; better patient experience; lower staff turnover and sickness absence	
Early pregnancy, Perinatal mental health, Learning and physical disabilities, Vulnerable groups	Potentially all conversations	PHE report: Local leadership, new approaches. How new ways of working are helping to improve the health of local communities (Public Health England, 2015)[88]	The report contributes some new insights into improving the health of local communities. It features 7 case studies. Each one describes a particular programme or close partnership between a local authority and local public health or health care teams, often with the additional support of the voluntary sector	Joint programmes often build on existing relationships and a history of working together. People value programmes that are simple and convenient and are able to help with multiple problems Teams from different sectors value the opportunity to work together and the greater impact that they can have on residents' wellbeing as a result

[86] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/402887/A_guide_to_community-centred_approaches_for_health_and_wellbeing.pdf
[87] http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/improving-nhs-care-by-engaging-staff-and-devolving-decision-making-jul14.pdf
[88] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/407060/2014712_Local_leadership.pdf

Key area	Conversation	Case study	Findings /evidence	Learning
Perinatal mental health, Learning and physical disabilities, Vulnerable groups	Smoking in pregnancy, Alcohol and drug abuse, Asylum seekers, Ethnicity, Language barriers, Teenage pregnancy, Domestic abuse, Poverty, Out of area births, Homelessness, Perinatal mental health, Vaccinations, Breastfeeding, Choices, Information, Housing, Partners' involvement, Complex needs	Report by the Early Intervention Foundation on integrated services (Early Intervention Foundation, 2014)[89]	This report, published by the Early Intervention Foundation, provides practical advice for local areas on how they can improve services for families with young children and makes recommendations for national and local policy and practice	Croydon Best Start is a partner
Pre-conception, Early pregnancy, Vulnerable groups	Domestic violence, Partners' involvement	Report by the Early Intervention Foundation on reducing domestic violence (Guy, 2014)[90]	The report assesses the effectiveness of existing services aimed at the prevention of domestic violence and abuse and asks whether broader Early Intervention services can also help address domestic violence and abuse or whether in fact, the existence of domestic violence and abuse undermines their effectiveness	Supports activity to support the quality of couple relationships. For example, in the (USA) Supporting Fathers' Involvement Programme, families with current reported domestic violence and abuse or child protection involvement are excluded from participation, but the programme offers promise as a targeted Early Intervention programme for groups at risk of domestic violence and abuse but where it is not currently happening.
Early Pregnancy; Vulnerable Groups		Report by Early Intervention Foundation: What works to improve the quality of parent-child interactions from conception to age 5 years? a rapid review of interventions (Axford, 2015)[91]	This very recent report (published 27 March 2015) is the first review commissioned by the EIF on UK-based early interventions for children from conception to the start of primary school. It considers the	The interventions illustrating the three themes include: Media-based e.g. Baby Express, Triple P Universal

[89] http://www.eif.org.uk/wp-content/uploads/2014/11/GETTING-IT-RIGHT-FULL-REPORT.pdf
[90] http://www.eif.org.uk/wp-content/uploads/2014/03/Early-Intervention-in-Domestic-Violence-and-Abuse-Full-Report.pdf

[91] http://www.eif.org.uk/wp-content/uploads/2015/03/The-Best-Start-at-Home-report.pdf

Key area	Conversation	Case study	Findings /evidence	Learning
			types of interventions that enhance parent-child interaction with a view to improving three important outcomes: **attachment and parental sensitivity; social and emotional development**; and **language and communication**. The report is illustrated by 32 programmes that illustrate the different types of interventions	Self-administered e.g. Triple P Self Directed Home visiting e.g. Family Nurse Partnership, Minding the Baby, PALS (Playing and Learning Strategies) Individually delivered programmes e.g. Book Start, Reach out and Read, Parents under Pressure Live demonstrations e.g. VIPP (Video feedback Intervention to promote Positive Parenting) Group-based e.g. Family Foundations, Baby Steps, Mellow Babies, Mellow Parenting, EPEC (Empowering Parents, Empowering Communities), Parent Corps
Early Pregnancy; Vulnerable Groups	Access to maternity services, Antenatal screening, Choices, Information	A literature review of immigrant women's perceptions of their maternity care: (Fisher, 2013)	Twelve quantitative and qualitative studies were included in the review, each approach contributing to the understanding of the subject area. Five themes were identified when the articles in the review were analysed.	The principal themes identified were: communication, impediments to accessing healthcare, relationships with healthcare providers, cultural standpoint and social circumstances
Early Pregnancy;	Access to maternity services, Antenatal screening, Choices,	Engagement: an indicator of difference in the perceptions of	The article explored whether pregnant women's perceptions	In women from socioeconomically deprived

Key area	Conversation	Case study	Findings /evidence	Learning
Vulnerable Groups	Information	antenatal care for pregnant women from diverse socioeconomic backgrounds. (Docherty, Engagement: an indicator of difference in the perceptions of antenatal care for pregnant women from diverse socioeconomic backgrounds, 2012)	of antenatal provision differed in relation to their socioeconomic deprivation ranking	areas, access may be a less useful indicator than engagement when assessing antenatal service quality. A more equitable antenatal service may need to be developed through the early identification of those women at risk of non-engagement
Early pregnancy, Vulnerable groups	Access to maternity services, Late booking, Antenatal screening, Smoking, Drug and alcohol misuse, Poverty, Out of area births, Breastfeeding, Vaccinations, Choices, Information, Criminal justice system, Asylum seekers, Ethnicity, Partners' involvement	Report on the NSPCC programme: *Baby Steps* (S Hogg, 2015)[92]	Baby Steps is a nine-session group programme for mums-and dads-to-be. It begins with a home visit, and then parents attend six weekly group sessions before the baby is born, followed by three more after the birth. Baby Steps focuses on building positive relationships between parents and their baby, as well as between the parents themselves. The programme is jointly delivered by a health practitioner (a midwife or health visitor) and a children's services practitioner (family support worker or social worker). Facilitators develop mutually respectful, valued relationships with parents, which enable them to benefit fully from the	The findings suggest that parents will be better equipped to provide sensitive, responsive care to their babies, which may ultimately result in these children having better long term outcomes. The programme is designed to be interactive and engaging for families who might traditionally be thought of as 'hard to reach'. Separate evaluations support the Baby Steps programmes for parents in prison and for minority ethnic groups

[92] http://www.nspcc.org.uk/preventing-abuse/research-and-resources/baby-steps-evidence-relationships-based-perinatal-education-programme

Key area	Conversation	Case study	Findings /evidence	Learning
			programme and to model the secure relationships they can create with their child.	
Early pregnancy, Perinatal mental health, Vulnerable groups, Learning and physical disabilities	Access to maternity services, Antenatal screening, Teenage pregnancy, Domestic abuse, Poverty, Perinatal mental health, Breast feeding, Choices, Information, Partners' involvement, Single mothers	Report All Party Parliamentary Group for Conception to Age Two : Building Great Britons (All Party Parliamentary Group for Conception to Age 2- first 1001 days, 2015)[93]	Report on the first 1001 days into perinatal mental health and child maltreatment, which investigated the various factors that affect the emotional and social development of children from conception to age 2.	The 1001 days strategy requests that local authorities, CCGs and Health & Wellbeing Boards to prioritise all factors leading to the development of socially and emotionally capable children at age 2, by: adopting and implementing a '1001-days' strategy, and showing how they intend to implement it, within 5 years, in collaboration with their partner agencies. Recommends that Children's centres should become a central source of support for families in the early years with access to multi-agency teams and multiple on-site services including health visiting, GP services, housing, finance, parenting classes, birth registration, library and other community services
Early pregnancy, Vulnerable groups	Access to maternity services, Antenatal screening, Teenage pregnancy, Domestic abuse, Asylum seekers, Perinatal mental health, Breast feeding, Choices,	An Evidence-Based, Pre-Birth Assessment Pathway for Vulnerable Pregnant Women (Barlow, 2015)	This briefing paper describes a new care pathway established within a UK-based social care team, which aims to provide early identification, intensive	A case study is presented to illustrate this care pathway. A mother is referred at eighteen weeks of pregnancy and supported post birth for six

[93] http://www.1001criticaldays.co.uk/~criticaldays/UserFiles/files/Building%20Great%20Britons%20Report%20%20APPG%20Conception%20to%20Age%202%20Wednesday%2025th%20February%202015%282%29.pdf

Key area	Conversation	Case study	Findings /evidence	Learning
	Information, Criminal justice system, Partners' involvement, Single mothers		support, timely assessment and decision making for a group of highly vulnerable, pregnant women, their partners and their infants	months. The combination of supporting structured professional judgement by the inclusion of standardised tools and training in a programme specifically developed for high-risk families
Vulnerable groups	Breastfeeding, Poverty, Choices, Information	Being baby friendly: evidence-based breastfeeding support (Cleminson, 2013)	This review summarises the evidence for effective and cost-effective strategies to help women, particularly those in low income groups, make informed choices, overcome barriers and establish and maintain breastfeeding	Adoption of, and particularly high rates of compliance with, Unicef BFI standards is associated with increases in the initiation and continuation of breast feeding.
Vulnerable groups	Access to maternity services, Antenatal screening, Smoking in pregnancy, Teenage pregnancy, Poverty, Breastfeeding, Vaccinations, Choices, Information, Housing, Partners' involvement	Evidence base for *Family Nurse Partnership* (NHS Family NUrse Partnership, 2015)[94]	Family Nurse Partnership is a preventive programme for vulnerable first time young mothers. It offers intensive and structured home visiting, delivered by specially trained nurses, from early pregnancy until the child is two	The developing evidence from the English programme indicates that mothers are successfully supported to: reduce smoking in pregnancy; initiate breast-feeding at a higher rate; cope better with pregnancy, labour and parenthood; increase confidence and aspirations for future; return to education and take up paid employment; increase levels of warm parenting and confidence in their parenting ability In addition, FNP children appear to be developing in line

[94] http://www.fnp.nhs.uk/sites/default/files/files/FNP%20Evidence%20Summary%20Leaflet%20Dec14.pdf

Key area	Conversation	Case study	Findings /evidence	Learning
				with the general population, which is again promising as expectations for this group are usually far lower
Vulnerable groups	Breastfeeding	Progress in breastfeeding in London 2013 report (Public Health England, 2013) [95]	This report provides new analysis of breastfeeding data, examination of local evidence, and examples of local breastfeeding practice in London. The document sheds light on the relationship between socio-demographic factors and breastfeeding prevalence in London and provides practical examples of local initiatives to improve breastfeeding rates at a local level	The local practice reported includes: Children's centre for support groups, peer support (1 2 1, telephone, remote), Baby Cafes, Breastfeeding Welcome, Community faith groups, Be a Star campaign; Smartphone apps, Young parents project
Early pregnancy, Perinatal mental health	Access to maternity services, Antenatal screening, Teenage pregnancy, Perinatal mental health, Breast feeding, Choices, Information, Partners' involvement, Single mothers	*Minding the baby*: NSPCC programme[96]	The programme was developed in the USA and is being trialled in 3 areas: Glasgow, Sheffield and York. It is an early intervention programme designed to improve the mother's relationship with her baby, from Month 7 of pregnancy to Year 2	The programme is being evaluated with the final report expected in 2018 [97]
Perinatal mental health, Vulnerable	Access to maternity services, Antenatal screening, Teenage pregnancy, Perinatal mental	All babies count: spotlight on perinatal mental health. (Hogg, 2012)[98]	This report looks at the mental illnesses affect more than 1 in 10 women during pregnancy	Recommends best practice such as the Oxford Parent infant Project, Kent Specialist

[95] http://www.lho.org.uk/Download/Public/18210/1/Progress%20in%20breastfeeding%20in%20London%20final%20report%2012%20Aug.pdf
[96] http://www.nspcc.org.uk/fighting-for-childhood/our-services/services-for-children-and-families/minding-the-baby/?_t_id=1B2M2Y8AsgTpgAmY7PhCfg%3d%3d&_t_q=prevention+in+mind&_t_tags=language%3aen%2csiteid%3a7f1b9313-bf5e-4415-abf6-aaf87298c667&_t_ip=86.137.222.175&_t_hit.id=Nspcc_Web_Models_Pages_TopicPage/_99dac094-ebc2-4c53-97c9-0a22cd3fd81e_en-GB&_t_hit.pos=2
[97] http://www.annafreud.org/training-research/research/understanding-mental-health-and-resilience/minding-the-baby/
[98] http://www.nspcc.org.uk/globalassets/documents/research-reports/all-babies-count-spotlight-perinatal-mental-health.pdf

Key area	Conversation	Case study	Findings /evidence	Learning
groups	health		and the first year after childbirth; it discusses their nature, prevalence, and effects on families; the care that women and their families need, and the gaps in services that currently exist in England	mental health Midwife; multidisciplinary Mother and Baby Mental Health Services in Hampshire, NSPCC partnerships with mental health services
Pre-conception, Early pregnancy, Perinatal mental health, Vulnerable groups, Learning and physical disabilities	Access to maternity services, Antenatal screening, Teenage pregnancy, Perinatal mental health, Choices, Information, Commissioning, Communication with other services	CMO Report for 2012: Our children deserve better (Chief Medical Officer, 2013)[99]	Focuses on the health and wellbeing of children and young people	Includes case studies such as participatory groups for bereaved mothers from vulnerable groups, reducing rates of unscheduled paediatric care use, interorganisational support to Warm homes healthy people initiatives, promoting resilience from antenatal through to middle childhood, Perinatal support project (for volunteer befrienders)
Pre-conception, Early pregnancy, Perinatal mental health, Vulnerable groups	Access to maternity services, Antenatal screening, Poverty, Perinatal mental health, Choices, Information, Partners' involvement	Mellow Parenting[100]	Attachment-based early intervention programmes with proven results, equipping practitioners with the necessary tools to help vulnerable families	Mellow Parenting programmes break negative cycles and build good relationships. They've been shown to improve: • parent-child interaction • child behaviour problems • parents' wellbeing • parents' effectiveness • child development • self-esteem and confidence • children's language development
Early	Commissioning	Healthy relationships: use and	This article explores the	States that CBPAs are

[99] https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays
[100] http://www.pipuk.org.uk/Portals/1/MellowParentingBrochureA4Fin%20Copy.pdf

Key area	Conversation	Case study	Findings /evidence	Learning
pregnancy		influence of community-based participatory approaches (CBPAs) (Waithe, 2009)	understanding and application of community based participatory action	relational; meaning-making occurs when we engage with others. Community-based participatory approaches require ongoing involvement in creating safe spaces so that all stakeholders can use their voices without fear of being silenced
Early pregnancy, Vulnerable groups	Choices, Information	Socially disadvantaged women's views of barriers to feeling safe to engage in decision-making in maternity care (Ebert, 2014)	This Australian research found that socially disadvantaged women want to engage in their care. However without adequate information and facilitation of choice by midwives, they believe they are outsiders to the maternity care culture and decision-making processes.	These findings suggest that midwives need to better communicate a valuing of the woman's participation in decision-making processes and to work with women so they do have a sense of belonging within the maternity care environment
Early pregnancy	Choices, Information, Communicating with other services	Mother knows best: developing a consumer led, evidence informed, research agenda for maternity care (Cheyne, 2012)	The article explored whether working with service users to generate possible future research questions may facilitate more women centred research	This project demonstrates that women are well able to articulate researchable questions when given the opportunity and support to do so
Early pregnancy	Choices, Information, Communicating with other services, Commissioning	Talkback: a strategic approach to working with maternity service users (Garrod, 2012)	This paper describes the implementation of a strategic approach to service user involvement in Stockport, demonstrating a strong culture of collaborative working, between service users, providers, and commissioners	It describes the establishment of a Service User Forum and the subsequent launch of the Maternity Services Liaison Committee, with service users forming approximately 75 per cent of the membership
Early pregnancy, Vulnerable groups	Antenatal screening, Vulnerable groups, Choices, Information, Communicating with other services, Commissioning	Engagement: an indicator of difference in the perceptions of antenatal care for pregnant women from diverse	To determine whether pregnant women’s perceptions of antenatal provision differed in relation to their socioeconomic	In women from socioeconomically deprived areas, access may be a less useful indicator than

Key area	Conversation	Case study	Findings /evidence	Learning
		socioeconomic backgrounds (Docherty, 2012)	deprivation ranking	engagement when assessing antenatal service quality. As engagement levels may be one method by which to predict and improve health outcomes, a more equitable antenatal service may need to be developed through the early identification of those women at risk of non-engagement
Early pregnancy, Vulnerable groups	Domestic abuse, Vulnerable groups, Communicating with other services, Commissioning	Facilitators and barriers to implementation of an evidence-based parenting intervention to prevent child maltreatment: The Triple P-Positive Parenting Program (Shapiro, 2012)	the Triple P-Positive Parenting Program (Triple P) is an evidence-based parenting intervention that is designed specifically as a public health approach to supporting parenting that is designed for use by a wide variety of providers from multiple disciplines. Triple P is a multilevel intervention designed to improve parenting confidence and competence. This article examines factors related to implementation of EBPs	These findings underscore the importance of taking a systems–contextual approach to training, implementation, and dissemination of evidence-based parenting interventions on a broad scale. Significant attention to program fit with current methods of service delivery and provider caseloads is important to address prior to training
Learning and physical disabilities, Vulnerable groups	Choices, Information, communicating with other services, Commissioning	Modifying the 'Positive Parenting Program' for parents with intellectual disabilities (Glazemakers, 2013)	This study explored whether the parenting training programme, known as 'Group Triple P' (Positive Parenting Program), could be successfully modified for parents with intellectual disabilities	The study found that research-informed adaptation of mainstream behavioural family interventions, such as Group Triple P, could make 'suitable support' more readily available, and more engaging for parents with ID
Early pregnancy, Vulnerable	Choices, Information, communicating with other services, Commissioning	Independent evaluation of the Triple P Positive Parenting Program in family support service	This Canadian study was to determine whether implementation of levels 2 and	The findings suggest that implementation of levels 2 and 3 of Triple P does not markedly

Key area	Conversation	Case study	Findings /evidence	Learning
groups		settings (McConnell, 2012)	3 of the Triple P system, designed for primary care settings, enhances parent, child, and family outcomes compared with services-as-usual	enhance parent, child and family outcomes compared with services-as-usual. However the authors acknowledge that the dissemination of Triple P may have other benefits as Triple P (levels 2 and 3) may add value to family support services in other ways
Early pregnancy, Vulnerable groups	Domestic violence, Choices, Information, Communicating with other services	Strengthening Positive Parenting Through Intervention, Evaluating the Moms' Empowerment Program for Women Experiencing Intimate Partner Violence (Howell, 2015)	This study examined the effectiveness of an evidence-based intervention in changing the positive and negative parenting practices of 120 mothers who experienced recent intimate partner violence	These findings suggest that even short-term interventions can improve positive parenting skills and parenting knowledge for women who have experienced partner abuse
Vulnerable groups	Access to maternity services, Antenatal screening, Smoking in pregnancy, Teenage pregnancy, Poverty, Breastfeeding, Vaccinations, Choices, Information, Housing, Partners' involvement	The effectiveness and cost-effectiveness of the Family Nurse Partnership home visiting programme for first time teenage mothers in England: a protocol for the Building Blocks randomised controlled trial (Owen-Jones, 2013)	This multi-centre individually randomised controlled trial will recruit 1600 participants from 18 Primary Care Trusts in England, United Kingdom. The trial will evaluate the effectiveness of Family Nurse Partnership programme and usual care versus usual care for nulliparous pregnant women aged 19 or under	*Completed study plans to report in Spring 2015*[101]
Early pregnancy, Vulnerable groups	Choices, Information, Communicating with other services, Commissioning	User engagement in the delivery and design of maternity services (Patel, 2013)	User engagement is defined as a mutual exchange of information between the patient and the health professional, which has shown to improve patient experience as well as	Through in-depth examinations of these barriers we are able to draw conclusions as to why current policies have failed and recommend potential solutions

[101] http://www.buildingblockstrial.info/bbnews/details/19

Key area	Conversation	Case study	Findings /evidence	Learning
			outcomes. Engaging the patient is vital for the healthcare system to remain sustainable. The National Health Service has attempted to incorporate and enhance patient engagement in the delivery of maternity services for the last decade. The financial crisis, changing socio-demographic status, increase in birth rate and public expectations-engaging the patient to take responsibility of their own health has not been achieved	
Pre-conception, Early pregnancy, Vulnerable groups	Antenatal screening, Teenage pregnancy, Domestic abuse, Poverty, Choices, Information, Partners' involvement	Wave Trust report: Conception to age 2 – the age of opportunity (Wave Trust, 2013)	Explored and considered how best to promote effective implementation of the principles set out in *Supporting Families,* with specific emphasis on children under the age of 2 and their parents, and families	Provides examples of practices within Sure Start Centres, joint working between professionals in adults' services including social care, the NHS, housing and Jobcentre Plus, Healthy Child Programme; Neonatal Behaviour Assessment, or the Neonatal Behavioural Observation; Healthy Child Programme, Big Lottery project: fulfilling lives: a better start
Pre-conception, Early pregnancy, Vulnerable groups	Antenatal screening, Teenage pregnancy, Domestic abuse, Poverty, Choices, Information, Partners' involvement	Website: Foundation Years 102	**Information and support for those working in the early years and childcare delivering services for children and families**	Includes resources for early learning, fathers' involvement; effective professional-parent relationship

[102] http://www.foundationyears.org.uk/working-with-parents/

Key area	Conversation	Case study	Findings /evidence	Learning
Pre-conception, Early pregnancy, Vulnerable groups	Antenatal screening, Choices, Information, Partners' involvement, Commissioning	CANparent Trial Evaluation: Final Report (Lindsay, 2014)	CANparent trial was a government initiative to examine the development of a *universal* offer of parenting classes potentially to all parents of children aged 0-5 years. The aim of the trial was to evaluate whether the free provision of parenting classes would provide sufficient incentive to providers to start offering additional parenting classes nationally, including for parents beyond the foundation stage and whether a universal approach could normalise and de-stigmatise parenting classes. NCT was one of the providers to this study[103]	In summary, the trial: was successful in stimulating a supply of providers of parenting classes financed by fixed price vouchers; and some demand from parents who were offered classes that were free. demonstrated that more time is necessary to increase the awareness of all parents of the benefits of quality universal parenting classes created the incentive for some providers to start offering online versions of their classes accessible to any parent reduced stigma around parenting classes.
Pre-conception, Early pregnancy, Vulnerable groups	Communicating with other services, commissioning	Factors that promote and hinder joint and integrated working between health and social care services: a review of research literature (Cameron, Factors, 2014)	This article reports the results of a review of the research evidence related to joint working in the field of adult health and social care services in the UK. It explores whether recent reforms to joint working have met the objectives set by policy-makers.	The review suggests that there is some indication that recent developments, in particular the drive to greater integration of services, may have positive benefits for organisations as well as for users and carers of services. However, the evidence consistently reports a lack of understanding about the aims and objectives of integration, suggesting that more work needs to be done if

[103] http://www.nct.org.uk/sites/default/files/related_documents/Neil%20Working%20with%20parents_NCT%20practitioner%20skills%20p7.pdf

Key area	Conversation	Case study	Findings /evidence	Learning
				the full potential of the renewed policy agenda on integration is to be realised
Pre-conception, Early pregnancy, Vulnerable groups	Communicating with other services, Commissioning	Time for some home truths: exploring the relationship between GPs and social workers (Mangan, 2014)	The purpose of this article is to explore the relationship between general practitioners (GPs) and social care professionals (with reference to adult care	The paper highlights the poor quality of the relationship between GPs and social workers. Findings that illustrate this include GPs' poor knowledge of social care services; a perception that social care services were of poor quality and rating the quality of their relationships with social workers as poor.
Pre-conception, Early pregnancy, Vulnerable groups	Poverty, Homelessness, Communicating with other services, Commissioning	Micro-enterprise: community assets helping to deliver health and well-being and tackle health inequalities (Lockwood, 2013)	This paper seeks to explore the potential of micro-enterprises to assist local health and well-being boards in delivering their strategies, especially in relation to tackling health inequalities, prevention and community support. It draws on experience gained by Community Catalysts from its work supporting social care and health micro-enterprise across the UK	The paper explains the importance of social care and health micro-enterprise to the work of health and wellbeing boards, emphasising its potential to help tackle health inequalities and contribute to effective health and well-being strategies. It draws on case studies from Community Catalysts
Vulnerable Groups		Effective relationships with vulnerable parents to improve outcomes for children and young people: final study report (Crowther, 2011)	This report focussed on how professionals develop effective relationships with vulnerable parents and how this makes a difference for children and young people. The focus of the research was to develop a skills framework that would define the key aspects of effective professional	Key elements of the skills needed to develop effective relationships included: maintaining a child-focussed approach; achieving a balance between challenging and supporting; building trust and mutual respect; empowering and enabling families; facilitating parents'

Key area	Conversation	Case study	Findings /evidence	Learning
			relationships and the competencies required to achieve them	understanding
Early Pregnancy; Vulnerable groups	Partners' involvement ; teenage pregnancy	Helping teen dads obtain and sustain paternal success. (Kirven, 2014)	The article gives an overview of the issues and problems of teenage fatherhood and summarises different interventions and approaches that have shown success	Successful interventions include: - Specially trained 'father-facilitators' in childbirth education - individualised case management focusing on mediation and building relationships with child's mother and family - Peer support group education -Providing linkage and referrals to medical, social services and home visits -Identifying community assets to foster employability and academic achievement
Early pregnancy, Perinatal mental health	Partners' involvement	Longitudinal associations among fathers' perception of co-parenting, partner relationship quality, and paternal stress during early childhood. (Fagan, 2014)	This study examined the associations among fathers' perceptions of partner relationship quality (happiness, conflict), co-parenting (shared decision making, conflict), and paternal stress	Programmes which teach and support healthy co-parenting and partner relationships have the potential to enhance father–child relationships and ultimately children's developmental outcomes
Pre-conception, Early Pregnancy, Perinatal mental health	Access to maternity services, Teenage pregnancy, Breastfeeding, Choice, Information, Commissioning	Parenting support for families with young children - a public health, user-focused study undertaken in a semi-rural area of Scotland. (Hogg R. , 2013)	This study identified and designed a range of public health interventions to provide support to parents of young children (i.e. families who were not identified as vulnerable and therefore were not eligible for pro-active health visiting interventions on an individual family basis beyond the early	The study findings suggest that while the health visiting service is a valuable source of support for parents, development of services for family's needs to incorporate increased peer support, multiagency working and a recognition and exploitation of innovative approaches involving the use of

Key area	Conversation	Case study	Findings /evidence	Learning
			days). Public health approaches are recommended for the majority of families who are not eligible for one-to-one professional support. *(NB this study is based in Scotland, where Sure Start is not part of the public health offer)*	new digital technologies
Pre-conception, Early Pregnancy,	Access to maternity services, Partners' involvement, Choice, Information	Supporting a caring fatherhood in cyberspace - an analysis of communication about caring within an online forum for fathers (Eriksson, 2013)	Describes communication about caring activities for infants among men who visited an Internet-based forum for fathers and elaborates on the dimensions of support available in the forum	Support offered in this kind of forum can be considered as a complement to formal support. Professionals can use it to provide choices for fathers who are developing themselves as caregivers without downplaying the parental support offered by formal health care regimes
Early pregnancy, Vulnerable groups	Access to maternity services, Partners' involvement, Choice, Information, Teenage pregnancy, Commissioning	What works to engage young parents into services? Findings from an appreciative inquiry workshop (Taylor, 2012)	This Australian study was developed to identify strategies that will improve engagement in service programs for young parents, after experience of low engagement and high attrition in this population group	Factors that influenced engagement in programmes were identified: staff characteristics, programme content, particular issues experienced by young parents such as reliance on public transport, lack of money and unemployment. Importantly, fathers were considered a neglected group when offering community services programmes
Early pregnancy, Vulnerable groups	Partners' involvement, Domestic abuse	Systematic review of fathers' involvement in programmes for the primary prevention of child maltreatment (Smith, 2012)	The review explored how many primary prevention programmes for child maltreatment included fathers and what evidence there was for the reduction of paternal risk factors	The review found that few empirically studied prevention programmes for child maltreatment included fathers

Key area	Conversation	Case study	Findings /evidence	Learning
Early pregnancy, Vulnerable groups	Partners' involvement; Criminal justice system	Developing an effective intervention for incarcerated teen fathers: the Baby Elmo Program (Brito, 2012)	This USA-based study reports on the Baby Elmo Program, a parenting and structured visitation programme, which aims to form and maintain bonds between children and their incarcerated teen fathers.	This intervention is based on building a relationship between the teen and his child, rather than on increasing the teen's abstract parenting knowledge. An evaluation of the program indicated improvements in quality of interactions and communication
Early pregnancy, Vulnerable groups, Learning and physical disabilities		Promoting social support for vulnerable parents (McKenzie, 2010)	The paper describes a group which is open to all young parents, including those with learning disabilities	Feedback from participants in this small Scottish study suggests that the most important factor for parents with learning disabilities is the legitimisation of their parenting roles. The structure of antenatal and postnatal groups should take account of the learning needs of individual parents and include more concrete examples and activities and have less reliance on written materials
Early pregnancy, Vulnerable groups, Learning and physical disabilities		Antenatal support for people with learning disabilities (Harrison, 2015)	This paper examined the provision of services for people with learning disabilities, and identify areas for improvement including educational needs for midwives	Training workshops delivered to midwives in local hospitals in Nottinghamshire resulted in an increase in referrals for parents with a learning disability to the learning disability services by midwives and midwives were more aware of supporting the additional needs of parents with a learning disability, including the referral process for the learning disability teams. Information was also provided to parents with a learning disability using improved

Key area	Conversation	Case study	Findings /evidence	Learning
				methods of communication, thus preparing them throughout the pregnancy and birth.
Early pregnancy		Improving Communication and Coordination of Complex Perinatal Patients (Gordon, 2015)	This paper discussed the findings from the adoption of Perinatal Patient Care Conferences, a US based hospital initiative for women with medical or obstetric complications	The conferences improved communication and patient satisfaction and decreased women's and caregivers' anxiety and supported a culture of trust and safety across the continuum of care.
Perinatal Mental Health		The Tameside and Glossop Early Attachment Service: Meeting the emotional needs of parents and their babies (Lee, P. & Mee, C. , 2015)	This paper describes the strategic and theoretical underpinnings of a comprehensive and cost-effective parent infant mental health service	The model improved partnership working between parents, the voluntary sector, midwifery, health visiting and other relevant agencies. Results from service evaluations showed improved outcomes across a number of mental health indicators on the relationship between parents and their (Lee, 2015) infants.

Sources:

Databases: CINAHL (Cumulative Index of Nursing and Allied Healthcare), MEDLINE, HMIC (Hospital Management Information Collaboration), Social Care Online, ASSIA (Applied Social Sciences Index and Abstracts)

Keywords: service provision, service providers, maternity services, perinatal care, interagency relationships, functional relationships, collaboration, patient empowerment, patient participation, healthy relationships, fathers, expectant fathers, parenting

Agencies: APHO, NICE (local practice collection), PHE, Kings Fund, SCIE, Health Foundation; National Child and Maternal Health Intelligence Network; Children and Young People's Health Outcome Forum; Royal College of Paediatrics and Child Health; Health Economics Research Group (Brunel University),; Early Intervention Foundation; Citizens UK; ICASE (Integrated Care and Support Exchange) ; Chief Medical Officer annual reports; NCB; Relationships Foundation; PIP UK(Parent Infant Partnership); NSPCC; Children and Young People's Mental Health and Well-Being Taskforce (*consultation closed; not yet reported*); WAVE Trust; Foundation Years

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16.3 NICE guidelines

ADDENDUM: NICE GUIDELINES RELATING TO MATERNAL HEALTH				
Guidance;[104] Year	**Title**	**Recommendations**	**Local practice**	**Learning**
PATIENT EXPERIENCE				
CG138; 2012	Patient experience in adult NHS services: improving the experience of care for people using adult NHS services	The recommendations in this guidance capture the essence of a good patient experience. Their implementation will help to ensure that healthcare services are acceptable and appropriate, and that all people using the NHS have the best possible experience of care	Embedding Shared Decision Making (SDM) in 32 national clinical teams[105]	Scope clearly the groups you will be working with, have executive or senior manager clear approval and communication to teams about their expected participation/ role in the work. Spend time communicating your key aims with those groups of staff you feel may be blockers to what you want to do, they can end up being your most vocal advocates and blockage removers if they are on side. Ensure clear project lead management and clear role allocation.
QS15; 2012	Quality standard for patient experience in adult NHS services	The quality standard covers improving the quality of the patient experience for people who use adult NHS services. It does not cover people using NHS services for mental health or the experiences of carers of people using NHS services	Applying CG138 NICE patient experience in adult NHS services and QS15 NICE quality standard for patient experience in adult NHS services to complaints & the complaint process	Persistence was required to overcome staff resistance; acknowledgement and support for staff emotional response was essential

[104] CG (Clinical Guideline); NG (NICE Guideline); PH (Public Health Guideline); QS (Quality Standard); LGB (Local Government Briefing)
[105] http://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_646

			(Dorset County Hospital NHS Foundation Trust) [106] Our pledge - empowering staff to deliver a high quality patient experience (Medway Community Healthcare CIC)[107]	Build on existing organisational values and look for opportunities to embed these by making the links clear and consistent for staff. Use clear guidelines and develop a how-to-guide for development. Ensure teams and especially senior managers are engaged with the idea.
PH9; 2008	Community engagement	This guidance aims to support those working with and involving communities in decisions on health improvement that affect them. It is for people working in the NHS and other sectors who have a direct or indirect role in - and responsibility for - community engagement.		
LGB14; 2014	Improving access to health and social care services for people who do not routinely use them [108]	This briefing summarises NICE's recommendations for local authorities and partner organisations on improving access to health and social care services for vulnerable people who do not routinely use them, promoting equitable access for all.		Key messages: Deliverables include: Meet public health responsibilities through local leadership; deliver inclusive services with a positive impact on people and communities; deliver early intervention; protect the public's health; prevent ill health and premature mortality
LGB16; 2014	Community engagement to improve health[109]	This briefing summarises NICE's recommendations for local authorities and		Key messages include: Local authorities have a

[106] http://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_772
[107] http://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_635
[108] https://www.nice.org.uk/advice/lgb14

[109] https://www.nice.org.uk/advice/lgb16

		partner organisations on how community engagement approaches can be used to improve the planning and delivery of all services, including those that impact on health		responsibility to promote and protect health, tackle the causes of ill-health and address health inequalities – engaging effectively with the local community can help achieve this.
PERINATAL CARE				
CG62; 2008 (partially updated by PH56 and CG192)	Antenatal care	This guidance covers the routine care that all healthy women can expect to receive during their pregnancy	Plymouth Great Expectations Antenatal education programme [110]	Partner organisations were involved throughout the development and implementation of this programme. This has fostered ownership of the content and added value through the multidisciplinary team contribution.
QS22; 2012	Quality standard for antenatal care	It provides a specific, concise quality statement and measures to provide the public, health and social care professionals, commissioners and service providers with definitions of high-quality care. This quality standard covers the antenatal care of all pregnant women up to 42 weeks of pregnancy, in all settings that provide routine antenatal care, including primary, community and hospital-based care		
CG37	Postnatal care	This clinical guideline offers evidence-based advice on the care of women and their babies in the first 6–8 weeks after birth.	Implementing and evaluating training for health visiting teams as part of the UNICEF UK Baby Friendly	The BFI accreditation is a change management process and has its own momentum. It requires

[110] http://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_740

			Initiative Community award (Bristol)[111] Targeted Paid Breastfeeding Peer Support Service (Bristol)[112]	work practice and culture to alter. The training was a central part of this change process. The bid originally included 3 postnatal visits but this was too expensive so it was re-commissioned based on two fixed points of contact with mothers; an antenatal contact and a postnatal contact at 48 hours after arrival home/after homebirth. - It took time to get the service off the ground but it was well liked once it was established. Only half of available mothers accessed the service; hard to reach mothers were especially difficult to access.
QS37; 2013	Postnatal care	This quality standard covers postnatal care, which includes the core care and support that every woman, their baby and if appropriate, their partner, and family should receive during the postnatal period. This includes recognising women and babies with additional care needs and referring them to specialist services.	Wigan breastfeeding peer support network[113]	The close partnership working and working relationship with midwifery and health visiting services enables the early contact with families. - The service was commissioned following a competitive tendering

[111] https://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_695
[112] https://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_694
[113] https://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_689

				process and is closely performance managed. - The integration of the peer support service within midwifery, health visiting and children centre services is enabled by having the full support and cooperation of senior management within those services and an implementation team who enable the partnership working and the removal of barriers to service delivery. - Clear referral pathways are very important. This ensures that all services may refer to each other seamlessly and appropriately. - The peer support service has an honorary contract with the acute provider service. This helps to ease the hurdles of data sharing and having access to IT provision.
			Blackpool breastfeeding network [114]	Women's views of the service, have led the development of the work. - a Peer Support (PS) scheme that enables

[114] https://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_687

				women to take their own decisions and which values any breastfeeding a woman undertakes is likely to help change cultural attitudes. - Detailed reporting has highlighted areas in need of development. An innovative weekly gift giving scheme was developed tied into face to face contact with a PS - The inclusion of the PS service in all aspects of the work to implement Baby Friendly standards, including recruitment of businesses to a local 'Welcome Breastfeeding Scheme', has helped integration of the service. - Volunteers need to be provided with adequate support. Dedicated PS volunteer coordinators can fulfil this - Effective training of PSs is essential. - Monthly supervision of PSs is an essential aspect of peer support schemes which maintains quality of the service
			Improved access to breastfeeding peer support	Advice includes early engagement with key stakeholders and being

			(NHS Plymouth)	prepared to compromise to meet the needs of all partners. Monitoring and evaluation, such as data collection and audit, should be in place, including arrangements and regulations around data sharing. Voluntary services need to have attention given to detail, with contingency plans/processes in place for all outcomes. Volunteers need support, personal development and to be valued like all practitioners. Develop a steering group who can monitor and influence service design. Be clear about your reporting mechanisms and lines of accountability for everyone involved in the project delivery. A clear terms of reference enables all stakeholders to specify their level of commitment
CG190; 2014	Intrapartum care: care of healthy women and their babies during childbirth	The guideline offers evidence-based advice on the care of women and their babies during labour and immediately after the birth. It covers healthy women with uncomplicated pregnancies entering labour at low risk of	Intelligent auscultation- 'listen' for fetal wellbeing (Royal Berkshire NHS Foundation Trust) [115]	Midwives have welcomed this guidance on IA. The professionally-produced pocket guides and posters were very successful and

[115] http://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_812

		developing intrapartum complications		evaluated positively by those who purchased them. Emphasises proper project methodology
			Birmingham's dedicated homebirth service (Birmingham Women's Hospital NHS Foundation Trust) [116]	
			24 Hour Labour Line (Hampshire Hospitals NHS Foundation Trust (HHFT) and South Central Ambulance Service (SCAS))[117]	Having a midwife based in the ambulance service has improved safety, the avoidance of unattended births and the inappropriate call-out of ambulances
			Providing a choice of a midwifery led unit (Birth centre) for women with low risk pregnancies. (Ashford & St Peters NHS Foundation Trust)[118]	Guidelines that are robust and underpinned by midwifery supervision ensure safe care for women and empower midwives to provide this. Ongoing audit of all notes within a new service provides a mechanism for risk management issues.
			My Birthplace®: A computerised place of birth	This project was the first of its kind to integrate

[116] http://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_813
[117] http://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_802
[118] http://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_806

			decision support tool for women and midwives (Portsmouth Hospitals NHS Trust)[119]	research findings into a tool for women and midwives to use together to discuss birthplace choices. Providing women with standardised non-subjective information about place of birth appears to influence their preference and is acceptable to them. Incorporating SDM (Shared decision making) into practice ensures women are active partners in decision making.
LGB22; 2014	Health visiting [120]	Health visiting teams lead and deliver the Department of Health's Healthy Child Programme (an early intervention and prevention public health programme) for all children aged 0–5. From October 2015, local authorities will build on current co-commissioning arrangements and take over full responsibility from NHS England for commissioning public health services for children up to the age of 5		Key messages include: NICE has produced guidance of direct relevance to each service level of the Healthy Child Programme
SPECIALIST PERINATAL CARE				
CG132; 2011	Caesarean section	The guidance offers evidence-based advice on the care of women who have had a caesarean section in the past and are now pregnant again, have a clinical indication for a caesarean section or are considering a	Using organisational change to enhance the experience of women giving birth by focusing on normalising births (Blackpool Teaching	The hospital set up VBAC clinics for all women who have had one or two Caesarean sections to support women in their

[119] http://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_803
[120] https://www.nice.org.uk/advice/lgb22

		caesarean section when there is no other indication	Hospitals NHS Foundation Trust)[121]	decision making and explain that previous Caesarean does not mean another Caesarean. A relaxed and information and learning sharing culture was developed at Incident Review meetings
QS32; 2013	Quality standard for caesarean section	Sets out the quality standards for a person-centred approach to provision of services which is fundamental to the delivery of high-quality care to women who may need, request or have a caesarean section	Explanatory letter to women who have had Caesarean Section (York)[122]	The letter was one of a package of initiatives put together to help reduce the CS rate
CG107; 2010	Hypertension in pregnancy. The management of hypertensive disorders in pregnancy	This clinical guideline offers evidence-based advice on the care and treatment of women who have or are at risk of developing hypertension (high blood pressure) in pregnancy. It contains advice on the diagnosis and management of hypertension during pregnancy, birth and the postnatal period. It also includes advice for women with chronic hypertension who wish to conceive and for women who have had a pregnancy complicated by hypertension		
QS35; 2013	Hypertension in pregnancy	This quality standard covers pre-pregnancy advice for women with pre-existing hypertension, as well as the antenatal, intrapartum and postnatal care of women at risk of or with hypertensive disorders of pregnancy.		
QS46; 2013	Multiple pregnancy	This quality standard covers the management of twin and triplet pregnancies in the antenatal period	Liverpool Women's Foundation Trust's Multiple Pregnancy Service[123]	It was necessary to convince other clinicians that it is more efficient and

[121] http://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_691
[122] https://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_669
[123] https://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_706

			The Newcastle upon Tyne Hospitals NHS Foundation Trust Multiple Pregnancy Service[124]	consistent to look after women under umbrella of one service or clinic, and to provide sufficient specialist staff to cover 52 weeks a year. A change to normal practice was required in that women with multiple pregnancies were referred to the specialised service. Sometimes, doctors are resistant to change or to letting go of their patients. A GP referral pathway has been set up to make it easier for GPs to refer women into the service. The service in Newcastle has a midwife for multiple births in post. Parents are part of the decision making process meaning that all aspects of care are jointly agreed.
CG129; 2011	Multiple pregnancy	This clinical guideline offers evidence-based advice on the care of women with multiple pregnancies (twins and triplets) in the antenatal period. Advises that these women should receive specialist care from an experienced multidisciplinary team to avoid higher than necessary rates of assisted birth and caesarean section, and ensure they	Multiple pregnancy service, St George's Hospital: influencing stakeholders to implement NICE guidance [125]	Baseline assessment of the current situation allows the provision of evidence of potentially substandard care that is not in line with national guidance. It also provides a baseline for comparison after

[124] https://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_693
[125] https://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_690

		receive appropriate neonatal risk assessment before birth. They also need more monitoring and more frequent antenatal visits due to the higher risks which can be associated with twin and triplet pregnancies		implementing the change. The involvement and support of the relevant key stakeholders were key to the success of our project. Awareness and knowledge are key first steps in implementing change. Local educational and risk management meetings, and dedicating a regional study day to the management of multiple pregnancies highlighted the key issues.
NG3; 2015 (replaces CG63, 2008)	Diabetes in pregnancy: management of diabetes and its complications from preconception to the postnatal period	This guideline offers best practice advice on the care of women with diabetes and their babies in pregnancy and after the birth.		
QS69; 2014	Ectopic pregnancy and miscarriage	This quality standard covers the diagnosis and initial management of ectopic pregnancy and miscarriage in women in their first trimester (up to 13 completed weeks of pregnancy).		
QS4; 2010	Specialist neonatal care quality standard	The quality standard addresses care provided for babies in need of specialist neonatal services including transfer services. Specialist neonatal services are those delivering special, high dependency, intensive or surgical care to babies.	Using the Quality Standard for specialist neonatal care to inform local quality improvement work in Taunton and Somerset NHS Foundation Trust[126]	The key determinant of success was effective clinical input. The QS was used as a vehicle to drive and support continuous improvement rather than a formal assessment /compliance procedure
CG70; 2008	Induction of labour	This updated guideline reviews the policy and methods of induction, and the care to be		

[126] http://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_557

		offered to women being offered and having induction of labour		
QS60; 2014	Induction of labour	This quality standard covers the induction of labour in hospital outpatient or inpatient settings. The quality standard does not cover the induction of labour for women with diabetes or multiple pregnancies, or augmentation (acceleration) of established labour.		
QS4; 2010	Venous thromboembolism prevention quality standard	This quality standard covers the reduction in risk of VTE in adults admitted as hospital inpatients or formally admitted to a hospital bed for day-case procedures. Pregnant women and women up to 6 weeks postpartum who are admitted to hospital are also specifically covered by this quality standard.		
CG149; 2012	Antibiotics for early-onset neonatal infection: Antibiotics for the prevention and treatment of early-onset neonatal infection	This clinical guideline offers evidence-based advice on the use of antibiotics to prevent and treat early-onset neonatal infection (that is, infection with onset within 72 hours of birth).	Supporting a 36 hour Neonatal Blood Culture status check by developing the availability of blood culture status in real time. (Liverpool Women's NHS Foundation Trust/ Royal Liverpool and Broadgreen University Hospitals NHS Trust) [127]	Changing clinical practice to reduce overtreatment
QS65; 2014	Hepatitis B	This quality standard covers testing, diagnosis and management of Hepatitis B in children (from birth), young people and adults.		
QS57; 2014	Neonatal jaundice	This quality standard covers the recognition and management of neonatal jaundice in newborn babies (both term and preterm)		

[127] http://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_592

		from birth to 28 days in primary care (including community care) and secondary care. It does not cover babies with jaundice who need surgery to correct the underlying cause, or the management of conjugated hyperbilirubinaemia in babies.		
PERINATAL MENTAL HEALTH				
CG192; 2014	Antenatal and postnatal mental health: Clinical management and service guidance	It offers evidence-based advice on the recognition, assessment, care and treatment of mental health problems in women during pregnancy and the postnatal period (up to 1 year after childbirth), and in women who are planning a pregnancy.	My pregnancy and post-birth well-being plan[128]	This plan is in line with the recommendations that support recognising mental health problems in antenatal and postnatal mental health and may help health professionals to recognise, support disclosure and to engage with women who may have mental health problems
CG136; 2011	Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services	This clinical guidance offers evidence-based advice on ensuring a good experience of care for people who use adult NHS mental health services.	Good Practice in Service User Involvement Training[129]	Service user led training sessions need to be led by service users at all stages - from initial development, to delivery, and evaluation. Support systems need to be considered and put in place to ensure that this is done in a meaningful way
MATERNAL AND CHILD NUTRITION				
PH11; 2008 (partially	Maternal and child nutrition	It relates to pregnant women (and those who are planning to become pregnant), mothers	Increasing Healthy Start vitamin uptake North East	Having dedicated and interested individuals'

[128] http://www.tommys.org/file/Wellbeingplan.pdf
[129] http://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_569

superseded by PH56, 2014)		and other carers of children aged under 5 and their children. It is particularly aimed at those on a low income or from a disadvantaged group.	Lincolnshire Care Trust Plus[130]	helps with overcoming any problems. -Work with and raise issues with the National Healthy Start team who can help.
PH56 2014	Vitamin D: increasing supplement use among at-risk groups	This guideline aims to increase supplement use to prevent vitamin D deficiency among at-risk groups	Addressing Vitamin D deficiency in Solihull [131]	The identification of Healthy Start Champions in both Community Midwifery and Health Visiting Services was key for driving the professionals to access the training and guidance documents, and the Champions themselves delivered training to teams of professionals. Engagement of community pharmacists was less effective
PH27; 2010	Weight management before, during, and after pregnancy	The guidance covers women who are pregnant or who are planning a pregnancy and mothers who have had a baby in the last 2 years	'The Monday Clinic'; Implementing a maternal obesity service (Doncaster and Bassetlaw Hospitals NHS Foundation [132] Pregnancy Plus (Dartford and Gravesham NHS Trust) [133]	Discusses why the project was poorly supported by potential users and by midwifery colleagues, and how they propose to overcome these barriers. This programme is tailored to the individualised needs of this particular client

[130] http://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_604
[131] http://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_807
[132] http://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_410
[133] https://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_625

				group. This has been a process of shared learning between facilitating midwives and the women attending the programme
CG93; 2010	Donor milk banks: the operation of donor milk bank services	The advice in the NICE guideline covers how milk banks should recruit, screen and support women who donate breast milk and how milk banks should handle and process the breast milk they receive from donors.		
SMOKING CESSATION				
PH48; 2013	Smoking cessation in secondary care: acute, maternity and mental health services	Advice on identifying people (patients and staff) who smoke, providing advice and appropriate quit techniques and practices	Blackpool: Implementing an Inpatient Stop Smoking Treatment Service in the secondary care setting. [134] Bolton: Hospital based smoking cessation practice[135]	Stop smoking specialist advisors were appointed within the hospital setting. '4 week' quit target is not followed Training on advice and intervention given to all hospital staff; easy referral pathway was established
QS43; 2013	Smoking cessation: supporting people to stop smoking	This quality standard covers smoking cessation, which includes support for people to stop smoking and for people accessing smoking cessation services		
PH26; 2010	Quitting smoking in pregnancy and following childbirth	NICE says all pregnant women who smoke – and all those who are planning a pregnancy or who have an infant aged under 12 months – should be referred for help to quit smoking. Advice is given to hep quitting. Barriers and additional factors discussed include: socio-economic situation, family and partners' attitude, post-birth relapse, cutting	Rotherham –smoking cessation in routine antenatal care. comprehensive one-stop-shop service at the antenatal clinic [136]	Recommends a pregnancy specialist in the Stop Smoking Service who could deliver the intervention. Good relationships between the stop smoking service, obstetrics and the

[134] https://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_630
[135] https://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_789
[136] http://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_448

		down vs quitting, professional barriers		commissioner are needed.
PH39; 2012	Smokeless tobacco cessation: South Asian communities	This guidance aims to help people of South Asian origin who are living in England to stop using traditional South Asian varieties of smokeless tobacco.	Open wide project: raising awareness of the risks of smokeless tobacco and shisha pipe smoking and the signs and symptoms of mouth cancer. (Bolton Council, Public Health Team/Bolton CVS Engagement Team)[137]	One of the outcomes is that participants have been encouraged to sign up to the local Smokefree Homes
COMPLEX SOCIAL FACTORS				
CG110; 2010	Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors	Pregnant women with complex social factors may need additional support to use antenatal care services. This guideline describes how access to care can be improved, how contact with antenatal carers can be maintained, the additional support and consultations that are required and the additional information that should be offered to pregnant women with complex social factors. Complex social factors are identified as including: substance misuse, recent arrival as a migrant, asylum seeker or refugee status, difficulty speaking or understanding English, age under 20, domestic abuse, poverty, and homelessness	Doncaster Family Nurse Partnership, making a real difference for young pregnant women and their baby [138]	The organization, both providers and commissioners need to support the programme and understand the commitment required to succeed. FNP is one part of whole care and the need for a different approach with pregnant teenagers is required to address the cycle of deprivation and risks of poorer outcomes. Additional communication skills such as practicing motivational interviewing and a modelling approach to parenting is accepted well with the client group and the commitment from clients is immense. The

[137] http://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_664
[138] http://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_481

				client group is very complex and a greater insight into relationships and containment has been achieved through this service delivery. The continued service user involvement is really important and time for reflection on their expressed opinions is necessary to influence change.
PH50; 2014	Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively	The recommendations cover the broad spectrum of domestic violence and abuse, including violence perpetrated on men, on those in same-sex relationships and on young people.	Against Violence & Abuse Stella Project Mental Health Initiative [139] Against Violence & Abuse Stella Project Young Women's Initiative: improving responses to young women with experience of domestic violence and/or sexual violence and substance misuse[140]	The practical benefits of the project resulted in increased staff capacity and confidence to address the needs of women presenting with these intersecting issues, even when the needs of such 'difficult' clients would previously have been regarded as not a 'part of my brief' Project recommendations included that practitioners have further training and support focused on how to identify and act on the intersecting issues of domestic and sexual violence and problematic substance use, including

[139] http://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_795
[140] http://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_793

				appropriate referral pathways
			REACH Domestic Abuse Service: Multi-lingual domestic violence/family abuse advice, advocacy and support based in an Accident and Emergency (A&E) department [141]	REACH based its success on: being part of the A&E team, building relationships with all A&E staff, supporting staff who are victims of abuse, building relationships with the police.
			Against Violence and Abuse (AVA) Community Groups Project: supporting the delivery of domestic violence and abuse services for children and young people[142]	Collaboration and commitment across partner agencies has been the absolute key to success in operating and sustaining the Community Groups Project.
LGB20; 2014	Domestic violence and abuse: how services can respond effectively[143]	This briefing summarises NICE's recommendations for local authorities and partner organisations on domestic violence and abuse. It is relevant to a range of services, voluntary sector bodies and professionals. Domestic violence or abuse is taken to include: psychological, physical, sexual, financial and emotional abuse, stalking, so-called 'honour'-based or 'honour' violence and forced marriage, and female genital mutilation		Key messages include: Multi-agency partnerships are needed, with clear, open communication channels and jointly agreed policies and procedures
ORAL HEALTH				
PH55; 2014	Oral health: approaches for	This guideline makes recommendations on	The development,	Recommendations

[141] http://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_792
[142] http://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_770
[143] https://www.nice.org.uk/advice/lgb20

	local authorities and their partners to improve the oral health of their communities	undertaking oral health needs assessments, developing a local strategy on oral health and delivering community-based interventions and activities.	implementation and monitoring of a community-based fluoride varnish programme in an inner-city London borough (Camden and Islington) [144] The Calderdale tooth brushing in schools scheme [145]	include: building relationships with staff in settings and outreach workers to identify and encourage participation from the most vulnerable families, including those where language and/or low literacy levels are barriers; identifying a link person in each setting and building relationships to ensure good communication between the FV team, settings and parents so that any concerns can be addressed quickly. Gaining early buy-in from the local authority, head teachers and Children's centre managers is crucial for the success and sustainability of the scheme. It is important to gain the support of a motivated & competent member of staff at the start to be a named co-ordinator for the programme.
VACCINATIONS				
PH21; 2009	Reducing differences in the uptake of immunisations	The guidance aims to increase immunisation uptake among those aged less than 19	Community engagement to increase childhood	Recommendations include: use a community

[144] http://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_798
[145] http://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_797

		years from groups where uptake is low. It also aims to ensure babies born to mothers infected with hepatitis B are immunised	immunisations (North East Lincolnshire Care Trust Plus)[146]	worker/organisation that knows the area and some of the barriers existing. Ensure that all organisations and professional groups are aware of the worker and their role
MIDWIFERY STAFFING				
NG4; 2015	Safe midwifery staffing for maternity settings	This guideline makes recommendations on safe midwifery staffing requirements for maternity settings. The guideline focuses on the pre-conception, antenatal, intrapartum and postnatal care provided by midwives in all maternity settings, including: at home, in the community, in day assessment units, in obstetric units, and in midwifery-led units (both alongside hospitals and free-standing).		
WELLBEING				
PH40; 2012	Social and emotional wellbeing: early years	This guidance aims to define how the social and emotional wellbeing of vulnerable children aged under 5 years can be supported through home visiting, childcare and early education.		

[146] https://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_534

16.4 Audit tool template: agencies

Strategic

Champions Are there senior champions for maternal health in the organisation? (NB reflect local structures) Who are they?
Accountable Leads Is there a senior accountable lead for maternal health? Who are they?

Data

Accountable lead Is there a senior accountable lead for maternal health data and intelligence? Who is the operational lead?
Data collection Are there protocols or agreements in place for systematic collecting and sharing data and intelligence across sectors to contribute to planning and performance management? What data is being shared?
Data use Is collected data analysed and used to inform planning and service delivery and review to improve maternal health? Do they collect surveys from service users, information or feedback from practitioners? Is this captured and reviewed as part of service improvement?
Provider data What data do they collect, monitor and review? Is there anything currently not collected that they feel they should?
Commissioners data What maternal data do commissioners request from providers? What are the gaps, the difficulties and how is that being addressed? Which contracts is maternal health considered as part of the agreed service specification?

Communication

Accountable lead Who is involved in the development and dissemination of effective communication?
Service arrangements Do you have a communication strategy? Do you use it? What communication strategies and arrangements are in place (consider all stages of care pathway appropriate to that service or organisation)? What provision is there to communicate effectively with targeted groups?
Partnership communication How is information disseminated and shared with associated partners and organisations?
Service users and families How is information provided to service users and families? What feedback has been given on the acceptability and appropriateness of the information given and the format used?
Monitoring and evaluation How do you monitor and evaluate the success of your communication strategy?

Workforce development

Training needs
Has there been a training needs assessment undertaken? What training does your organisation provide in relation to maternal health for your workforce? What are the gaps? What are the successes?
Accountability Who is accountable for and responsible of development and delivery of training in the workforce?
Monitoring How is your training monitored and reviewed and how frequently?

Universal provision/ early intervention
Early booking What services proactively and positively encourage mothers to be to book early and continue to use antenatal services throughout their pregnancy?

(Include consideration of fathers).
Lead professional How is your organisation or service involved and contribute to the development and delivery of a pregnant woman's maternal care plan?
Support and information What support and information is provided to a pregnant woman and families by your organisation?
Monitoring How is the maternal support your organisation/ service provide monitored and evaluated and how frequently? How have you used this and has this changed practice? What are the gaps identified from the evaluations?

Risk Factors/ Complex needs

Support and information What support and information does your service / organisation provide to pregnant women and their families with complex needs and/ or additional risk factors?
Monitoring How is the maternal support your organisation/ service provide for pregnant women with complex and/ or additional needs monitored and evaluated? How frequently? How have you used this information? Has this changed practice? How do you know this? What are the gaps identified from the evaluations?
Policy What maternal health related policies, guidance and pathways does your organisation have in place? What are the gaps? How often are these reviewed?

Additional Information

Is there any additional information or comments you would like to share that has not been included?

16.5 Audit tool template: service users

If the pregnancy was planned, did you have discussions with your GP/ contraception services to optimise your health before becoming pregnant? If long term condition being managed, did you get support and advice about planning for pregnancy? Who was this from? When first accessing maternity services, how were you informed about the appointments e.g. online, letters, texts? Was this helpful? How could this be improved? Were you asked about any additional needs e.g. if hearing impairment, disabilities and access, language? How could this be improved? Who was the first health professional you saw when you thought you were pregnant and how many weeks pregnant were you? How many weeks pregnant were you when you had your 'booking' appointment? Did you know that it is being encouraged that mothers try and have their booking appointment with the midwife before 10 weeks. How did you find out about this? **If booking over 10 weeks pregnant** why do you think there was a delay in you booking? How did you feel about the choice you had about the venue and timings for your antenatal check-ups?
Were you aware as soon as you were pregnant of the tests and scans available to you? When were you given information about the tests and scans? Was it sufficient and did it give you a good understanding to make informed decisions? Did you agree to all of the screening? If not why was that?
Communications What information were you given about your appointments for booking with the midwife and your subsequent antenatal appointments? What about GP?

Other professionals involved in care e.g. obstetricians, physiotherapists, dieticians etc.? If you contacted a midwife or the midwifery team, were you given the help you needed?(AN/PN) Do you feel that the different agencies communicated with each other to fully support your care in pregnancy and after the baby was born? Do you feel you were listened to by those involved in your antenatal care?
Do you feel that you were kept fully informed about your care and what was happening throughout your pregnancy? Did you have to take the initiative (chase) to follow-up on appointments etc.? During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy? Did you attend parent education classes? Were they helpful? What did they cover? Would the information have been obtained elsewhere? Did you attend all the classes? Was the venue and time suitable for you? Was your partner encouraged to attend? If you/ your partner did not attend why was this?
Relationships Do you feel that you had a good relationship with the health professionals and others that cared for you during your pregnancy? Did you feel that those caring for you and those within the different services, had good relationships with each other so that you received the care that you expected. E.g. social care, obstetricians etc.? If you saw a midwife for your antenatal check-ups, did you see the same one every time? Thinking about your antenatal care, were you spoken to in a way you could understand? Did you understand what was happening?

Were you involved enough in decisions about your care? If you needed to be referred to another service do you feel that was a smooth process? If you had additional health problems in pregnancy how were these handled by the health professional and were you involved in any decisions made? Was your husband/partner involved in your care?
Environment Did you get enough information from either a midwife or doctor to help you decide where to have your baby and were you offered choice?(which hospital) Were you offered choices about where to have your baby? (Home, birthing centre, CDS)
Other Overall, do you feel you had a good experience? Tell me what went well for you? What made a difference for you? What was not so good for you? What do you think could be improved upon?
Was your partner with you during labour and at the birth? Did you and your partner cuddle baby as soon as the baby was born (skin to skin) if not do you know why?
Did you feel that you were given appropriate advice and support?
Was your partner or someone else close to, you involved as much as you or they wanted?
Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?
Were your decisions about how you wanted to feed your baby respected by staff?
When you were at home after the birth of your baby, was there good communication between the hospital and the CMWs/GPs/HVs?

Did you see the same midwife for both your antenatal and postnatal care? Or the same one for the antenatal care then postnatal care?
Would you have like more information about having a new baby?
Would you have like more information about your recovery after having your baby?
Is baby fit and healthy? Further exploration. Did your baby need specialist care: Explore this: Care, support, information If baby born with or developed a long term condition what support and information given, how soon, type of information Did you care for your baby? e.g. wash, change, feed etc.
During the six weeks after the birth of your baby did you receive help and advice from health professionals about you, and your baby's health and progress?
Were you given enough information about any emotional changes you might experience after the birth?
Were you given information or offered advice from a health professional about what becoming a mother / father has meant to you and other members of the family?
Do you feel that the different agencies communicated with each other to fully support your care after the baby was born? Do you feel you were listened to by those involved in your postnatal care?
Have you been given information on where to go for help, advice, and support?
Is English your first language? If not what support have you had to be able to understand the services and to receive the best care?
Do you have any disabilities or any conditions? Thinking about provision of appropriate care or services.
Would you have like to have seen more support, joint working, with who?
Is there any other information or comments you want to share that have not been included?
What do you think could be improved upon?

16.6 Data – Maternal health

Maternal health intelligence – Croydon/London/England

Indicator	Croydon	Croydon no. per yr.	London	England	Source
PRECONCEPTION					
Ectopic pregnancy admissions per 100,000 women 15–44 yr.	137.7 (significantly worse than England)	111 women	115.4 (significantly worse than England)	89.6	Public Health England 2013/14
Female genital mutilation, estimated new cases per yr. per 100,000 females	19.6	Est 38 females	71.7	22.6	Health & Social Care Information Centre 2014/15[147]
ANTENATAL					
12-week risk assessments, % of all pregnant women assessed for risk by 12 weeks 6 days of pregnancy	78.3%	4164 women[148]	127.6%[149]	113.8%[3]	NHS England 2013/14
HIV antenatal screening coverage, % of eligible pregnant women tested, with a conclusive result	99.7%	4728 women	99.7%	98.8%	UK National Screening Committee, Quality Assurance Data, 2013/14
Sickle cell and thalassaemia antenatal screening coverage, % of eligible pregnant women tested, with a conclusive result	98.9%	4680 women	99.1%	98.5%	UK National Screening Committee 2013/14
Sickle cell or thalassaemia carrier (i.e. blood test is positive), % of pregnant women with antenatal blood sample tested	Not reported[150]	Not reported	5.2%	2.1%	NHS Screening Programmes 2013/14

[147] Estimated rates from preliminary, experimental statistics for Sep 2014 to Feb 2015, applied to 2014 population projections
[148] 2013/14 Q3 to 2014/15 Q2 inclusive
[149] Percentages over 100% are possible as not all pregnancies end in delivery, and some women are assessed more than once

Indicator	Croydon	Croydon no. per yr.	London	England	Source
Under-18 yr. conceptions per 1000 women aged 15–17 yr.	32.5 (significantly worse than London & England)	232 women	21.8 (significantly better than England)	24.3	Public Health England 2013
Under-16 yr. conceptions per 1000 girls aged 13–15 yr., 3-year average	6.5	Average 45 girls/yr.	4.8 (significantly lower than England)	5.5	Public Health England 2013
Under-18 yr. conceptions leading to abortion, % conceptions in women aged under 18 yr.	61.6% (significantly higher than England)	143 women	64.2% (significantly higher than England)	51.1%	Public Health England 2013
Under-18 yr. abortion rate per 1000 women aged 15–17 yr. (based on year of abortion)	18.2 (significantly higher than London & England)	131 women	13.5 (significantly higher than England)	11.7	Public Health England 2013
Abortions under 10 weeks' gestation, % NHS-funded abortions	84.6% (significantly better than London &	1826 abortions	82.9% (significantly better than England)	79.4%	Public Health England 2013

[150] Croydon data not reported

Indicator	Croydon	Croydon no. per yr.	London	England	Source
	England)				
Total abortions per 1000 women aged 15–44 yr.	27.3 (significantly worse than London & England)	2199 abortions	22.8 (significantly worse than England)	16.6	Public Health England 2013
Pregnant and received flu vaccination (and not in a clinical risk group); % of pregnant, GP-registered women	37.0%	2285 women	39.9%	44.1%	Public Health England 1/9/2014–31/1/15
Pregnant and received pertussis vaccination, % of pregnant, GP-registered women	Not reported[151]	Not reported	49.9%	58.9%	Public Health England 2014
Smoking during pregnancy, % of maternities	7.3% (significantly worse than London, significantly better than England)	387 women	5.1% (significantly better than England)	12.0%	Public Health England 2013/14
Households accepted as homeless due to pregnancy[152], % of all homelessness acceptances	6.5%	57 households	Unavailable	8%	Croydon P1(E) homelessness acceptance data 2014/15

[151] Croydon data not reported
[152] Applicant households found to be eligible for assistance, unintentionally homeless and in priority need because applicant is, or household includes, a pregnant woman and there are no other dependent children

Indicator	Croydon	Croydon no. per yr.	London	England	Source
Perinatal psychiatric referrals – see postnatal data					
BIRTH					
Births (live) per 1000 women aged 15–44 yr.	70.3	5,645 infants	63.3	62.2	Birth registrations 2014
Under-18 yr. births per 1000 women aged 15–17 yr. (based on year of birth)	7.8 (significantly worse than London)	56 women	5.1 (significantly better then England)	7.8	Public Health England 2013
Births (live) to women aged 40 yr. +, % of all live births	5.0%	278 births	5.9%	4.2%	Birth registrations 2013
Low birth weight births (i.e. less than 2500 g, live and still births), % of all births of known weight	8.3%	466 births	7.9%	7.4%	Birth registrations 2013
Down syndrome births per 10,000 live births	Not reported[153]	Est 6 infants[154]	11.2	10.7	Health & Social Care Information Centre 2012/13
Total CCG spend on maternal & reproductive health, £million per 100,000 population	£4.6 m	£18.1 m total	£6.7 m (CCG cluster)[155]	£4.9 m	NHS England 2013/14
CCG spend on unscheduled care[156] for maternal & reproductive health, £million	£3.6 m	£14.2 m total	£3.0 m	£2.0 m	NHS England 2013/14

[153] Croydon data not reported
[154] Estimated Croydon number, applying 2012/13 London rate to 2013 Croydon live births
[155] CCG cluster = 11 CCGs used as regional benchmark in the NHS Programme Budgeting Benchmarking Tool (i.e. NHS Waltham Forest, Greenwich, Lewisham, Haringey, Brent, Croydon, City & Hackney, Barking & Dagenham, Enfield, Southwark, and Lambeth CCGs)

Indicator	Croydon	Croydon no. per yr.	London	England	Source
per 100,000 population			(CCG cluster)		
CCG spend on daycase and elective care for maternal & reproductive health, £million per 100,000 population	£0.2 m	£0.8 m total	£0.2 m (CCG cluster)	£0.2 m	NHS England 2013/14
CCG spend on outpatient care for maternal & reproductive health, £million per 100,000 population	£0.0 m[157]	£0.1 m total	£1.0 m (CCG cluster)	£0.3 m	NHS England 2013/14
CCG spend on community and integrated care for maternal & reproductive health, £million per 100,000 population	£0.5 m	£2.1 m total	£2.0 m (CCG cluster)	£2.0 m	NHS England 2013/14
Death of mother in pregnancy, childbirth & puerperium, women	Less than 5	Less than 5	10	44	Death registrations 2013
Perinatal psychiatric referrals – see postnatal data					
POSTNATAL					
Breastfeeding initiation within 48 hours of delivery, % of mothers	87.2% (benchmark not yet published)	4048	85.5% (benchmark not yet published)	74.0%	Public Health England 2013/14

[156] Unscheduled care = non-elective admissions, accident and emergency, emergency transport and other urgent admissions
[157] Exact Croydon value = £18,744/100,000 population

Indicator	Croydon	Croydon no. per yr.	London	England	Source
Breastfeeding[158] prevalence at 6–8 weeks after birth, % of infants due a 6–8 wk health check	70.2% (benchmark not yet published)	3646	60.6% (benchmark not yet published)	45.8%	Public Health England 2013/14
Perinatal psychiatric referrals		180	Unavailable	Unavailable	Croydon Clinical Commissioning Group, Adult Mental Health activity data, 2014/15
Children in poverty, % of children aged under 16 yr	23.0% (significantly better than London, significantly worse than England)	17,655	23.7% (significantly worse than England)	19.2%	Public Health England 2012
Index of multiple deprivation score (high is bad)	22.8		25.2	21.5	Department of Communities & Local Government 2010
Homeless acceptances per 1000 households	6.0	913 households (based on 2014 data)	4.4	2.4	Department of Communities & Local Government 2012/13

[158] Total or partial breastfeeding

Additional notes

Index of Multiple Deprivation (IMD)

– The most deprived Croydon ward is Fieldway (IMD 2010 score = 41.3); this ward falls within the most deprived 30% of English Super Output Areas

– The least deprived Croydon ward is Selsdon & Ballards (IMD 2010 score = 8.1); this ward falls within the least deprived 30% of English Super Output Areas

– Definition: The Index of Multiple Deprivation is calculated by combining appropriately weighted results for 38 separate indicators, organised across 7 distinct domains of deprivation (income, employment, health and disability, education skills and training, barriers to housing and other services, crime, and living environment)

(Source: Dept of Communities & Local Government, 2010)

NHS England Programme Budgeting Data 2013/14

– https://www.england.nhs.uk/resources/resources-for-ccgs/prog-budgeting/

– For ICD10 codes used to define 'Maternal and reproductive health', see '2012-13 guidance and mapping document' in 2012/13 Programme Budgeting Data:

https://www.networks.nhs.uk/nhs-networks/health-investment-network/news/2012-13-programme-budgeting-data-is-now-available (list also held by Lisa Colledge)

16.7 Data – maternal health sub-categories

Indicator	Croydon	London	England	Source
PRECONCEPTION				
● **Croydon total population**				Office for National Statistics 2013
– 0–4 yr; male / female / persons	14,531 / 14,120 / 28,651			
– 5–19 yr; male / female / persons	36,484 / 35,333 / 71,817			
– 20 yr +; male / female / persons	129,762 / 142,522 / 272,284			
● **Female contraceptive method**				Croydon Sexual and Reproductive Health service use data 2014/15
– *15 yr and under*				
– Condoms[159]	114 (38.0%)			
– Long-acting reversible contraception[160]	90 (30.0%)			
– Oral contraceptive pill[161]	62 (20.7%)			
– Other[162]	<5 (0.3%)			
– Unknown	33 (11.0%)			
– Total	300 (100.0%)			

[159] Male or female condom
[160] Injectable contraception, implant, Intrauterine device or intrauterine system
[161] Combined pill or progestogen only pill
[162] Vaginal ring, contraceptive patch, cap/diaphragm, spermicide or natural family planning

Indicator	Croydon	London	England	Source
– 16–17 yr				
– Condoms	405 (41.1%)			
– Long-acting reversible contraception	278 (28.2%)			
– Oral contraceptive pill	173 (17.6%)			
– Other	10 (1.0%)			
– Unknown	119 (12.1%)			
– Total	985 (100.0%)			
– 18–19 yr				
– Condoms	476 (39.1%)			
– Long-acting reversible contraception	282 (23.2%)			
– Oral contraceptive pill	315 (25.9%)			
– Other	5 (0.4%)			
– Unknown	139 (11.4%)			
– Total	1217 (100.0%)			
– 20–24 yr				
– Condoms	897 (38.8%)			
– Long-acting reversible contraception	491 (21.2%)			
– Oral contraceptive pill	615 (26.6%)			

Indicator	Croydon	London	England	Source
– Other	31 (1.3%)			
– Unknown	280 (12.1%)			
– Total	2314 (100.0%)			
– 25–29 yr				
– Condoms	497 (33.9%)			
– Long-acting reversible contraception	271 (18.5%)			
– Oral contraceptive pill	476 (32.4%)			
– Other	20 (1.4%)			
– Unknown	204 (13.9%)			
– Total	1468 (100.0%)			
– 30–34 yr				
– Condoms	261 (28.5%)			
– Long-acting reversible contraception	181 (19.7%)			
– Oral contraceptive pill	304 (33.2%)			
– Other	18 (2.0%)			
– Unknown	153 (16.7%)			
– Total	917 (100.0%)			
– 35–39 yr				

Indicator	Croydon	London	England	Source
– Condoms	163 (24.3%)			
– Long-acting reversible contraception	132 (19.7%)			
– Oral contraceptive pill	274 (40.8%)			
– Other	10 (1.5%)			
– Unknown	92 (13.7%)			
– Total	671 (100.0%)			
– 40–44 yr				
– Condoms	96 (21.7%)			
– Long-acting reversible contraception	89 (20.1%)			
– Oral contraceptive pill	192 (43.4%)			
– Other	7 (1.6%)			
– Unknown	58 (13.1%)			
– Total	442 (100.0%)			
– 45 yr +				
– Condoms	67 (18.9%)			
– Long-acting reversible contraception	59 (16.7%)			
– Oral contraceptive pill	170 (48.0%)			
– Other	5 (1.4%)			

Indicator	Croydon	London	England	Source
– Unknown	53 (15.0%)			
– Total	354 (100.0%)			
● **Estimated 16–49 yr women with poor/no English, by main language**[163]				Census 2011
– South Asian language: Total	1086 (20.7%)			
– South Asian language: Panjabi	53 (25.7%)			
– South Asian language: Urdu	173 (15.7%)			
– South Asian language: Bengali (with Sylheti and Chatgaya)	110 (29.2%)			
– South Asian language: Gujarati	176 (21.1%)			
– South Asian language: Tamil	293 (18.6%)			
– South Asian language: Any other South Asian language	16 (1.4%)			
– Other European language (EU): Total	708 (16.5%)			
– Other European language (EU): Polish	474 (23.8%)			
– Other European language (EU): Any other European language	0 (0.0%)			
– Other European language (non EU)	35 (3.6%)			

[163] Estimate based on number of 16–49 yr old Croydon women speaking each main language, and London prevalence of poor/no English in each main language group

Indicator	Croydon	London	England	Source
– African language	282 (14.9%)			
– East Asian language: Total	280 (21.0%)			
– East Asian language: Chinese	170 (29.1%)			
– East Asian language: Any other East Asian language	6 (0.9%)			
– West/Central Asian language	128 (22.1%)			
– Portuguese	161 (19.5%)			
– Spanish	68 (12.8%)			
– French	61 (5.7%)			
– Arabic	55 (17.0%)			
– Other language	20 (12.7%)			
ANTENATAL				
● **Antenatal bookings, by Index of Multiple Deprivation England quintile**[164]				Croydon University Hospital 2014/15
– 1st quintile (worst)	1019 (22.4%)			
– 2nd quintile	1815 (40.0%)			
– 3rd quintile	1134 (25.0%)			
– 4th quintile	330 (7.3%)			

[164] Note that 1.7% of bookings (n = 78) did not have a recognisable recorded post code so were excluded from analysis

Indicator	Croydon	London	England	Source
– 5th quintile (best)	164 (3.6%)			
BIRTH				
● Live births past 3 years[165]				Birth registrations
– 2012	5884 (16.0/1000)	134,186 (16.2/1000)	694,241 (13.0/1000)	
– 2013	5605 (15.0/1000)	128,332 (15.2/1000)	664,517 (12.3/1000)	
– 2014	5642 (15.0/1000)	127,399 (14.9/1000)	661,496 (12.2/1000)	
– Total	17,131	389,917	2,020,254	
● Deliveries, by Index of Multiple Deprivation England quintile[166]				Croydon University Hospital 2014/15
– 1st quintile (worst)	833 (22.3%)			
– 2nd quintile	1493 (39.9%)			
– 3rd quintile	928 (24.8%)			
– 4th quintile	298 (8.0%)			
– 5th quintile (best)	118 (3.2%)			
● Multiple maternities[167] (i.e. one mother, more than one infant)				Birth registrations
– 2011	14.7/1000 (84 multiple	17.4/1000	16.0/1000	

[165] Crude birth rate: births per 1000 residents
[166] Note that 2.0% of deliveries (n = 73) did not have a recognisable recorded postcode so were excluded from analysis
[167] Per 1000 maternities

Indicator	Croydon	London	England	Source
	maternities)			
– 2012	Unavailable	Unavailable	Unavailable	
– 2013	14.8/1000 (83 multiple maternities)	17.0/1000	15.4/1000	
– 2014[168]	18.5/1000 (103 multiple maternities)			
● **Croydon birth projections**[169]				Greater London Authority 2013
– 2015	6142 (16.1/1000)			
– 2016	6177 (16.0/1000)			
– 2017	6207 (16.0/1000)			
– 2018	6231 (15.9/1000)			
– 2019	6231 (15.8/1000)			
– 2020	6226 (15.6/1000)			
– 2021	6220 (15.5/1000)			
– 2022	6213 (15.4/1000)			
– 2023	6207 (15.3/1000)			
– 2024	6198 (15.1/1000)			

[168] 2014 data is not yet available for London or England
[169] Crude birth rate: births per 1000 residents

Indicator	Croydon	London	England	Source
– 2025	6186 (15.0/1000)			
– 2026	6176 (14.9/1000)			
– 2027	6166 (14.8/1000)			
– 2028	6157 (14.7/1000)			
– 2029	6151 (14.6/1000)			
– 2030	6149 (14.5/1000)			
– 2031	6151 (14.4/1000)			
● **Ethnicity – births** (source for Croydon: Mother's ethnicity, Croydon birth notifications 2012; source for London and England, baby's ethnicity as reported by mother, Office for National Statistics, 2010)				Croydon birth notifications 2012 (maternal ethnicity); Office for National Statistics 2010 (London and England, infant's ethnicity reported by mother)
– Bangladeshi	38 (1%)	4820 (4%)	9347 (1%)	
– Indian	344 (6%)	8121 (6%)	20,962 (3%)	
– Pakistani	269 (5%)	4687 (4%)	26,648 (4%)	
– Black African	696 (12%)[170]	14,538 (11%)	24,608 (4%)	
– Black Carribbean	267 (5%)[8]	4367 (3%)	7208 (1%)	
– White British	1288 (23%)	38,990 (30%)	444,132 (65%)	

[170] Excluding Black British

Indicator	Croydon	London	England	Source
– White Other	525 (9%)	26,136 (20%)	56,760 (8%)	
– Other (Chinese, Other Asian, Other Black, Other and all Mixed groups)	902 (16%)	25,471 (19%)	65,080 (10%)	
– Not stated	1245 (22%)	4392 (3%)	27,815 (4%)	
● **Mother's age at birth**				Birth registrations
– *2011*				
– <20 yr	226 (4.0%)	3538 (2.7%)	34,025 (4.9%)	
– 20–24 yr	865 (15.1%)	18,125 (13.6%)	126,842 (18.4%)	
– 25–29 yr	1618 (28.3%)	34,370 (25.9%)	190,244 (27.6%)	
– 30–34 yr	1736 (30.3%)	43,198 (32.5%)	197,987 (28.8%)	
– 35–39 yr	1008 (17.6%)	26,286 (19.8%)	110,791 (16.1%)	
– 40–44 yr	246 (4.3%)	6752 (5.1%)	26,456 (3.8%)	
– 45 yr +	21 (0.4%)	574 (0.4%)	1775 (0.3%)	
– *2012*				
– <20 yr	230 (3.9%)	3358 (2.5%)	31,566 (4.5%)	
– 20–24 yr	843 (14.3%)	17,309 (12.9%)	124,531 (17.9%)	
– 25–29 yr	1624 (27.6%)	34,148 (25.4%)	192,183 (27.7%)	
– 30–34 yr	1840 (31.3%)	44,756 (33.4%)	206,788 (29.8%)	

Indicator	Croydon	London	England	Source
– 35–39 yr	1054 (17.9%)	27,066 (20.2%)	110,325 (15.9%)	
– 40–44 yr	272 (4.6%)	6890 (5.1%)	26,941 (3.9%)	
– 45 yr +	21 (0.4%)	659 (0.5%)	1907 (0.3%)	
– 2013				
– <20 yr	196 (3.5%)	2772 (2.2%)	27,213 (4.1%)	
– 20–24 yr	797 (14.2%)	14,982 (11.7%)	112,365 (16.9%)	
– 25–29 yr	1583 (28.2%)	32,753 (25.5%)	186,582 (28.1%)	
– 30–34 yr	1785 (31.8%)	43,666 (34%)	203,193 (30.6%)	
– 35–39 yr	966 (17.2%)	26,638 (20.8%)	107,131 (16.1%)	
– 40–44 yr	250 (4.5%)	6855 (5.3%)	26,098 (3.9%)	
– 45 yr +	28 (0.5%)	666 (0.5%)	1935 (0.3%)	
– 2014[171]				
– <20 yr	173 (3.1%)			
– 20–24 yr	744 (13.2%)			
– 25–29 yr	1558 (27.6%)			
– 30–34 yr	1839 (32.6%)			
– 35–39 yr	1041 (18.5%)			

[171] 2014 data is not yet available for London or England

Indicator	Croydon	London	England	Source
– 40–44 yr	259 (4.6%)			
– 45 yr +	28 (0.5%)			
● **Place of birth**				Birth registrations[172]
– NHS	5515 (98%)	123,012 (97%)	639,146 (97%)	
– Non-NHS	4 (<1%)	1414 (1%)	2185 (<1%)	
– Home	115 (2%)	2192 (2%)	14,550 (2%)	
– Elsewhere	8 (<1%)	185 (<1%)	1296 (<1%)	
● **Method of delivery**[173]				Croydon University Hospital 2014/15 Health & Social Care Information Centre 2013/14
– Spontaneous	57.3%	56.3%	60.9%	
– Elective caesarean	8.6%	11.3%	11.0%	
– Emergency caesarean	18.5%	18.0%	15.2%	
– Instrumental	15.6%	14.3%	12.9%	

[172] 2014 for Croydon, 2013 for London and England
[173] 2014/15 deliveries at Croydon University Hospital; 2013/14 deliveries for London and England

Indicator	Croydon	London	England	Source
● **Birth weight**[174]				Birth registrations 2013
– <1000 g	38 (0.7%)	767 (0.6%)	3250 (0.5%)	
– 1000–1499 g	39 (0.7%)	797 (0.6%)	3895 (0.6%)	
– 1500–1999 g	88 (1.6%)	1862 (1.5%)	9055 (1.4%)	
– 2000–2499 g	285 (5.1%)	6232 (4.9%)	30,424 (4.6%)	
– 2500–2999 g	1119 (20.0%)	23,403 (18.2%)	108,717 (16.4%)	
– 3000–3499 g	2044 (36.5%)	47,450 (37.0%)	234,471 (35.3%)	
– 3500–3999 g	1487 (26.5%)	35,124 (27.4%)	194,372 (29.3%)	
– 4000 g +	496 (8.8%)	11,476 (8.9%)	73,445 (11.1%)	
– Not stated	9	1221	6888	
● **Maternal parity (married mothers only)**[175]				Birth registrations 2013
0 previous liveborn children	31.8%[176]	37.5%	34.5%	
1 previous liveborn child	37.4%	36.7%	38.2%	
2 previous liveborn children	21.3%[177]	15.7%	17.1%	

[174] Number of live births plus percentage of all births of known weight
[175] Expressed as a percentage of all births (live or still) to married mothers
[176] Significantly lower than London and England

Indicator	Croydon	London	England	Source
3 previous liveborn children	6.1%	5.9%	6.3%	
4 or more previous liveborn children	3.5%	4.2%	3.9%	
● **Stillbirth rate[178], annual**				Health & Social Care Information Centre
– 2011	Data removed[179]	5.7/1000 [5.3–6.1][180]	5.2/1000 [5.1–5.4]	
– 2012	Data removed	5.6/1000 [5.2–6.0]	4.8/1000 [4.7–5.0]	
– 2013	3.7/1000 [2.4–5.7]	5.3/1000 [4.9–5.7]	4.6/1000 [4.5–4.8]	
● **Stillbirth rate[181], 3-year pooled**				Health & Social Care Information Centre
– 2009–11	Data removed	5.5/1000 [5.3–5.8]	5.2/1000 [5.1–5.3]	
– 2010–12	Data removed	5.6/1000 [5.4–5.8]	5.0/1000 [4.9–5.1]	
– 2011–13	5.4/1000 [4.4–6.6]	5.5/1000 [5.3–5.8]	4.9/1000 [4.8–5.0]	
POSTNATAL				
● **Perinatal mortality rate[182], annual**				Health & Social Care Information Centre

[177] Significantly higher than London and England
[178] Per 1000 total births
[179] Data removed as may potentially identify an individual
[180] 95% confidence interval
[181] Per 1000 total births
[182] Per 1000 total births

Indicator	Croydon	London	England	Source
– 2011	Data removed	7.9/1000 [7.5–8.4]	7.6/1000 [7.4–7.8]	
– 2012	Data removed	7.7/1000 [7.2–8.2]	7.0/1000 [6.8–7.2]	
– 2013	5.5/1000 [3.9–7.8]	7.3/1000 [6.9–7.8]	6.7/1000 [6.5–6.9]	
● Perinatal mortality rate[183], 3-year pooled				Health & Social Care Information Centre
– 2009–11	8.9/1000 [7.6–10.5]	7.9/1000 [7.6–8.1]	7.5/1000 [7.4–7.6]	
– 2010–12	Data removed	7.8/1000 [7.6–8.1]	7.3/1000 [7.2–7.4]	
– 2011–13	7.2/1000 [6.1–8.6]	7.6/1000 [7.4–7.9]	7.1/1000 [7.0–7.2]	
● Neonatal mortality rate[184], annual				Health & Social Care Information Centre
– 2011	2.3/1000 [1.3–3.9]	2.9/1000 [2.6–3.2]	3.0/1000 [2.9–3.2]	
– 2012	2.2/1000 [1.3–3.8]	2.6/1000 [2.4–2.9]	2.9/1000 [2.7–3.0]	
– 2013	2.7/1000 [1.6–4.4]	2.6/1000 [2.4–2.9]	2.7/1000 [2.6–2.8]	
● Neonatal mortality rate[185], 3-year pooled				Health & Social Care Information Centre
– 2009–11	3.0/1000 [2.2–3.9]	3.0/1000 [2.9–3.2]	3.1/1000 [3.0–3.1]	
– 2010–12	2.3/1000 [1.7–3.2]	2.9/1000 [2.7–3.1]	3.0/1000 [2.9–3.0]	

[183] Per 1000 total births
[184] Per 1000 live births
[185] Per 1000 live births

Indicator	Croydon	London	England	Source
– 2011–13	2.4/1000 [1.8–3.2]	2.7/1000 [2.6–2.9]	2.9/1000 [2.8–2.9]	
● Infant mortality rate[186], annual				Health & Social Care Information Centre
– 2011	4.0/1000 [2.7–6.0]	4.1/1000 [3.8–4.5]	4.3/1000 [4.2–4.5]	
– 2012	3.7/1000 [2.5–5.7]	3.9/1000 [3.5–4.2]	4.1/1000 [4.0–4.3]	
– 2013	4.1/1000 [2.7–6.2]	3.8/1000 [3.5–4.1]	3.9/1000 [3.8–4.1]	
● Infant mortality rate[187], 3-year pooled				Health & Social Care Information Centre
– 2009–11	4.4/1000 [3.5–5.5]	4.4/1000 [4.2–4.6]	4.4/1000 [4.3–4.5]	
– 2010–12	4.0/1000 [3.2–5.1]	4.2/1000 [4.0–4.4]	4.3/1000 [4.2–4.4]	
– 2011–13	4.0/1000 [3.1–5.0]	3.9/1000 [3.7–4.1]	4.1/1000 [4.0–4.2]	
● Infant feeding at 6–8 weeks, by type				NHS England 2013/14
– Totally breastfed	2031 (38.8%)	39,669 (35.0%)	196,790 (31.3%)	
– Partially breastfed	1641 (31.3%)	29,016 (25.6%)	91,429 (14.5%)	
– Any breastfeeding	3672 (70.1%)	68,685 (60.6%)	288,219 (45.8%)	
– Artificially fed	1563 (29.8%)	25,009 (22.1%)	275,503 (43.8%)	

[186] Per 1000 live births
[187] Per 1000 live births

16.8 Data – Croydon University Hospital

Maternal health intelligence – Croydon University Hospital 2014/15

(Source: Croydon University Hospital data)

ANTENATAL

• **Referrals**[188]	Q1		Q2		Q3		Q4		Total	
GP referrals	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
≤9 wk	749	74.3%	742	70.3%	834	70.2%	830	64.6%	3155	69.6%
10–12 wk[189]	145	14.4%	155	14.7%	181	15.2%	245	19.1%	726	16.0%
13–19 wk	65	6.4%	80	7.6%	91	7.7%	113	8.8%	349	7.7%
20–35 wk	44	4.4%	66	6.3%	66	5.6%	83	6.5%	259	5.7%
≥36	5	0.5%	12	1.1%	16	1.3%	13	1.0%	46	1.0%
Total	1008	100.0%	1055	100.0%	1188	100.0%	1284	100.0%	4535	100.0%
Self-referrals	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
≤9 wk	21	63.6%	17	39.5%	17	54.8%	26	55.3%	81	52.6%
10–12 wk	8	24.2%	11	25.6%	1	3.2%	10	21.3%	30	19.5%
13–19 wk	1	3.0%	6	14.0%	5	16.1%	6	12.8%	18	11.7%
20–35 wk	2	6.1%	9	20.9%	8	25.8%	5	10.6%	24	15.6%
≥36	1	3.0%	0	0.0%	0	0.0%	0	0.0%	1	0.6%
Total	33	100.0%	43	100.0%	31	100.0%	47	100.0%	154	100.0%

• **Bookings**	Q1		Q2		Q3		Q4		Total	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
≤9 wks	74	7.1%	129	11.7%	270	22.1%	407	30.6%	880	18.8%
10–12 wks[190]	756	72.6%	708	64.5%	631	51.8%	513	38.5%	2608	55.6%
13–19 wks	138	13.3%	152	13.8%	202	16.6%	288	21.6%	780	16.6%
20–35 wks	62	6.0%	93	8.5%	93	7.6%	100	7.5%	348	7.4%
≥36 wks	11	1.1%	16	1.5%	23	1.9%	23	1.7%	73	1.6%
Total	1041	100.0%	1098	100.0%	1219	100.0%	1331	100.0%	4689	100.0%
Transfers in	39		56		59		30		184	
DNA bkg appts[191]	282		266		317		208		1073	

[188] Note that extra referrals would have been received which did not progress to booking, because the woman miscarried or decided to book elsewhere
[189] For all referrals data, 12 wk = 12 weeks 6 days
[190] 12 wk = 12 weeks 6 days
[191] 'Did not appear' booking appointments

• **Antenatal admission – not delivered**	*n*
Total	1312

• **Age at booking**	*n*	%
<16 yr	10	0.2%
16–19 yr	189	4.0%
20–24 yr	746	15.9%
25–29 yr	1375	29.3%
30–34 yr	1436	30.6%
35–39 yr	726	15.5%
40–44 yr	196	4.2%
≥45 yr	11	0.2%
Total	4689	100.0%

• **Ethnicity at booking**	*n*	%
Any other Asian background	160	3.4%
Any other black background	217	4.6%
Any other ethnic group	193	4.1%
Any other mixed background	100	2.1%
Any other white background	422	9.0%
Asian Bangladeshi	42	0.9%
Asian Indian	264	5.6%
Asian Pakistani	192	4.1%
Black African	475	10.1%
Black British	1	0.0%
Black Caribbean	187	4.0%
Mixed white and Asian	10	0.2%
Mixed white and black African	12	0.3%
Mixed white and black Caribbean	45	1.0%
Not recorded	527	11.2%
Not stated	690	14.7%
Other Chinese	39	0.8%
Sri Lankan	7	0.1%
White British	1015	21.6%
White Irish	91	1.9%
Total	4689	100.0%

• **Body mass index**[192]	*n*	%
<18.5 kg/m^2	117	3.3%
18.5–24.9 kg/m^2	1651	46.1%
25–29.9 kg/m^2	1047	29.3%
30–34.9 kg/m^2	489	13.7%
35–39.9 kg/m^2	175	4.9%
40–49.9 kg/m^2	89	2.5%
>50 kg/m^2	10	0.3%
Total	3578	100.0%

• **Diabetes**	*n*	%
Diabetic not on insulin	18	8.1%
Diabetic on insulin	12	5.4%
Gestational diabetic not on insulin	163	73.8%
Gestational diabetic on insulin	19	8.6%
Not stated	9	4.1%
Total	221	100.0%

• **Hearing impairment**	*n*
Deaf	3
Hard of hearing	6
Total	9

• **Other disability**	*n*
Mobility problems	6
Visual impairment	4

• **Domestic violence disclosed**	*n*
Total	16

[192] 165 records had no body mass index (BMI) recorded

• **Smoking status**	Q1		Q2		Q3		Q4		Total	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Smoking at booking	105	11.0%	95	9.8%	98	10.5%	98	10.9%	396	11%
Smoking at delivery	62	6.5%	70	7.2%	76	8.1%	77	8.6%	285	8%

• **Alcohol dependency**	*n*
Total	5

• **Drug abuse history**	*n*
Amphetamine	1
Cannabis or marijuana	20
Cocaine or crack	14
Codeine	1
Ecstasy	7
Heroin	3
MDMA[193]	1
Methadone	1
Total[194]	37

[193] 3,4-methylenedioxy-methamphetamine, also known as Ecstasy
[194] Note that some women used multiple types of drug

BIRTH

• **Total deliveries and births**[195]	*n*
Total deliveries	3752
Total births[196]	3818

• **Multiple births**	*n*
Total twins	124 (62 sets)
Total triplets	6 (2 sets)

• **Birth weight**	Smoker at delivery		Non-smoker at delivery		Total	
	n	%	*n*	%	*n*	%
<1500 g	10	3.5%	42	1.2%	52	1.4%
1500–2499 g	30	10.6%	192	5.6%	222	5.9%
2500–4499 g	242	85.2%	3174	91.8%	3416	91.3%
≥4500 g	2	0.7%	51	1.5%	53	1.4%
Total	284	100.0%	3459	100.0%	3743	100.0%

• **Gestation at delivery**	Smoker at delivery		Non-smoker at delivery		Total	
<24 wk	1	0.4%	3	0.1%	4	0.1%
24–31 wk	9	3.2%	41	1.2%	50	1.3%
32–35 wk	13	4.6%	94	2.7%	107	2.9%
36–37 w	41	14.4%	284	8.2%	325	8.7%
38–41 wk	214	75.4%	2933	84.8%	3147	84.1%
≥42 wk	6	2.1%	104	3.0%	110	2.9%
Total	284	100.0%	3459	100.0%	3743	100.0%

[195] Note that nine records are missing from all other statistics in this dataset, as some records were made inactive due to duplicate hospital numbers
[196] Live and still births

• **Age at delivery**	Smoker at delivery		Non-smoker at delivery		Total	
	n	%	*n*	%	*n*	%
<16 yr	0	0%	9	0.3%	9	0.2%
16–19 yr	17	6.0%	96	2.8%	113	3.0%
20–24 yr	67	23.6%	450	13.0%	517	13.8%
25–29 yr	104	36.6%	1009	29.2%	1113	29.7%
30–34 yr	64	22.5%	1102	31.9%	1166	31.2%
35–39 yr	25	8.8%	621	18.0%	646	17.3%
40–44 yr	7	2.5%	158	4.6%	165	4.4%
≥45 yr	0	0.0%	14	0.4%	14	0.4%
Total	284	100.0%	3459	100.0%	3743	100.0%

• **Stillbirths by smoking**	*n*
Smoker at delivery	2
Non-smoker at delivery	18
Total	20

• **Stillbirths by gestation**	*n*
24–29 wk	3
30–35 wk	6
36–39 wk	10
≥40 wk	1
Total	20

• **Maternal deaths**	*n*
Total	0

• **Method of delivery**	*n*	%
SVD[197]	2151	57.3%
Ventouse	410	10.9%
Forceps	176	4.7%
Emergency CS[198]	695	18.5%
Elective CS	322	8.6%
Total	3754	100.0%

[197] Spontaneous vaginal delivery
[198] Caesarian section

• **Water births**	*n*
Labour ward	10
Birth centre	97
Home	28

• **Episiotomy**	*n*
SVD	171
Instrumental	472

• **Midwife to birth ratio**	Apr '14	May '14	Jun '14	Jul '14	Aug '14	Sep '14	Oct '14	Nov '14	Dec '14	Jan '15	Feb '15	Mar '15
Funded:projected births	1:28	1:28	1:28	1:28	1:28	1:28	1:28	1:28	1:28	1:28	1:28	1:28
Actual	1:26	1:28	1:23	1:24	1:29	1:26	1:27	1:26	1:26	1:27	1:28	1:26[199]

• **Care**[200]	%
Midwife-led care	41%
Obstetric-led care	59%
Skin to skin (incl SCBU[201] admission)	73%
Skin to skin (excl SCBU admission)	78%
One to one care in labour	95%

• **Place of birth**	*n*	%
Labour ward or theatre	3246	86.5%
Birth centre	368	9.8%
Home	75	2.0%
Born before arrival	63	1.7%
Total	3752	100.0%

[199] Figure includes bank and agency staff and takes sickness into account
[200] Values for midwife-led care, obstetric-led care and one to one care are proportions of deliveries; values for skin to skin are proportions of infants
[201] Special Care Baby Unit

• **Feeding at delivery**	Q1		Q2		Q3		Q4		Total	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Artificial	91	9.6%	113	11.7%	100	10.7%	113	12.6%	417	11.1%
Breast plus complement	111	11.7%	94	9.7%	95	10.2%	74	8.2%	374	10.0%
Breast	724	76.1%	741	76.5%	722	77.4%	683	76.0%	2870	76.5%
Expressed breast milk	5	0.5%	1	0.1%	3	0.3%	4	0.4%	13	0.3%
Not applicable	5	0.5%	8	0.8%	9	1.0%	7	0.8%	29	0.8%
Not indicated	15	1.6%	12	1.2%	4	0.4%	18	2.0%	49	1.3%
Total	951	100.0%	969	100.0%	933	100.0%	899	100.0%	3752	100.0%

• **Interpreter need**	*n*
No understanding of English	131
Slow understanding – needs interpreter	139
Slow understanding – no interpreter	131

• **Perinatal mental heath**	*n*
Mental health problems	351

• **Parity**	*n*
First baby	1544
Second baby	1202
Third baby	569
Fourth baby	241
Fifth baby	95
Sixth baby	48
Seventh baby	21
Eighth baby	5
Ninth baby	7
Tenth baby	3
Thirteenth baby	1
Not recorded	7

• **Ethnicity at delivery**	*n*	%
Any other Asian background	185	4.9%
Any other black background	182	4.9%
Any other ethnic group	157	4.2%
Any other mixed background	82	2.2%
Any other white background	413	11.0%
Asian Bangladeshi	32	0.9%
Asian Indian	266	7.1%
Asian Pakistani	187	5.0%
Black African	437	11.7%
Black Caribbean	163	4.4%
Mixed white and Asian	5	0.1%
Mixed white and black African	16	0.4%
Mixed white and black Caribbean	48	1.3%
Not stated	573	15.3%
Other Chinese	34	0.9%
White British	956	25.5%
White Irish	7	0.2%
Total	3743	100.0%

POSTNATAL

• **Parents in family**	*n*	%
1	357	9.5%
2	3323	88.8%
Not known	63	1.7%
Total	3743	100.0%

• **Referred to Social Services**	*n*
Child in need	26
Child protection referral	66
Yes – no reason recorded	28
Total	120

• **MMR[202] vaccination**	*n*
Declined	14
Given	141
Mother opted to go to GP	10

• **Payment by Results tariff type[203]**	%
AN[204] – standard	61.1%
AN – intermediate	29.8%
AN – intensive	9.2%
Intrapartum with complication[205]	41.3%
Intrapartum without complication[206]	58.7%
PN[207] – standard	72.7%
PN – intermediate	26.8%
PN – intensive	0.4%

[202] Measles, mumps and rubella
[203] Values for antenatal care are proportions of booked women; values for intrapartum and postnatal care are proportions of women who delivered
[204] Antenatal
[205] March 2015 data unavailable
[206] March 2015 data unavailable
[207] Postnatal

16.9 Data – South West London Maternity Network Dashboard

2014/15 averages and comparison against 2013/14

Performance Measure	Croydon	Epsom and St Helier	Kingston	St Georges	Local average 2014/15	Local average 2013/14
Booking assessments completed by 9 + 6 gestation	17.47%	Data not available	11.78%	37.00%	Data not available from EStH	Data not collection in 2013/14
Booking assessments completed by 12 + 6 gestation	74.46%	87.27%	92.65%	82.24%	84.15%	82.43%
1:1 care by a midwife during labour	95.27%	95.79%	100.00%	74.43%	91.37%	91.97%
Normal Vaginal births	37.5%	31.31%	31.32%	43.45%	35.93%	38.98%
Spontaneous vaginal births	56.96%	57.28%	55.53%	58.57%	57.08%	58.62%
Instrumental births	15.62%	15.17%	15.18%	18.33%	16.07%	15.59%
Caesarean section rate	27.16%	27.54%	28.79%	23.11%	26.65%	25.50%
Planned Caesarean-section	8.63%	9.64%	13.98%	9.76%	10.50%	10.72%
Unplanned Caesarean-section rate	18.53%	17.90%	14.81%	13.35%	16.14%	14.77%
Breastfeeding rates of women breastfeeding exclusively at 10 days postpartum	52.00%	76.04%	Data not available	74.29%	Data not available from Kingston	72.71%
Pre-term babies	2.46%	1.84%	1.16%	3.64%	2.28%	Data not collected in 2013/14
Rate of Neonatal Mortality per 1000 births	0.52	0.60	0.84	2.58	1.16	2.14
Rate of Stillbirths per 1000 births	5.24	3.80	5.52	5.15	4.94	4.13
Number of women giving birth	3752	4923	5739	4929	4836	4898

Number of babies born	3818	5003	5973	5048	4961	Data not collected in 2013/14
Obstetric led births	59.21%	68.61%	78.99%	84.24%	72.76%	77.67%
Home Births	2.04%	1.37%	1.55%	2.15%	1.78%	1.45%
AMU births	9.71%	14.76%	19.07%	12.75%	14.07%	13.97%
Smoking at time of birth	7.60%	5.89%	3.34%	4.67%	5.38%	5.60%

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