REVIEW OF MATERNITY SERVICES IN NORTHERN IRELAND:

CONSULTATION RESPONSE QUESTIONNAIRE ON A DRAFT MATERNITY STRATEGY FOR NORTHERN IRELAND

You can respond to the consultation document by e-mail, letter or fax.

Before you submit your response, please read Appendix 1 about the effect of the Freedom of Information Act 2000 on the confidentiality of responses to public consultation exercises.

Responses should be sent to:

E-mail: secondary.care@dhsspsni.gov.uk

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Room 1, Annexe 1
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Belfast BT4 3SQ

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Responses must be received no later than 23rd December 2011

I am responding: as an individual ☐
on behalf of an organisation ☑

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Proposals within the draft Maternity Strategy

The remit of the Institute of Public Health in Ireland (IPH) is to promote cooperation for public health between Northern Ireland and the Republic of Ireland in the areas of research and information, capacity building and policy advice. Our approach is to support Departments of Health and their agencies in both jurisdictions, and maximise the benefits of all-island cooperation to achieve practical benefits for people in Northern Ireland and the Republic of Ireland.

We welcome this opportunity to comment on the draft Maternity Strategy for Northern Ireland.

Q1.Are the areas covered in the draft maternity strategy comprehensive to meet the needs of the population over the next 5 years? YES/NO

IPH welcomes the adoption of increased awareness of health inequalities as a key area within the strategic context of the strategy. In particular, we welcome the recognition that socio-economic circumstances can be a very important determinant of pregnancy outcomes. Adopting a life course approach to tackling health inequalities offers significant synergy with the forthcoming Public Health Strategy in Northern Ireland.

Beyond the issue of awareness, the strategy could better characterise the health inequality issue in order that more specific targets and actions can be developed. For example specific data on the nature and extent of health inequality associated with pregnancy and birth outcomes could be included, utilising Northern Ireland, Republic of Ireland or UK data where available. This data could encompass socio-economic inequality aspects of some key maternal and neonatal outcomes, for example the risk among lower income/disadvantaged women in terms of

- teenage pregnancy
- lower use of pre-conceptual and early pregnancy folic acid
- later booking with antenatal care, more often in second/ third trimester
- unbooked pregnancies
- smoking before and during pregnancy
- obesity
- low birth weight baby
- congenital anomaly
- stillbirths, perinatal and neonatal mortality
- lower likelihood of breastfeeding initiation.

Analysis conducted by IPH on births in the Republic of Ireland showed that babies born to unemployed women or those in the lowest socio-economic group were far more likely to be low birth weight http://www.publichealth.ie/healthinequalities/healthiinequalitiesandlowbirthweight

Actions are needed to secure better pregnancy outcomes for groups who are known to be at particular risk of experiencing poverty and social exclusion as

their needs are complex and without particular attention these needs may not be adequately met within mainstream provision. This should be more clearly articulated in the strategy. These groups would include pregnant teenagers, lone parents, women prisoners, Travellers and women attending drug and alcohol services.

Greater clarity between the key actions proposed to address health inequalities at the pre-conceptual and antenatal stages would be welcome.

We welcome the overarching commitment to normalise birth as much as possible in the majority of cases. However, we recommend that a similar degree of emphasis and attention should be afforded to achieving better outcomes for at-risk pregnancies whether these pregnancies fit into recognised risk profiles or not. Women who are more likely to experience a high risk pregnancy are listed in sections 1.14, 2.5 and in other sections of the document. However, greater detail should be provided on how optimal outcomes will be achieved for each of these at risk groups in light of their very different risk profiles. For example, further detail is required in respect of securing optimal outcomes for multiple pregnancies, detailing how the NICE guidelines can fit within the current Northern Ireland service context.

The Strategy deals comprehensively with the delivery of health and social services aspect of pregnancy. Many other sectors have a role to play in supporting women to enjoy a healthy pregnancy and maximise the chances of delivering a healthy full term baby. The 'best outcome for women and babies in Northern Ireland' proposed in this draft maternity strategy will depend heavily on service delivery. However, consideration might also be afforded to other relevant domains including

- workplace health and safety for pregnant women (including manual lifting, chemical exposures and communicable disease)
- maternity and paternity leave entitlements ;equality legislation in respect of maternity and breastfeeding rights in the workplace
- social protection including benefits and entitlements intended for children, teenage mothers, lone parents, homeless women and parents of children with disabilities.
- health protection – clear leadership and lines of communication on communicable disease threats such as H1N1strain influenza and general immunisation programmes as they relate to pregnant and non-pregnant women (e.g. immigrant children and others with no MMR vaccination)
- safety guidelines in respect of exposure of pregnant and potentially pregnant women to harmful substances (food safety, environmental exposures, radiation, prescribed and over the counter medications.)
- fortification of foods with folic acid in respect of reducing the population incidence of neural tube defects.

Q2. Do you agree with the outcome for the strategy (chapter 1) YES/NO

Yes

Q.3 Are the challenges recognized for Maternity Services appropriate or do you feel there are others? (chapter 1) YES/NO

Some additional issues are suggested in the recommendations section below.

Q.4 Are the recommendations appropriate or would you like to add/remove any? Chapters 2-6 YES/NO

Some recommendations clearly state the lead agency responsible for implementation but many do not thus potentially reducing accountability mechanisms. In addition, we would welcome specific targets or data indicators in respect of benchmarking changes, e.g. in recommendation 1 this may include levels of maternal obesity and smoking in pregnancy.

For the most part, recommendations are aimed at the population level. There should be clearer recognition of the need to tailor recommendations for different groups in order to reduce the likelihood of inequalities in outcomes occurring.

A number of recommendation-like statements are made in chapters 1, 4 and 5 highlighted in red italics (black italics in one case). The purpose of these statements should be clarified. We suggest recommendations may also be considered in the following areas:

<u>Chapter 2 - Preconception care</u>
Obesity is an important public health issue but we would welcome recognition of the impact of poor nutrition generally on pregnancy which may include underweight.

Public health messages in preconception should also address issues such as the impact of sexually transmitted infection on fertility and pregnancy as well as advice on contraception. This could be integrated into school sex education programmes and outreach programmes for early school leavers.

There should be greater awareness of the need for and access to genetic counselling.

<u>Chapter 3 – Antenatal care</u>
The Public Health Agency could have a role to play in delivering public health messages in pregnancy including the importance of early booking. Data from the Republic of Ireland Perinatal Reporting System demonstrates a significant association between late booking and worse perinatal outcomes. While it is not possible to assume causality given the many confounding variables, the recommendation to facilitate early diagnosis of pregnancy and booking before 12 weeks would seem a sensible goal in terms of improving perinatal outcomes. Women from lower socio-economic backgrounds are over

represented among ‘late bookers’ so this group could reasonably form a particular target for this type of approach and contribute towards the reduction of health inequalities.

The promotion of midwives as the first point of contact in communities is a welcome development. Ideally linkages and referral pathways should be developed by community midwives with those community services associated with vulnerable girls and women including services for early school leavers, children in care, drug and alcohol services and homeless services. Where antenatal education for teenage mothers is delivered as part of a comprehensive package which includes education, social welfare and housing, the risk of low birthweight baby can be reduced.

The distinction between complex and straightforward pregnancies requires clarification if recommendations 5 and 6 are to be meaningful. For example are all obese women considered complex cases? Have established protocols in respect of obese women been developed and evaluated?

There should be a recommendation regarding the holistic care of women who suffer miscarriage, still birth and termination of pregnancy. There should also be a clear mechanism established for the assessment of recurrent miscarriage.

Further detail is required in respect of early pregnancy clinics, particularly regarding the diagnosis of problems in pregnancy and/or miscarriage and the appropriateness of non-maternity trained staff in dealing with these situations.

Chapter 4 – Intrapartum care

A significant change is being proposed in the delivery of maternity services which is likely to take some time to implement. In the intervening period it may be useful to have a recommendation regarding the normalisation of birth within the hospital situation with an emphasis on active labour and minimal medical intervention.

Chapter 6 – Maternity services

Bullet point 4.13 refers to the challenges faced by the maternity service in respect of an increasing number of older mothers and rising levels of overweight and obesity. This sort of horizon scanning is useful and the impacts of these sorts of changes should be more explicitly stated and integrated into the strategy or subsequent service and workforce planning processes. For example, in terms of an increase in the number of older mothers this could be expected to increase the demand on services associated with miscarriage, screening and management of certain congenital anomalies and genetic syndromes. An increase in obesity in pregnancy is likely to result in increased numbers of women with diabetes and gestational diabetes requiring specific additional resources for monitoring.

Similarly it may be helpful to discuss implications associated with increases in

the ethnic diversity of mothers as well as increases in multiple pregnancies associated with fertility treatments. In respect of ethnic diversity in Northern Ireland there is a need for more staff training both in terms of appropriate communication and in recognition of variance in disease risk profile for different ethnic groups.
Q.5 Taking account of the Terms of Reference and content of this document are there any other important issues not addressed? YES/NO
A significant change in the way antenatal and intrapartum care is delivered in Northern Ireland is proposed in the strategy. Notwithstanding the evidence supporting these changes and the experience in other parts of the UK, this change should be evaluated. The strategy should include a statement regarding the approach being taken to evaluation of a new programme of antenatal and intrapartum care in Northern Ireland. The strategy should also clarify whether an action plan will be published subsequent to the strategy and a process for monitoring and review of implementation. Where cost efficiencies are delivered by the changes, these monies could be fed back into the system to further improve outcomes for at risk groups. There is an opportunity to review the routinely collected data and how it can be used to monitor service quality and efficiency and inform quality improvement cycles. A review of the NIMAT system should not be limited to ease of data entry and retrieval but also consider ease of sharing. A health equity audit should be performed to assess health inequalities.
Please use space below to address any issues not asked in above questions We suggest accessing and using the Irish Perinatal Reporting System to cite data on births in the Republic of Ireland (Table 19) instead of the source currently cited. Annual reports are available at www.esri.ie The implications of the forthcoming European Directive on cross-border care should be considered in the management of maternity services in Northern Ireland.

Equality implications

Q6. Do you think the proposals are likely to have an adverse impact on any of the nine equality groups identified under Section 75 of the Northern Ireland Act 1998? If yes, please state the group or groups and provide comment on how these adverse impacts could be reduced or alleviated in the proposals

Yes ☐ No ☐

Some proposals have the potential to adversely impact two groups, age and racial group, depending on how they are implemented.

Q7. Are you aware of any evidence, qualitative or quantitative, that the proposals may have an adverse impact on equality of opportunity or on good relations? If yes, please give details and comment on what you think should be added or removed to alleviate the adverse impact.

Yes ☐ No ☐

No

Q8. Could the proposals better promote equality of opportunity or good relations? If yes, please give details as to how.

Yes ☐ No ☐

There should be more explicit recognition of the greater need of some groups such as those from disadvantaged backgrounds through all stages of maternity services.

THANK YOU FOR YOUR COMMENTS

Appendix 1

FREEDOM OF INFORMATION ACT 2000 – CONFIDENTIALITY OF CONSULTATIONS

The Department will publish a summary of responses following completion of the consultation process. Your response, and all other responses to the consultation, may be disclosed on request. The Department can only refuse to disclose information in exceptional circumstances. **Before** you submit your response, please read the paragraphs below on the confidentiality of consultations and they will give you guidance on the legal position about any information given by you in response to this consultation.

The Freedom of Information Act gives the public a right of access to any information held by a public authority, namely, the Department in this case. This right of access to information includes information provided in response to a consultation. The Department cannot automatically consider as confidential information supplied to it in response to a consultation. However, it does have the responsibility to decide whether any information provided by you in response to this consultation, including information about your identity should be made public or be treated as confidential.

This means that information provided by you in response to the consultation is unlikely to be treated as confidential, except in very particular circumstances. The Lord Chancellor's Code of Practice on the Freedom of Information Act provides that:

- the Department should only accept information from third parties in confidence if it is necessary to obtain that information in connection with the exercise of any of the Department's functions and it would not otherwise be provided

- the Department should not agree to hold information received from third parties "in confidence" which is not confidential in nature

- acceptance by the Department of confidentiality provisions must be for good reasons, capable of being justified to the Information Commissioner

For further information about confidentiality of responses please contact the Information Commissioner's Office at

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