NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

CLINICAL COMMISSIONING GROUP OUTCOMES INDICATOR SET (CCG OIS) INDICATOR DEVELOPMENT PROGRAMME

Consultation report on potential CCG OIS indicator(s)

CCG OIS indicator area: Antenatal Care

Consultation period: 03/02/2014 – 03/03/2014

Potential output: Recommendations for NICE menu

Introduction

The following report provides a summary of the responses received from the recent consultation on potential new indicators for the 2015/16 Clinical Commissioning Group Outcomes Indicator Set (CCG OIS). The Committee is asked to consider the results of consultation alongside testing reports produced by the Health and Social Care Information Centre.

Indicator(s) included in the consultation

ID	Indicators	NHS Outcomes Framework Domain	Overarching/ Improvement area	Evidence source
IND-4	The proportion of pregnant women accessing antenatal care who are seen for booking by 10 weeks 0 days	1	Reducing premature mortality from the major causes of death	NICE quality standard 22 Antenatal care (2012)
IND-5	The proportion of pregnant women who are not seen for antenatal care by 20 weeks 0 days	1	Reducing premature mortality from the major causes of death	NICE quality standard 22 Antenatal care (2012)

Summary of consultation responses

IND-4: The proportion of pregnant women accessing antenatal care who are seen for booking by 10 weeks 0 days

IND-5: The proportion of pregnant women who are not seen for antenatal care by 20 weeks 0 days

Note: the well-recognised target for early antenatal assessment by 13 weeks is already included within the 2014/15 CCG OIS. It is important to note that the NICE Guideline Development Group agreed three gestations that should be used as audit targets: 10 weeks, 12+6 weeks and 20 weeks of pregnancy. The GDG acknowledged that 10 weeks could be a difficult target to attain, especially for women in vulnerable groups, and so added a second target for early booking; a target well recognised within maternity services, which is booking by the end of the first trimester of pregnancy (12+6 weeks). A gestation for late booking was chosen by consensus based on what the GDG recognised as a widely accepted definition and which is associated with the upper limit for carrying out serum screening for Down's syndrome and anomaly screening using ultrasound (20 weeks). These two potential new indicators for the CCG OIS would complete the set for antenatal booking.

Stakeholders acknowledged that both of these indicators reflect good antenatal care and the importance of early assessment so that identification of factors contributing to maternal mortality and any pregnancy related complications can be identified. Epilepsy Action supported both the 10 and 20 week antenatal booking target commenting that referral to antenatal care to secure specialist opinion early in pregnancy is very important in women with long term medical conditions, including epilepsy and noted evidence showing poor maternal and foetal outcomes in women who access antenatal care late in pregnancy.

Some stakeholders felt that the 10 weeks was unlikely to be achievable for many women since women do not often present until 6 weeks or later, especially in areas of higher deprivation and in women with irregular cycles. It was highlighted that in such cases this would allow maternity services 4

weeks for both the initial midwife contact and booking appointment which was felt to be unfeasible with current restraints. One local council felt this target would result in booking more women who miscarry early in pregnancy and that a 12 weeks target is early enough for Down's syndrome screening and early scanning.

One CCG felt the 20 week target was more important as the potential for harm or missed opportunities is more obvious after 20 weeks. A local council agreed commenting that 20 weeks can be influenced by partnership and developmental programmes as well as commissioning.

Stakeholders suggested that maternity services need to be designed around the local population, integrated with primary care, health visiting and children's services and delivered equitably regardless of ethnicity, sexuality and disability.

Consultation comments

ID	Stakeholder organisation	Comment
IND-4	NHS Stockport CCG	Support its inclusion.
IND-4	Royal College of Paediatrics and Child Health	Fundamentally to this and other similar ones - should this not be 'offered' the opportunity not 'seen'. Seen removes patient choice.
IND-4	Kirklees Public Health Intelligence	Follows NICE recommendations – but how achievable is this? (existing CCG indicator is booking at <13 weeks)
IND-4	NHS Heywood, Middleton and Rochdale CCG	Both of these indicators reflect the importance of good antenatal care to pick up factors that would contribute to the maternal mortality rate and address them early. That said, 10 weeks is unlikely to be achievable. Women on average present around 6/40 pregnant but this can be later in areas of higher deprivation such as HMR. This only gives the maternity service four weeks to both have the initial midwife contact and then arrange a booking appointment which is unlikely to be feasible with current restraints. This needs to be equitably delivered across all the population regardless of ethnicity, sexuality and disability and services to be designed around the local population. It needs to be delivered in line with evidence based guidelines. Again there is a wider project ongoing to determine barriers and variability of care across the area. Maternity services need to be integrated with primary care, health visiting and children's services. Indicators will need to reflect this.
IND-4	NHS Bristol CCG	We note the indicator and its potential value, and have no further comments at this stage.
IND-4	Epilepsy Action	Epilepsy Action fully support this indicator. Early referral to antenatal care to secure specialist opinion early in pregnancy is really important in providing adequate antenatal care to women with long term medical conditions (including epilepsy) [CMACE & CEMACH].
IND-4	Outcomes Based Healthcare Ltd	Summary: Process, not an outcome. Comments as per IND-1. Important (quality) process but not an outcome.
IND-4	Somerset CCG	Antenatal Care - The proportion of pregnant women accessing antenatal care who are seen for booking by 10 weeks For topics that have a number of potential indicators proposed, what do you think are the priority indicators for further development and inclusion in the CCG OIS? Women with irregular cycles might not know there are pregnant in time to book by 10 weeks. Is there any evidence that this would lead to poorer outcomes?
IND-4	Somerset CCG	Do you think there is potential for the indicators to impact differently on any particular groups in terms of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation? If yes, is the impact adverse or positive and in which group? If the impact is adverse, can you suggest how the indicator could be changed in order to reduce the impact?

		Might young women be more likely to delay booking than older women?
IND-5	NHS Stockport CCG	Support its inclusion but prefer IND4 (positive message)
IND-5	Royal College of Paediatrics and Child Health	Fundamentally to this and other similar ones - should this not be 'offered' the opportunity not 'seen'. 'Seen' removes patient choice. (cf IND-7)
IND-5	Kirklees Public Health Intelligence	Follows NICE recommendations – seems sensible to capture this too.
IND-5	NHS Bristol CCG	We note the indicator and its potential value, and have no further comments at this stage.
IND-5	Epilepsy Action	Again we fully support this indicator. CMACE reports have evidenced poor maternal and feotal outcomes in women who accessed antenatal care late in pregnancy.
IND-5	Outcomes Based Healthcare Ltd	Summary: Process, not an outcome. Comments as per IND-1. Important (quality) process but not an outcome.
IND-5	Somerset CCG	The proportion of pregnant women who are not seen for antenatal care by 20 weeks For topics that have a number of potential indicators proposed, what do you think are the priority indicators for further development and inclusion in the CCG OIS? This feels a more important indicator than the 10 week one. Do many women and babies come to harm by not booking by 10 weeks? There is obvious potential for harm or missed opportunities if booking does not happen until after 20 weeks.
General	Leeds City Council Public Health team	I would favour the ones reducing low birthweight and stillbirths, as they cover broad programmes which can be influences by primary care, commissioned services and developmental work (rather than just commissioned services) so I think they are stronger measure of overall CCG outcomes. Of the maternity ones, I would favour the reduction in late booking after 20 weeks, which again can be influences by partnership and developmental programmes as well as commissioning eg health equity audit work and targeted initiatives at vulnerable populations. I am not sure of the rationale for pulling booking forward to 10 weeks which will be very difficult, and will result in booking more women who sadly miscarry early in pregnancy. We have worked to 12 completed weeks to date, which is early enough for Down's screening and early scans.
General	Roche Diagnostics	With the recent introduction of a new payment system for antenatal care, we support the introduction of quality/outcome indicators in this pathway as a priority.
General	National LGB&T Partnership	A lack of patient sexual orientation and gender identity monitoring across the healthcare system means that the needs of lesbian, gay, bisexual and trans (LGB&T) people will not be recognised within this indicator, resulting in adverse impact on these protected characteristics groups. LGB&T people experience a range of health inequalities compared to the general population (see the Public Health Outcomes Framework LGB&T Companion Document for a presentation of the evidence: www.lgf.org.uk/phof) and if their needs are not recognised in resources such as the CCG OIS, there is

		a risk that they will not be acknowledged in service design and delivery, leading to continued inequalities. A continued lack of monitoring affects the ability of CCGs and others in the healthcare system to understand populations and direct interventions and services effectively. NICE should work where it can to influence leaders in the healthcare system to implement comprehensive and consistent patient sexual orientation and gender identity monitoring. CCGs should also be encouraged to take account of local need (presented in documents such as the JSNA) and not focus solely on these indicators at a broad level. Otherwise there is a risk of locally pertinent issues being ignored, such as LGB&T health.
General	The Lesbian and Gay Foundation	A lack of patient sexual orientation and gender identity monitoring across the healthcare system means that the needs of lesbian, gay, bisexual and trans (LGB&T) people will not be recognised within this indicator, resulting in adverse impact on these protected characteristics groups. LGB&T people experience a range of health inequalities compared to the general population (see the Public Health Outcomes Framework LGB&T Companion Document for a presentation of the evidence: www.lgf.org.uk/phof) and if their needs are not recognised in resources such as the CCG OIS, there is a risk that they will not be acknowledged in service design and delivery, leading to continued inequalities. A continued lack of monitoring affects the ability of CCGs and others in the healthcare system to understand populations and direct interventions and services effectively. NICE should work where it can to influence leaders in the healthcare system to implement comprehensive and consistent patient sexual orientation and gender identity monitoring. CCGs should also be encouraged to take account of local need (presented in documents such as the JSNA) and not focus solely on these indicators at a broad level. Otherwise there is a risk of locally pertinent issues being ignored, such as LGB&T health.
General	Epilepsy Action	Reducing premature mortality through antenatal care and reducing deaths in babies and young people Epilepsy Action fully support, both of these aims. Quality antenatal care is key to reducing infant and maternal mortality linked to maternal long term medical conditions (including epilepsy). Epilepsy is the most common serious neurological condition. The UK has approximately 139,000 women with epilepsy of childbearing age. Each year around 2,400 babies are born to mothers who took anti-epileptic drugs to control their epilepsy during their pregnancy. The majority of women with epilepsy experience an uneventful pregnancy, normal labour and give birth to a healthy baby. However, there is a significant increased risk of foetal malformations, developmental delay, foetal and maternal death. Fortunately such complications are rare, but warrant extra caution in monitoring all aspects of maternal and foetal well-being. CCGs have a vital role to play in ensuring that women have timely access to antenatal care. For women with epilepsy, her GP must ensure she is urgently reviewed by a specialist in pregnancy (CEMACH).

		We welcome indicators 4, 5, 15, 16, 17 and 18 accordingly. However to really improve rates of maternal and foetal death associated with maternal long-term conditions, women need access to pre-conception counselling. We would like to propose the addition of a new indicator: • Preconception care: percentage of women with a long term medical condition taking teratogenic medication referred for preconception counselling prior to pregnancy. Preconception counselling (and its indicator) presents an enormous proactive opportunity for CCGs to improve the health and wellbeing of mothers and babies before pregnancy occurs. Access to pre-conception counselling is vital to the future health of women with epilepsy and their unborn baby during pregnancy. Uncontrolled epileptic seizures in pregnancy increase the risk of maternal death. However, taking anti-epileptic drugs (AEDs) in pregnancy increases the risk of malformation and neurodevelopment impairments in the baby. Once a woman discovers she is pregnant, important organs (for example the neural tube) have started to develop in the unborn baby. Making changes to her medication now, increases her risk of seizures and can't reverse any malformations already formed in the unborn baby. Pre-conception counselling allows women to work with specialists to potentially reduce the risks posed to themselves and their future unborn child – before they conceive.