

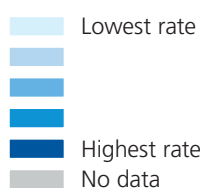
MATERNITY AND REPRODUCTIVE HEALTH

Map 58: Proportion (%) of medical abortions to all legal abortions undertaken at 13 weeks' gestation and under by PCT

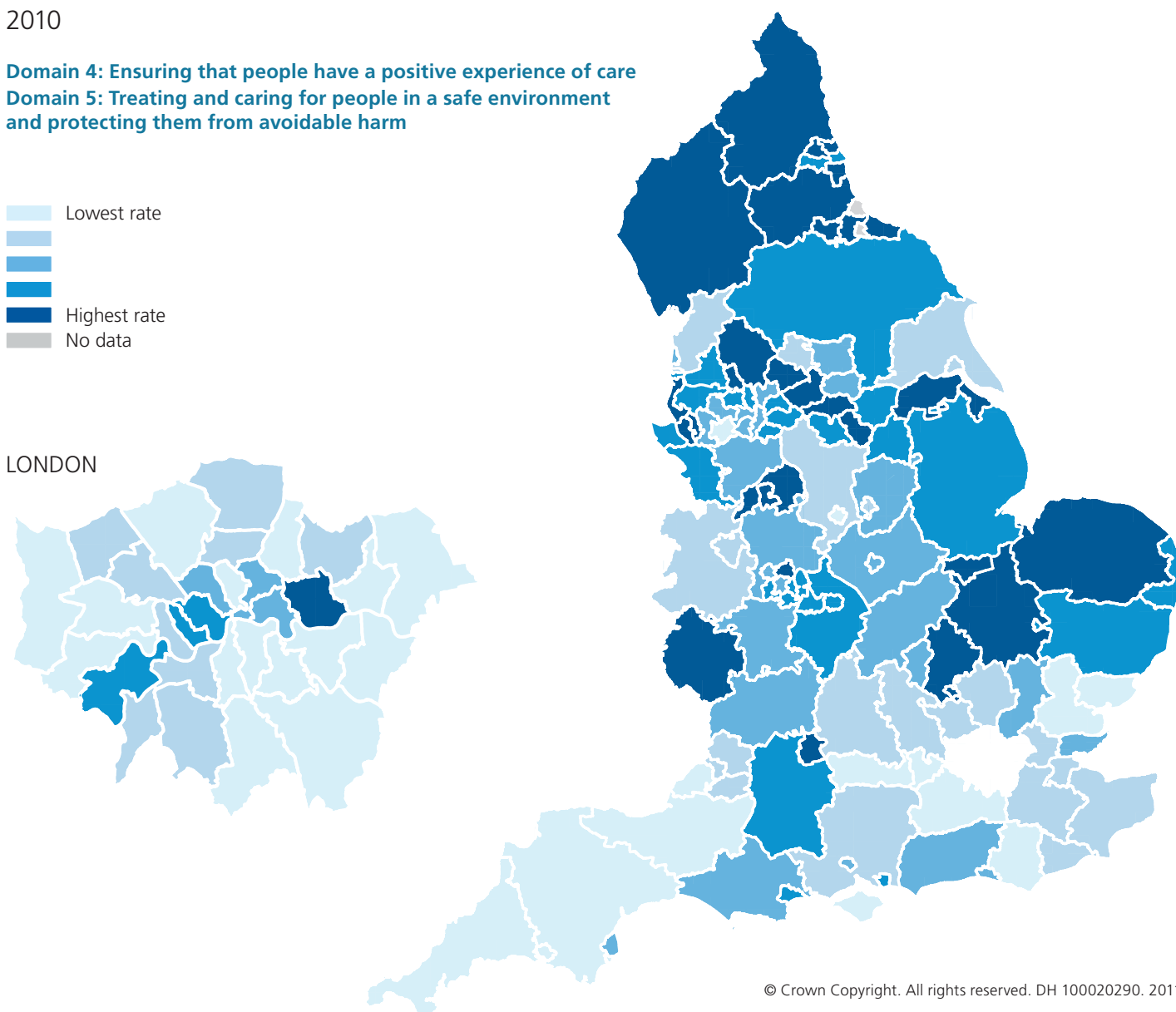
2010

Domain 4: Ensuring that people have a positive experience of care

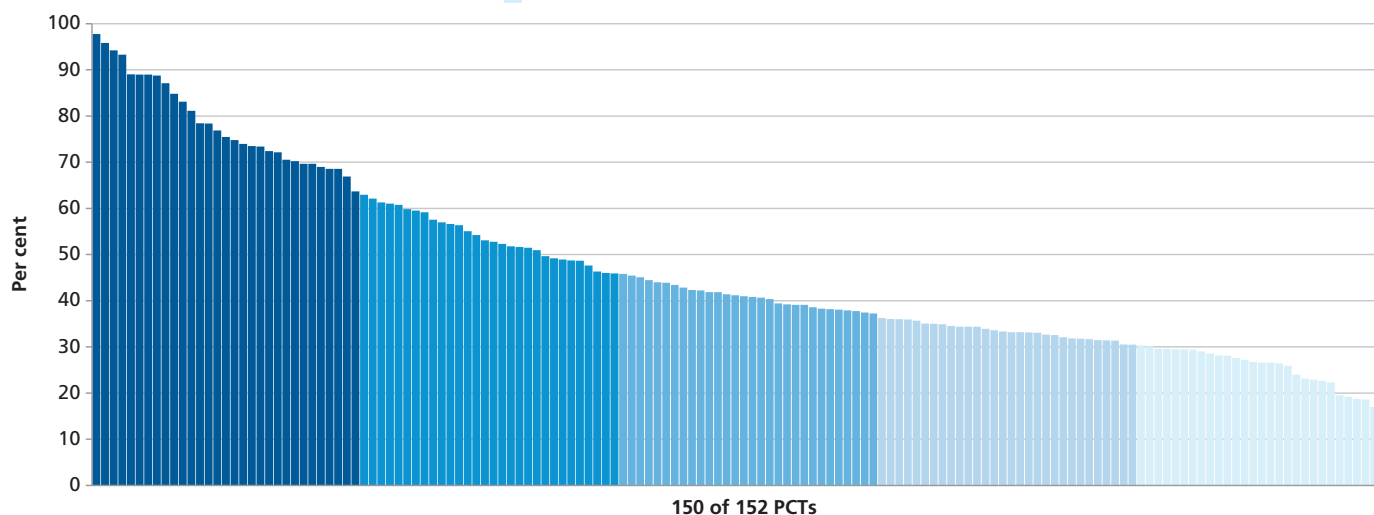
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm



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Context

Over 200,000 legal abortions are carried out in England and Wales, over 98% of which are undertaken because of the risk to the mental or physical health of the woman or her children.

In 2009, the NHS funded 94% of abortions in England and Wales, but over half (60%) took place in the independent sector under NHS contract.

In the Royal College of Obstetricians and Gynaecologists (RCOG) Guideline (see "Resources"), the aim is to ensure that all women considering abortion have access to uniformly high-quality care. It gives recommendations for professionals providing care, but is also a resource for those responsible for planning and commissioning services.

The earlier an abortion is performed, the lower the risk to women. In England and Wales, the proportion of procedures undertaken at gestational age under 10 weeks has increased to 75%. Increasing the number of early abortions results in reduced risks to women for:

- severe bleeding;
- uterine perforation and cervical damage at surgical abortion.

There is a small risk of:

- requiring surgical evacuation after medical abortion (<5%);
- failure to terminate the pregnancy following medical and surgical methods of abortion (<1%).

For abortion under 63 days, early discharge after administration of misoprostol is acceptable to some women. In an evaluation of early medical abortion (EMA; see "Resources"), women chose EMA because it:

- avoided surgery;
- enabled an earlier abortion;
- was less invasive;
- avoided physical trauma;
- avoided the administration of anaesthetic.

There is increasing evidence that taking misoprostol at home is safe. This intervention may be possible in future; at present, it is not legal.

Magnitude of variation

For PCTs in England, the proportion of medical abortions to all legal abortions undertaken at 13 weeks' gestation and under

ranged from 13.5% to 97.8% (7-fold variation). When the five PCTs with the highest percentages and the five PCTs with the lowest percentages are excluded, the range is 19.5–89.0%, and the variation is 4.6-fold.

One possible reason for variation is differences in women's preferences, demonstrating what is known as a preference-sensitive cause of variation. However, it seems unlikely that women's preferences vary to the degree observed in this indicator. It is probable, therefore, that the principal reason for the variation observed is differences in the organisation of service provision, and local practice, for instance, a failure to consider the full range of alternatives for abortion for gestations up to 13 weeks (see Figure 58.1), an example of a supply-sensitive cause of unwarranted variation.

Options for action

Commissioners need to:

- review the balance of medical to surgical abortions locally, and assess whether it meets the needs and preferences of women in the local population;
- ensure that women have access to abortion services locally, including a choice of medical or surgical abortion for all gestations up to the legal limit.

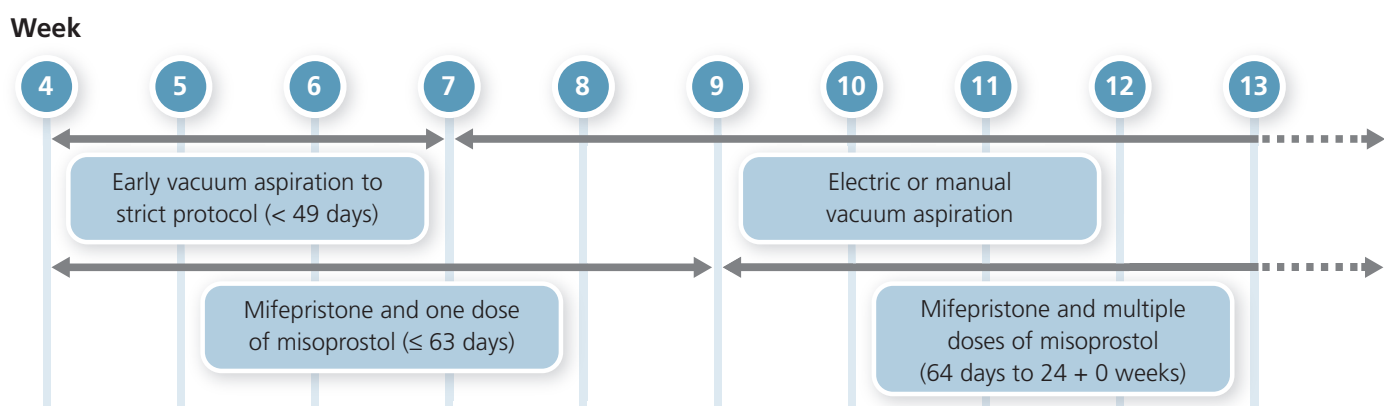
Commissioners and providers should collaborate to develop local pathways, including clinical care after engagement with abortion services.

Commissioners need to ensure that providers are undertaking suitable training and skills development, including developing the role of nurses, and for the counselling of women about their options.

RESOURCES

- Medical Foundation for AIDS & Sexual Health (MedFASH) (2008) Progress and priorities – working together for high quality sexual health. Review of the National Strategy for Sexual Health and HIV. http://www.medfash.org.uk/publications/documents/Progress_and_priorities_working_together_for_high%20quality_sexual_health_FULL_REPORT.pdf
- Department of Health (2008) Evaluation of Early Medical Abortion (EMA) Pilot Sites. Final Report. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084618
- Royal College of Obstetricians and Gynaecologists (2011) The Care of Women Requesting Induced Abortion. Evidence-based Clinical Guideline Number 7. http://www.rcog.org.uk/files/rcog-corp/Abortion%20guideline_web_1.pdf

Figure 58.1: Abortion methods appropriate for use in abortion services in Great Britain up to 13 weeks' gestational age (adapted with permission from the RCOG Guideline Number 7; see 'Resources')

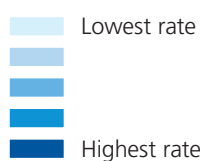


CONDITIONS OF NEONATES

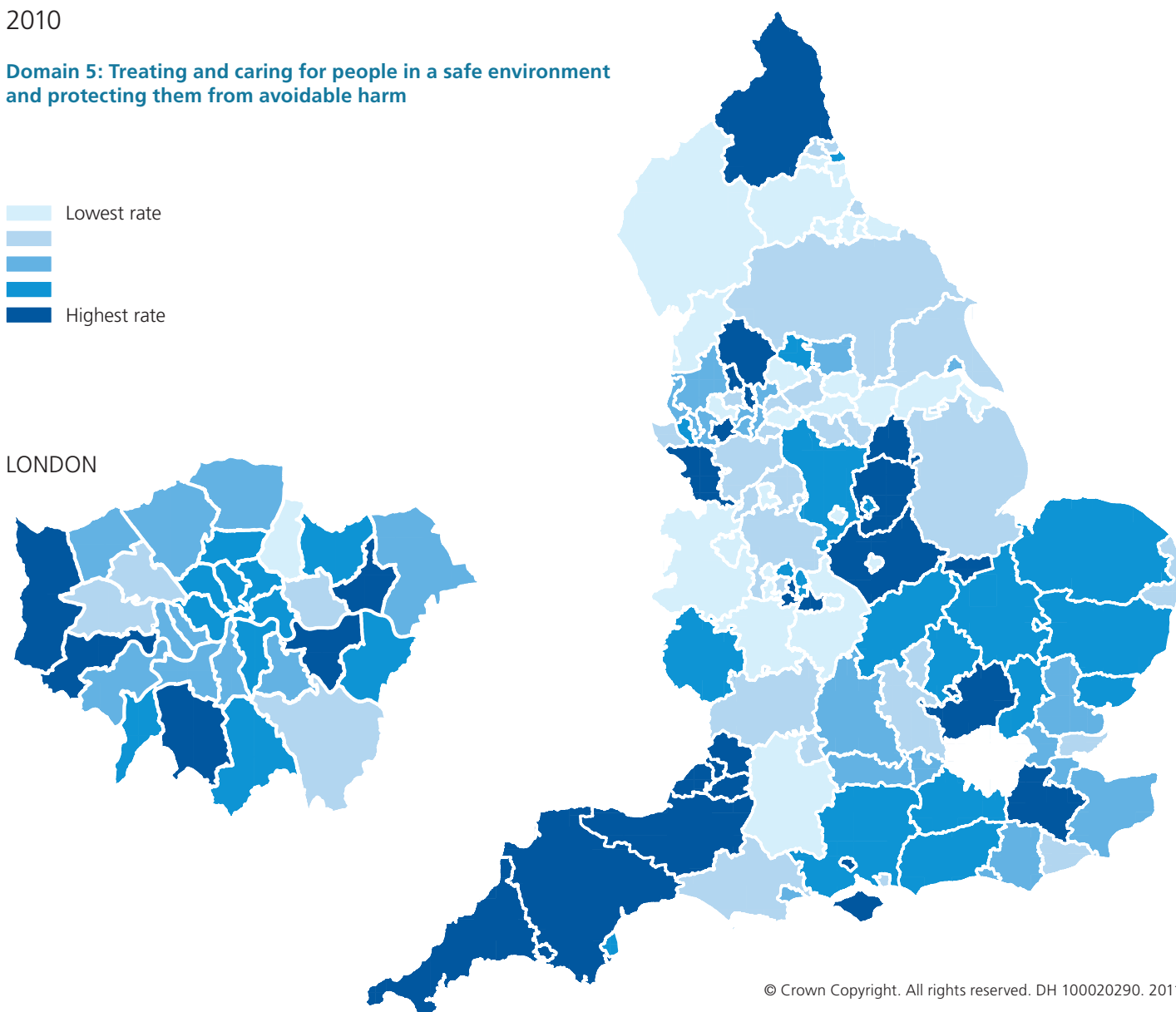
Map 59: Percentage of full-term babies (≥ 37 weeks' gestational age at birth) admitted to specialist neonatal care by PCT

2010

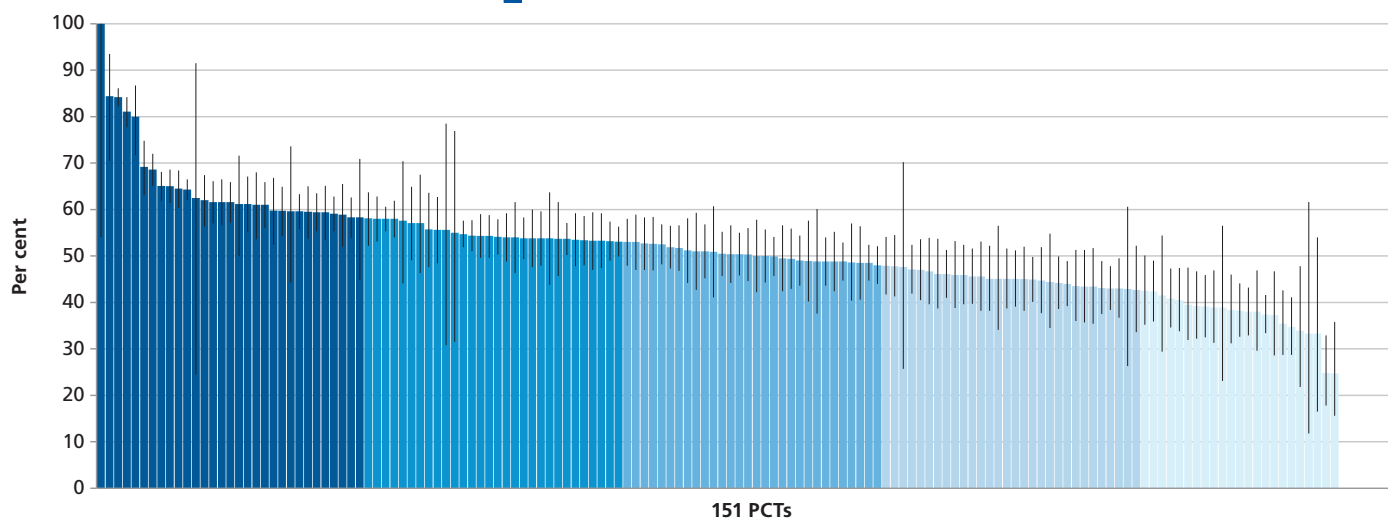
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm



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Context

In the NHS Outcomes Framework 2011/12, this is a national quality indicator.

Most activity in neonatal in-hospital care arises from managing premature babies. The number of premature babies is determined by local demography and socio-economic deprivation, and is not amenable to change through commissioning. However, sick babies of any gestation may be admitted for a variety of reasons amenable to intervention.

The health of newborn babies can be affected by maternal health, including:

- › Smoking habit and alcohol consumption;
- › Conditions such as diabetes.

Newborn babies can have respiratory distress syndrome as a complication of birth by Caesarean section. Often the baby needs to be admitted for treatment.

Record-level data from the National Neonatal Database, which holds live patient data from most neonatal units in England, were analysed by the Neonatal Data Analysis Unit, Imperial College London, to derive PCT-level data according to mother's usual place of residence. Of 171 neonatal units, 135 (79%) had complete data for 2010.

Magnitude of variation

For PCTs in England, the percentage of full-term babies (≥ 37 weeks' gestational age at birth) admitted to specialist neonatal care ranged from 24.7% to 100% (4-fold variation).¹ When the five PCTs with the highest percentages and the five PCTs with the lowest percentages are excluded, the range is 34.7–69.2%, and the variation is twofold.

Although socio-economic deprivation can affect neonatal mortality and morbidity, it has a greater impact on premature births and cannot explain the degree of variation in this indicator, which includes all births.

Possible reasons for variation are differences in:

- › coding;
- › maternal health;
- › access to antenatal care;
- › clinical practice in perinatal care or neonatal team clinical decision-making;
- › admission criteria to neonatal units, special care baby units and transitional care within individual hospitals.

There are parallels with variations analysis of adult intensive care units where bed capacity has an independent effect on the level of medical intervention irrespective of clinical need. The decision to admit a full-term baby to specialist neonatal care is influenced by:

- › the baby's clinical condition;
- › the availability of cots.

Some variation may be due to different levels of provision, exemplifying what Wennberg termed a supply-side cause of unwarranted variation.

In total, 25,420 full-term babies were admitted to 135 reporting neonatal units. The total number of livebirths in England in 2009/10 was 687,007 (ONS, 2010). Assuming rates of premature births of 7% (ONS, 2008), this equates to an average of 4% of all babies ≥ 37 weeks' gestation being admitted in 2010. As there were data for only 79% of units, this percentage could be higher.

Reducing the admissions of full-term babies to specialist neonatal care could save substantial costs and allow resource reallocation.

Options for action

Each neonatal network needs to develop guidelines for clinical admission criteria, and all neonatal units need to implement them.

To reduce complications to newborn babies, commissioners and providers could review:

- › interventions to reduce alcohol consumption and smoking during pregnancy;
- › access to antenatal care and screening.

Commissioners and providers could review local Caesarean section rates in conjunction with admissions of full-term babies to specialist neonatal care.

Performance data could be analysed and benchmarked to enable comparisons:

- › among units in each network;
- › among networks in England;
- › with other developed countries.

RESOURCES

- › NICE Guidance. Gynaecology, pregnancy and birth. <http://guidance.nice.org.uk/Topic/GynaecologyPregnancyBirth>
- › NICE Guidance. Postnatal care: Routine postnatal care of women and their babies. <http://www.nice.org.uk/CG037>
- › NICE Specialist neonatal care quality standard. <http://www.nice.org.uk/guidance/qualitystandards/specialistneonatalcare/specialistneonatalcarequalitystandard.jsp>

This indicator is from the Child Health Themed Atlas

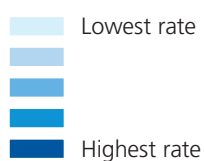
¹ Data from seven PCTs have been removed.

CONDITIONS OF NEONATES

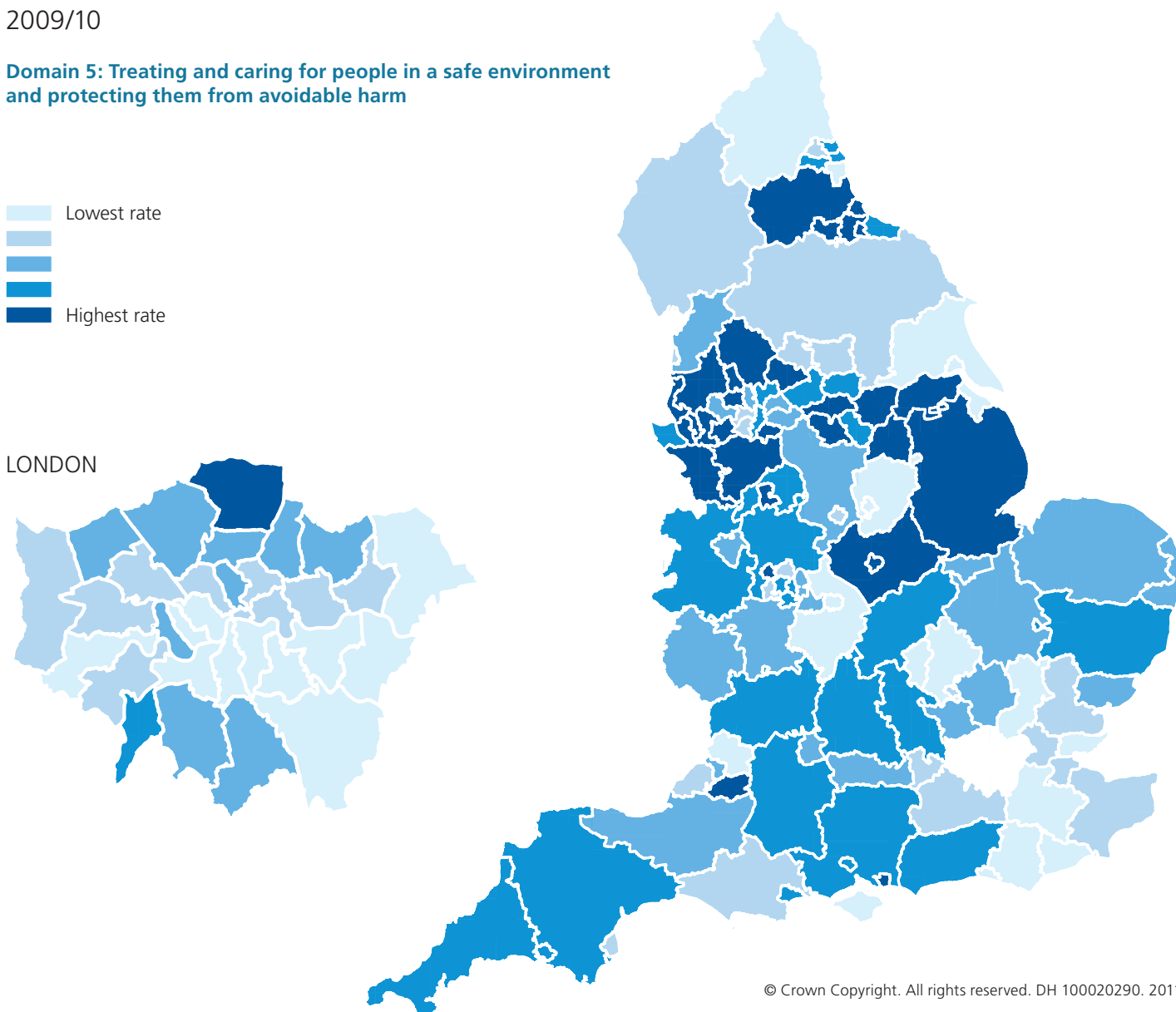
Map 60: Emergency admissions of home births and re-admissions to hospital of babies within 14 days of being born per all live births by PCT

2009/10

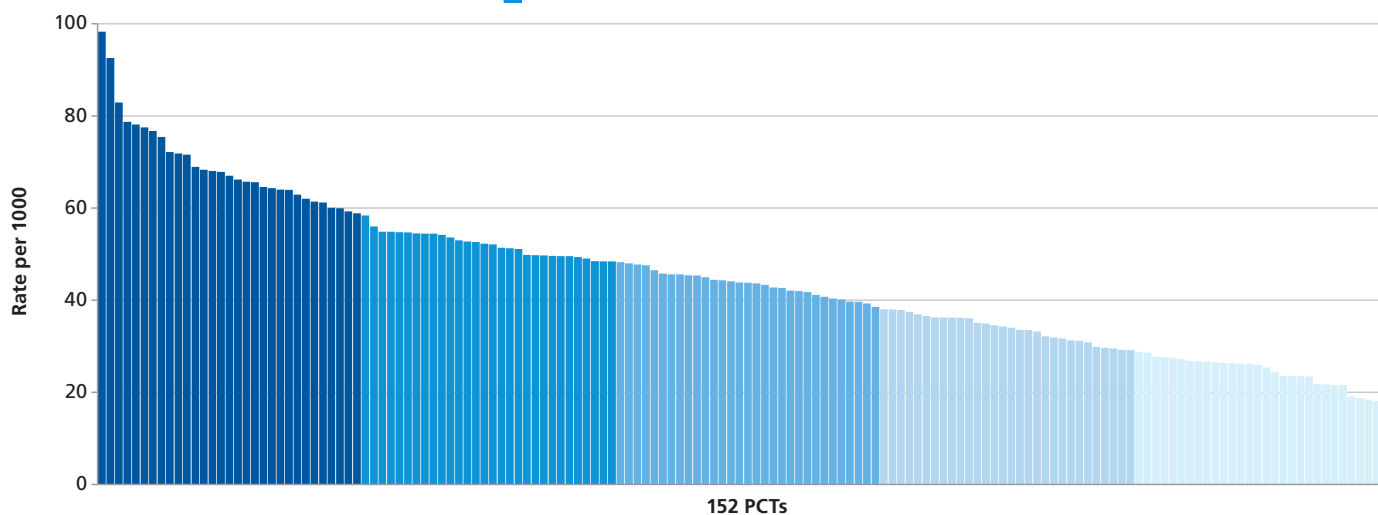
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Context

The Healthcare Commission report *Towards better births: a review of maternity services in England* drew attention to the problem of re-admission of mothers and babies.

*"High levels of re-admissions of either mother or babies can suggest problems with either the timing or quality of health assessments before the initial transfer or with the postnatal care once the mother is home. Dehydration and jaundice are two common reasons for re-admission of babies and are often linked to problems with feeding. Half of the trusts had an admission rate of eight per 1,000 babies or greater for these conditions two or more days after birth."*¹

Postnatal care provision crosses acute and primary healthcare sectors, with the majority of care taking place in the woman's home. Care is likely to include:

- routine clinical examination and observation of the woman and her baby;
- routine infant screening to detect potential disorders;
- support for infant feeding;
- ongoing provision of information and support.

Helping mothers to know what signs and symptoms indicate something serious and what is normal gives them reassurance and confidence.

Giving babies the best start in life through good-quality postnatal care means they are less likely to have health problems during childhood and into adulthood.

Magnitude of variation

For PCTs in England, the emergency admissions of home births and re-admissions to hospital of babies within 14 days of being born per all live births ranged from 15.8 to 98.3 per 1000 (6-fold). When the five PCTs with the highest rates and the five PCTs with the lowest rates are excluded, the range is 21.5–77.5 per 1000, and the variation is 3.6-fold.

Options for action

Commissioners and providers need to ensure that improved antenatal education and information is provided to parents. At each postnatal contact, parents

should be offered information and advice to enable them:

- to assess their baby's general condition;
- to identify signs and symptoms of common health problems in babies;
- to contact a healthcare professional or emergency service if required.

Commissioners should ensure the implementation of the NICE guidelines on postnatal care (see "Resources"), and in particular that:

- examination of the newborn is undertaken by suitably qualified healthcare professionals;
- each woman has her own personalised care plan which takes into account not only her needs but also her baby's.

As a minimum standard, all maternity care providers should implement an externally evaluated structured programme that encourages breastfeeding, such as the Baby Friendly Initiative (see "Resources").

Healthcare professionals need to care for newborn babies according to NICE guidance (see "Resources"):

- evaluating babies who develop jaundice within the first 24 hours;
- for babies aged ≥ 24 hours, monitoring and systematically recording the intensity of the jaundice together with the baby's overall well-being with particular regard to hydration and alertness.

Healthcare professionals need to encourage the mother of a breastfed baby who has signs of jaundice to breastfeed frequently; if the baby is significantly jaundiced or appears unwell, evaluation of the serum bilirubin level should be carried out.

RESOURCES

- NICE Guidance. CG37 Postnatal care – NICE guideline. <http://guidance.nice.org.uk/CG37/NICEGuidance/pdf/English>
- Baby Friendly Initiative. <http://www.babyfriendly.org.uk>
- Royal College of Obstetricians and Gynaecologists (RCOG) Standards for Maternity Care. <http://www.rcog.org.uk/womens-health/clinical-guidance/standards-maternity-care>

This indicator is from the Child Health Themed Atlas

¹ Healthcare Commission (2008) *Towards better births: A review of maternity services in England*. <http://webarchive.nationalarchives.gov.uk/20101014074803/http://www.cqc.org.uk/aboutcqc/howwedoit/involvingpeoplewhouseservices/patientsurveys/maternityservices.cfm>