East Midlands Clinical Networks

East Midlands Maternity Services Specification 2017 - 19

Document Outline

East Midlands Maternity Clinical Network - Generic Maternity Services Specification

This document sets out a generic maternity services specification based on the NHS Standard Contract Schedule 2 for 2017-19.

It draws on national documents, published evidence and locally available data and information. This collaborative document has been produced with input from local CCG commissioners of maternity and children's services from across the East Midlands as well as service providers and clinicians.

It recommends an approach to local commissioning based on best practice to support maternity services to reduce unwarranted variation and improve quality outcomes across the East Midlands. It is anticipated that it will be amended following local negotiation but should be seen to represent current best practice.

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1 Background

1.1 Introduction

Maternity Services have been subject to much detailed political and policy scrutiny over recent years and there is a wealth of evidence-based guidance on clinical and cost effective care. Most recently the National Maternity Review 'Better Births' 2015 sets out the 5 year national vision for maternity services to improve outcomes for mothers and babies.

Our vision for maternity services across England is for them to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances.

And for all staff to be supported to deliver care which is women centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries.

Building on this vision this document sets out a generic maternity service specification based on best practice, published literature and input from local CCG commissioners, healthcare professionals and service users across the East Midlands.

These services are unique: they cannot be demand managed and activity cannot be controlled through referrals. They are a core NHS service but one that whilst delivered by acute trusts, happens mainly in the community with interdependencies with primary and community services. This specification reflects the multiagency approach necessary to providing effective maternity services within a Local Maternity System.

Maternity Services in the East Midlands: Key Facts

- 53,641 Live births in 2015
- Across the EM there are 8 maternity services delivering care over 12 sites including 1 freestanding midwifery unit.
- 252 stillbirths in 2015 in the EM
- The East Midlands Clinical Network was established in 2013 and has been supporting local services to reduce variation and outcomes for women and their babies

ITEM	Data Source/year	England	East Midlands
Live Births	ONS 2015	664,852	53,641
Stillbirths	ONS 2015 MBRRACE 2014	2952 4.19 per 1000 total births	252 4.9 per 1000 total births
Perinatal mortality	MBRRACE 2014	5.36 per 1,000 total births	Not available

Infant mortality (first week of life)	HSCIS 2012-14 average	4.1 per 1,000 live births	Not available
Death per live births in first year (infant mortality)	HSCIS 2012 not updated	2.9 per 1,000 live births	Not available
% of all live births with low birth weight <2500g	HSCIS 2013	7.4 per 1,000 live births	Not available
% women smoking at delivery (Q1 16/17)	HSCIS	10.2 per 1000 live births	Not available
% deliveries to mothers aged under 18 years	(13/14)	1.1 per 100 live births	1982 women
% deliveries to mothers aged 35 years and above	HSCIS 2012/13	19.2 per 100	Not available
Admission of full term babies to neonatal care	HSCIS 2012	6.1% of full term live births	Not available
Proportion of babies born to mothers who were born overseas	ONS 2011	24% of births in UK	Not available

1.2 The purpose of the Service Specification

The purpose of this service specification is to:

Inform commissioners, providers and other relevant stakeholders of the standards expected for Maternity services in the East Midlands. The service specification takes a system wide approach that recognises the important role of adjacencies and other services involved in the care of women and children and of their impact on short and long term patient outcomes and experience;

- Sets out the standards expected of maternity service providers
- Describe at a high level the requirements for effective, efficient and reliable maternity services
- Provide a benchmark for identifying specific local areas for development and improvement in line with best practice
- Inform the development of action plans for the achievement of specific goals or targets
- Provide a structure for monitoring and measuring performance against agreed objectives
- Facilitate the planning, implementation and evaluation of changes

1.3 Outcomes

Maternity care is recognised specifically in the Health Outcomes Frameworks and indicator sets and these are included in the specification providing the framework to improve maternity services for women and their babies.

NHS Outcomes Framework	
Domain 1	Reducing deaths in babies and young children – infant and neonatal mortality and stillbirth
Domain 3	Reducing emergency readmissions within 30 days

Domain 4	Improving women and their families experience of maternity services
Domain 5	Improving the safety of maternity services

Public Health Outcomes Framework	
Domain 1	Health Improvement – low birth weight of term babies, breast feeding rates
Domain 4	Healthcare Public Health & preventing premature mortality – reducing infant mortality

CCG Improvement and Assessment Framework 2016/17 MATERNITY	
Better Health	Maternal smoking at time of delivery
Better Care	Neonatal mortality and stillbirths Women's experience of maternity services Choice in maternity services

1.4 Equality and Diversity

Services should explicitly target inequalities in health including mental health, and aim to meet the needs of vulnerable and socially disadvantaged groups. This includes ensuring information about treatment and care is culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. This should include easy reading information available in a range of formats and languages appropriate to the local community.

It is also important that local areas actively engage with women with 'complex social factors' who may be less likely to access or maintain contact with maternity services which can affect outcomes for mothers and babies.

1.5 NICE Guidance

NICE Guidance and standards referred to in this specification are outlined below, along the pathway of care:

NICE GUIDANCE*	Publication Date
Antenatal care for uncomplicated pregnancies CG62	Mar 2008 / Mar 2016
Antenatal Care QS 22	Sept 2012 / Apr 2016
Antenatal and Postnatal Mental Health CG192	Dec 2014 / Jun 2015
Pregnancy and complex social factors CG 110	Sept 2010
Safe midwifery staffing for maternity settings NG4	Feb 2015

Hypertension in pregnancy CG 107	Aug 2010 / Jan 2011
Quitting smoking in pregnancy and following childbirth PH 26	June 2010
Smoking: acute, maternity and mental health services PH48	Nov 2013
Weight management before, during and after pregnancy PH 27	July 2010
Diabetes in Pregnancy NG3	Feb 2015 / Aug 2015
Epilepsies: diagnosis and management CG137	Jan 2012 / Feb 2016
Induction of labour CG70	July 2008
Preterm labour and birth NG25	Nov 2015
Intrapartum Care: Management and delivery of care to women in labour CG190	Dec 2014
Caesarean section CG 132 QS 32	Nov 2011 / Aug 2012
Multiple pregnancy CG 129	Sept 2011
Neonatal jaundice CG98	May 2010 / May 2016
Maternal and child nutrition PH11	Mar 2008 / Nov 2014
Routine Postnatal Care up to 8 weeks after birth CG37	July 2006 / Feb 2015
When to Suspect Child Maltreatment CG89	July 2009

*Please note that the list above reflects the published guidance in October 2016 and the NICE website should be sourced for amended, updated and new guidance. The provider shall adhere to all guidance.

1.6 Workforce Standards

The standards below provide guidance for the development of high quality and safe services and they should be used as a tool for planning and quality assuring maternity services.

Midwifery

- Providers must have a system in place for determining how many midwives are required at all times to safely care for and support women and their babies (see NICE Safe midwifery staffing for maternity settings guidance).
- Midwifery staffing levels should be determined every 6 months for each maternity service (for example, pre-conception, antenatal, intrapartum and postnatal services) and a systematic process undertaken to calculate the midwifery staffing establishment. Review staffing and skill mix, including the percentage of non-permanent staff used to ensure they are appropriate to meet the needs of mothers and their babies (see NICE Safe midwifery staffing for maternity settings guidance).
- A dedicated screening coordinator / midwife and a deputy should ensure protocols and pathways are robustly maintained to; deliver services in line with NSC standards, deliver

training and education, undertake audits and ensure timely data collection for monitoring programmes.

- All women should be provided with 1:1 care during established labour from a midwife, across all birth settings (NICE guidance, Cochrane Review Continuous Support for Women during Childbirth).
- Providers should maintain a Supervisor to Midwife ratio of 1.15 (Nursing and Midwifery Council, Midwives Rules and Standards).
- A midwife labour ward coordinator, to be present on duty on the labour ward 24 hours a day, 7 days a week and be supernumerary to midwives providing 1:1 care (The Kings Fund Improving safety in maternity services, NHS Institute for Innovation and Improvement, NHS maternal death review).

Medical

Ensure levels of obstetrician and anaesthetic cover on the labour ward meet the standards of care, guidance based on numbers of deliveries and complexity of caseload or have a plan to be working towards the appropriate level of presence Royal College of Obstetrics and Gynaecology (RCOG / OAA / AAGBI Guidelines for obstetric anaesthesia services).

Unit Category*	Delivers per year	Consultant presence
	(n)	Hours
A	<2,500	60
B	2,500 - 4,000	60
C1	4,000 - 5,000	98
C2	5,000 - 6,000	168
C3	>6,000	168

*Hospital/unit categories defined in Safe Childbirth

1.7 Tariff & Payment

Payment for maternity services is by tariff under the Maternity Services Payment by Results PBR Guidance 2014-15 DH (2013) and in the National Tariff Payment System 2016/17.

Maternity payments are split into three modules; antenatal care; birth spell to discharge; postnatal care, including the care of well babies. Each module split into levels of intensity based on a woman's characteristics and factors.

Although some elements of the antenatal care pathway may commence early in pregnancy, it will be at the booking appointment where this information will be used to determine the payment level against the maternity tariff. There are three tariffs levels: Standard, Intermediate or Intensive.

Antenatal Care – it is expected most women (65.5%) will be offered core maternity care in line with NICE guidance 62 and NICE Quality Standards 22.

- Primi-gravidas will be offered up to 12 antenatal visits dependant on time of delivery
- Multi-gravidas will receive up to 9 appointments dependant on time of delivery.

- Women will be provided with additional care where they meet the additional criteria

Antenatal Care	Intermediate (27.3%)	Intensive (7.1%)
Current Factors	Complex social factors Obesity BMI >35 Physical Disabilities Underweight BMI <18 Substance/Alcohol Misuse Low pregnancy-associated plasma protein A (PAPP-A) reading	Twins or more Body Mass Index BMI>49
Medical Factors	Mental Health Hepatitis B or C Genetic/Inherited Disorder Epilepsy requiring anti-convulsants Hypertension Previous uterine surgery (exc. LSCS) Serious gastrointestinal condition's	Cardio vascular disease HIV Malignant Disease Diabetes/other endocrine Rhesus isoimmunisation Renal disease Severe (brittle) asthma Autoimmune disease Venous thromboembolic disease Sickle cell/ thalassaemia Thrombophilia/clotting disorder Cystic Fibrosis Previous organ transplant Serious neurological conditions (excluding epilepsy as this is already in the intermediate pathway)
Previous obstetric history	Pre-eclampsia, HELLP Puerperal psychosis Term baby ,21/2kg or 41/2kg Intrauterine growth restriction Placenta accrete Fetal loss (2nd or 3rd trimester) Neonatal death/stillbirth 3 or more consecutive miscarriages early pre-term birth <34 weeks fetal congenital abnormality	Previous fetal congenital anomaly that required specialist fetal medicine

The antenatal payment is payable for all pregnancies that involve an antenatal assessment, regardless of when the pregnancy ends. In some cases of termination or miscarriage, depending on the healthcare requirements of the woman, a birth payment and/or a postnatal pathway payment may still be warranted.

Delivery Spell - Removes payment by type of birth or setting and covers only with (28.6%) or without (71.4%) recognised complications, incentivising normality and proactive antenatal birth.

Postnatal

The postnatal pathway describes the specific characteristics and factors, based on information gathered throughout the antenatal and birth periods that allocate women into a specific postnatal payment category based on expected resource use.

The postnatal care pathway also has three levels of payment based on expected resource usage - Standard, Intermediate or Intensive. The relevant payment will be determined by a woman's specific health and social care characteristics and factors.

These factors and characteristics will include those collected at the antenatal booking appointment, but supplemented with information gathered throughout the previous stages of the maternity.

It is expected most women (64.2%) will require core/standard care where women will be offered core maternity provision in line with NICE postnatal guidance CG37.

	Intermediate (35%)	Intensive (0.8%)
Current factors	Complex social factors Obesity BMI >35 Women in prison Substance/Alcohol Misuse	
Medical factors	Mental Health Diabetes/other endocrine Genetic/Inherited Disorder Rhesus isoimmunisation/other significant blood group antibodies Cardiovascular disease	Renal disease HIV
During this pregnancy	Pre-eclampsia, eclampsia, HELLP Twins or more Diabetes DVT/Pulmonary embolism Hypertension Neonatal death/stillbirth	

Where women receive some of their care from a different provider due to choice or clinical need, this care is paid to the provider by the lead provider.

The following are included in the payment system:

- All routine antenatal appointments, maternity ultrasound scans, and all relevant maternal and new-born screening which is part of National Screening Programmes
- Early Pregnancy Assessment Unit activity
- Fetal medicine

All specialised services activity that is paid for directly by NHS England Specialised Commissioning is excluded from the pathway (for example, pre-pregnancy / pre-conception care and reproductive services).

1.8 Existing Reporting

Maternity services are subject to significant monitoring and reporting of a range of data to a variety of agencies or organisations. The table below provides an overview of the extent of this. It is anticipated that this information together with data set out in the quality framework will form part of the performance and quality monitoring of any contract.

To Whom	What information	Frequency
MBRRACE	Maternal & fetal loss and early neonatal death	As occur
Child Death Overview Panels	All child deaths under 18 years old for any reason	As occur
Antenatal & Newborn Screening Programme	KPI's for all screen programmes, including • AN Sickle Cell & Thalassaemia (SCT) • Downs Syndrome • Infectious diseases in pregnancy (IDP) • Anomaly screening (FASP) • Newborn hearing (NHSP) • Newborn infant examination (NIPE) • Newborn bloodspot screening (NBBS)	Quarterly
CCG Commissioners	Never events • Retained swab, following vaginal birth • Retain instruments/swabs following caesarean section • Maternal death following elective caesarean section for massive obstetric haemorrhage	As occur Report within agreed timescales
CCG Commissioners	Serious Incidents • Acts or omissions in care which caused or contributed towards the outcome	As occur Report within agreed time scales
CCG Commissioners/LA	• Smoking rates at booking and delivery • Breast feeding initiation rates	Quarterly
RCOG – Each Baby Counts	Stillbirths, neonatal deaths and brain injuries occurring due to incidents in labour. All UK units to submit data.	As occurs
Health and Social Care Information Centre Maternity Services Data Set (MSDS)	Routine data collection for: • routine booking appointment activities • maternity care plan • dating scan • antenatal screening tests • structural fetal anomaly screening • labour & delivery • newborn screening • maternal or neonatal death	Monthly data submitted over the following 2 months

1.9 RightCare Commissioning for Value (CfV)

The NHS RightCare programme is designed to provide intelligence to make sure that the right person has the right care, in the right place, at the right time, making the best use of available resources.

It is committed to giving clinical commissioning groups (CCGs) and local health economies practical support in gathering data, evidence and tools to help them improve the way care is delivered for their patients and populations and reduce unwarranted variation. Providers are encouraged to work with local commissioners to consider how this information can support local quality and service improvement.

The focused data packs were published in April 2016 and include data on maternity and early years and the refreshed packs by CCG for October 2016 can also be accessed here.

2 SCHEDULE 2 – THE SERVICES

A. Service Specifications

Mandatory headings 1 – 4: mandatory but detail for local determination and agreement
Optional headings 5 – 7: optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

Service Specification No.	
Service	Maternity Services
Commissioner Lead	
Provider Lead	
Period	2017-19
Date of Review	

1. Population Needs

1.1 National Context

Good maternal health and high quality maternity care is not confined to the antenatal and intrapartum period but also includes preconception health, counselling and adequate postpartum care extending into the early childhood years. Good quality care can have a positive impact on the health of newborn babies, on the healthy development of children, on their resilience to health problems including later in life. Having a baby is the single most common reason for admission to hospital and the experience families have around pregnancy often affects their long-term health and wellbeing and their future interactions with health services. Good quality care should encompass women's physical mental and psychological wellbeing, which must be personalised. Safe, high quality Maternity Services are fundamental to reducing infant mortality and increasing life expectancy. The foundations for healthy human development; '*physical, intellectual and emotional'*, are laid in utero and in the early childhood years, thus every child is entitled to the best possible start in life.

The second of the Confidential Enquiry into Maternal Deaths annual reports produced by the MBRRACE-UK collaboration and published in 2015; observes that overall there has been a statistically significant decrease in the maternal death rate between 2009-12 and 2011-13 in the UK. Maternal death rates from direct causes continue to decrease, but indirect maternal death rates remain high with no significant change in the rate since 2003. Almost a quarter of women who died between six weeks and one year after the end of pregnancy died from psychiatric disorders, and this report has identified a number of key messages to improve the care of women with mental illness. There was very clear evidence of fragmented care, gaps in care, and a lack of an individual taking overall responsibility for each woman which was particularly evident postnatally.

The vision of the national maternity review Better Births 2016 recognises that every woman, every pregnancy, every baby and every family is different. Therefore quality services (safe, clinically effective and providing a good experience) must be personalised.

Maternity services face considerable demographic and social challenges;

- increasing complex needs with higher maternal age, rising obesity, smoking, alcohol and substance misuse
- increasing numbers of vulnerable women and families, including those with learning disabilities
- maternal mental health and perinatal mental health

The total number of births in England has fluctuated. In *[local area]* the number of births in 2016 is predicted to *increase/decrease* to *XXXX*. Whilst outcomes are generally good, there is a high degree of unexplained variability around the country and international comparisons suggest room for improvement. The rates of stillbirth, perinatal mortality, neonatal and infant mortality are all declining in England yet remain greater than many European countries. The regional averages can hide wide variations in the level of service provision and configuration and in available outcome measures. There are particular challenges faced in [local area] in relation to factors which may influence a healthy pregnancy and birth and impact maternal and infant health.

1.2 Local Context

To be completed by local commissioners - consider local JSNA, local trust dashboard data, service user feedback from FFT, CQC maternity services survey and local CHIMAT data. http://www.chimat.org.uk/maternity

1.2.1 Sustainability and Transformation

Services should contribute to local maternity systems (LMS) supporting and informing local sustainability and transformation plans (STPs)

1.2 National Evidence Base

Please note that the list below reflects the published guidance as at October 2016 and the relevant websites should be sourced for amended, updated and new guidance as published. The provider shall adhere to all guidance.

The major drivers include:

- CCG Improvement and Assessment Framework 2016-17
- The NHS Outcomes framework 2016-17
- The Governments Mandate to NHS England 2016-17
- Public Health Outcomes Framework 2013-16
- Healthy Child Programme 0-19years 2016
- Local Supervising Authority Single Operating Model 2016
- Saving Babies Lives, a care bundle for reducing stillbirth, 2016
- Sustainability and Transformation Plans 2016
- Spotlight on Maternity 2016
- Better Births National Maternity Review 2015
- Hidden Voices of Maternity 2015
- State of maternity services report (RCM) 2015
- Fathers in the first 1001 days 2015
- MBRRACE report 2015
- Five Year Forward View 2014
- NAO Report Maternity Services in England Nov 2013
- Prevention in mind – all babies count: Spotlight on Perinatal Mental Health 2013
- Birthplace in England 2012
- A Government pledged in 2012 set out to improve maternity care. The pledge includes one named midwife overseeing antenatal and postnatal care and one-to-one midwife care during labour and delivery. *"Continuity in all aspects of maternity care is vital, from antenatal care through to support at home. Mothers and their families should feel supported and experience well-coordinated and integrated care." (para 2.39)* In addition the importance of choice was also recognised in this document *"Choice is critical to giving service users more power in our systems. During 2012/13 this means continuing the implementation of choice about*

maternity care." (para 3.22)

- NICE Standards and Guidance – see section 1.5
- National Maternal and Neonatal Screening
- Safer Childbirth – standards for the organisation and delivery of care in labour
- Royal College of Obstetrics and Gynaecology good practice documents on consultant presence on labour wards

2. Outcomes

2.1 Outcomes Frameworks Domains & Indicators

The expected service outcomes should be aligned to the NHS Outcomes framework 2016-17, CCG Improvement and assessment framework 2017-19 and the Public Health Outcomes Framework 2013-16. Those related to this specification include:

Domain and description	NHSOF	CCG IAF 16/17	PHOF
Domain 1: preventing people from dying prematurely	Reducing deaths in babies and young children Overarching indicator 1c Neonatal mortality and stillbirths 1.6i Infant mortality (PHOF 4.1)	1.14 Maternal smoking at time of delivery 1.25a Neonatal mortality & stillbirth	
PH Domain 2: **Health Improvement**			2.01 Low birth weight of term babies 2.02i Breastfeeding initiation 2.03 Smoking status at time of delivery 2.04 Under 18 conceptions 3.02 - Chlamydia detection rate (15-24 year olds) (Female) 3.03xv - Population vaccination coverage - Flu (at risk individuals-specifically pregnant women)
Domain 3: Helping people to recover from episodes of	Overarching indicators 3a Emergency admissions for acute conditions that should		

ill-health or following injury	not usually require hospital admission 3b Emergency readmissions within 30 days of discharge from hospital (PHOF 4.11) *To reflect a reduction in the impact and incidence of morbidity following childbirth*		
Domain 4: Ensuring people have a positive experience of care	4.5 Women's experience of maternity services	125b Women's experience of maternity 125c Choice in maternity services	
Domain 5: Treating and caring for people in safe environment and protecting them from avoidable harm	5a Patient safety incidents reported Improving the safety of maternity services 5.5 Admission of full term babies (37+) to neonatal care include only higher levels (1-3) of specialist neonatal care		

2.2 Local Outcomes

The service provider will deliver improved outcomes for mothers and babies with reduced risk of morbidity and mortality, stillbirth, low birth weight and infant mortality, by working in partnership with the local health economy where appropriate.

Care will be delivered in line with national standards and evidence based practice and will be responsive to local population needs, women's choice and personalisation of care.

Details of anticipated clinical and quality outcomes and their measurement is given in Section 5.

The services will be an integral and influential partner in a Local Maternity Systems (LMS) which promotes early presentation to maternity services, maximising benefit and enabling intervention around behavioural risk factors to improve outcomes for pregnant women and their babies.

3. Scope

3.1 Aims and objectives of service

Commissioned maternity services in the XXXX CCG area are based on the Better Births vision for maternity services across England. They should become safer, more personalised, provide continuity of carer, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is joined up and centred around their individual needs and circumstances. And for all

staff to be supported to deliver care which is women centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries.

These services should provide high quality, evidence based and safe care, delivered at the right time, in the right place, by a properly planned, educated and trained workforce, and that women and their families have access to the personalised services and support they need during pregnancy, childbirth and postnatal period and into early childhood.

This will be delivered by:

1. Personalised care, centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information
2. Continuity of carer, to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions.
3. Safer care, with professionals working together across boundaries to ensure rapid referral, and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation, honesty and learning when things go wrong.
4. Better postnatal and perinatal mental health care, which can have a significant impact on the life chances and wellbeing of the woman, baby and family.
5. Multi-professional working, breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies.
6. Working across boundaries to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed
7. A payment system that fairly and adequately compensates providers for delivering high quality care to all women efficiently, while supporting commissioners to commission for personalisation, safety and choice.

3.2 Basic commissioning principles

- The Provider will use a Maternity Dashboard based on CMO Annual Report (2006) and RCOG (2008) as agreed with local commissioners. This may be reviewed in year in line with the proposed development of a national dashboard as part of the implementation of the national Maternity Review recommendations.
- The Provider is expected to supply regular reports of activity, broken down as agreed, based on electronic records. Reports will reflect the monitoring priorities of the CCG, which may change in the light of new information and in discussion/consultation with stakeholders.
- A series of clearly defined indicators will form the basis of performance monitoring covering the clinical pathways and will include staff skills and attitudes and service user feedback.
- The Provider will work with Commissioners to resolve external or third party issues that impact on service provision
- Full compliance with all aspects of this service specification is expected and if any aspect is not achieved this constitutes non – compliance and this must be discussed with Commissioners at the earliest opportunity to agree a way forward. However, commissioners will recognise actions and progress towards compliance.
- Payment will be made in line with national Maternity Pathway Tariff Payment system and relevant PBR tariffs.

3.2 Service description/care pathway

This specification encompasses all elements of the services regardless of location of service delivery and covers the following aspects of maternity provision

- Pre- pregnancy care
- Antenatal care
- Screening
- Intra-partum care
- Post-natal care for mother and baby

3.2.1 Service Description

Access Principles

Providers will:

- Deliver core services related to birth and emergency assessment and care 24/7, 365 days of the year and provide clearly identified 24/7 direct telephone access.
- Offer routine assessment and care, not associated with delivery, in a more restricted time banding appropriate to the nature of that service, but with home visiting available seven days per week.
- Work in partnership with other local units to proactively manage any ward closures. Have in place a robust escalation policy around managing capacity and acuity which is monitored and reported.
- Provide clear communication to women and their families in the event of ward closure and care transfer on birthing place of choice.
- Provide information about the service and care in a way that is accessible to all services users including those with learning disabilities or where English is not their primary language.

3.2.2 Preconception

All maternity care providers should promote the provision of the following information to women and their partners around the importance of;

- pre-conceptual folic acid
- minimising alcohol intake
- not smoking during pregnancy and having a smoke-free environment
- pre-pregnancy flu, pertussis and rubella immunisation – guidance from NHS England (NHS England pertussis vaccination in women 2015)
- seeing a healthcare professional as early as possible in pregnancy

Women with relevant clinical conditions such as epilepsy, personal or family history of congenital or chromosomal anomalies, diabetes, previous poor obstetric history, history of mental health problems or those at high risk of developing pregnancy complications should have access to preconception advice from relevant health professionals where they can make informed decisions about their care and treatment, in partnership with their healthcare professionals.

Obstetric support should be easily available (Note this is excluded from the maternity tariff.) or pathways for referral should be clearly defined for example as per NICE guidance CG137 Epilepsy, NG3 Diabetes

3.2.3 Under 18 conceptions

- In line with expectations around partnership working the Provider shall support initiatives targeting the reduction of second and subsequent pregnancies for young people with whom the service is engaged.
- The Provider shall support and work collaboratively with the 0-19 Public Health Services and similar programmes and provide a clear pathway for support for teenage and young women who are pregnant.

3.2.4 Antenatal Care

Providers will:

- Deliver ante-natal care in accordance with NICE guidelines, including Quality Standard 22 and CG62 2016
- Offer antenatal services in a range of settings appropriate to the nature of the type of intervention being delivered and the needs of the client taking into consideration questions of equity and efficiency, Community Hubs
- Collaborate between primary and secondary care to promote early access to services to facilitate early referral and appropriate screening to meet national booking targets
- Routinely notify booked women to the Health Visiting Service by 16 weeks of pregnancy and

refer to Family Nurse Partnership for all eligible young women in a timely manner

- Have in place an explicit process of direct access to midwives as a first point of contact when pregnancy is confirmed and increase the proportion of women accessing maternity services by 10 weeks This avoids delays and will help ensure early antenatal screening standards are met
- Make information available to prospective parents with clear explanations of the roles of healthcare professionals and peer supporters involved, to help them understand the services provided and make informed choices. Including information about the purpose and timing of appointments and an individualised programme of appointments shall be agreed based on the clinical need of the woman, and in line with NICE guidance
- Where appropriate, promote pregnancy and birth as a normal life event and in line with the principles outlined in Better Births, providing unbiased information to inform choice of type of care and place of birth
- Deliver continuity of care across the maternity pathway and ensure all women have a named midwife, units should be working towards continuity of carer as set out in Better Births
- Ensure that safeguarding is embedded across the pathway following local safeguarding board procedures.
- Promote breastfeeding and UNICEF Baby Friendly principles
- Offer antenatal screening in line with the UK National Screening Programme
- Consider testing for chlamydia in under 25 year olds as part of the pathway of antenatal care
- All women will have carbon monoxide testing to assess exposure to tobacco smoke at booking and **36** weeks gestation and throughout the pregnancy. All women who smoke will be offered opt out referral to smoking cessation services and risk assessed and managed accordingly in line with PH26 and PH48.
- Screening of mental health and current emotional wellbeing as a minimum at booking and again between **26 and 30** weeks of pregnancy in line with CG192 Antenatal and postnatal mental health guidance.
- Deliver and discuss appropriate health promotion information on healthy diet, folic acid, vitamin D, refer to Healthy Start Programme and promote healthy start vitamins to eligible families Discuss the benefits of seasonal flu vaccine and whooping cough vaccine
- Provide all women with a personal maternity record that is accessible to professionals providing maternity care
- Refer women with a BMI of over 35 to an obesity pathway in line with East Midlands raised BMI standards
- Have in place pathways and provision to support women or their partners with learning disabilities in line with recommendations from Hidden Voices of Maternity
- Manage women with complex fetal conditions within a recognized agreed feto-maternal medicine pathway
- Providers should have expertise available for women who have had female genital mutilation in relation to supporting and safeguarding, in accordance with national guidance and ensure that they comply with reporting requirements
- In line with the Saving Babies Lives national care bundle, undertake actions to ensure formal risk assessment and management of women at risk of stillbirth
- Raise awareness of detecting and reporting reduced fetal movements
- Ensure a standardised approach and management to the identification of the growth restricted baby, which involves appropriate referral to the maternity team care
- Support all women to have a birth plan in place by 36 weeks gestation and reconsider birth place of choice
- The service delivery model will meet the needs of pregnant women with complex social factors including alcohol and substance misuse in line with NICE CG110 and provide enhanced antenatal care in line with the maternity tariff
- Perform domestic abuse routine enquiry at the earliest safest opportunity
- Prepare women and their partners for parenthood via antenatal education programmes or 1:1 sessions where required. Signpost all women to the NHS Information Service for Parents and educate women about benefits available, in line with Preparation for Birth & Beyond (2011)
- Discussion re contraception following birth and linking this into the 6 week GP check. .

- Promote and offer all pregnant women a pertussis (ideally at 20 weeks, but up to 32 weeks) and annual flu vaccination (any gestation) (commissioned by NHS England).

3.2.5 Intrapartum Care

Providers will:

- Deliver intrapartum care in line with NICE CG 190 and minimum standards for organization and care in labour irrespective of place of birth
- Demonstrate achievement of 1:1 midwifery care in established labour
- Identify clear criteria for obstetric intervention and clear procedures for dealing with obstetric or medical emergencies
- Ensure there are opportunities to have home births for all low risk women
- All staff who care for women in labour to undertake and pass an annual training and competency assessment on cardiotocograph (CTG) interpretation and use of auscultation. No member of staff should care for women in a birth setting without evidence of competence within the last year.
- Buddy system in place for review of cardiotocograph (CTG) interpretation, with protocol for escalation if concerns are raised. All staff to be trained in review system and escalation protocol.
- Ensure there are facilities or clear pathways in place to provide high dependency care
- Put in place appropriate arrangements to notify other services involved in a women's care following birth for example children's social care, mental health services, health visiting, GP's and Drug and Alcohol Services
- Ensure arrangements are in place for open access for birthing companions particularly for those with additional needs

3.2.6 Postnatal Care

The Provider will:

- Ensure all women should have access to their midwife as they require after having had their baby.
- Maternity services should ensure a smooth transition from midwife, obstetric, neonatal care and appropriate liaison with ongoing community support from their community midwife, health visitor, GP and any other service involved in her care.
- Offer all women at least 3 face to face postnatal contacts in the most appropriate environment and home visiting should be provided wherever required
- Undertake a needs assessment on health, social and environmental factors to provide a personalised postnatal birth plan for all women
- Ensure that the initial newborn physical examination is undertaken prior to discharge if possible or within 72 hours of birth following a robust referral mechanism.
- Offer newborn screening tests to all babies in line with UK National Screening Programme
- Ensure that all women to be monitored for signs of post-delivery physical and mental ill health and given advice on warning signs prior to discharge
- Assess mental health and current emotional wellbeing in line with CG192 Antenatal and postnatal mental health guidance.
- Ensure new parents are given support in adapting to parenthood
- Encourage and offer all mothers and babies appropriate protection from disease and ill health through uptake of immunisation programmes
- Provide post-delivery contraception advice to all women
- Ensure women and infants will be discharged post birth following handover to and engagement of appropriate services as per care plans
- Promote UNICEF Baby Friendly principles for breast feeding and bonding
- Promote principles for safe sleeping UNICEF Baby Friendly and NICE CG37
- Reinforce postnatal non-smoking messages

3.2.7 Specialised Services

Throughout the processes described, there will be a need for services, provided in partnership with other agencies to deal with cross cutting issues or relatively rare events. This includes identifying pathways to access specialised services including specialised fetal medicine, perinatal mental health, the management of complex maternities and appropriate levels of neonatal care.

3.2.8 Workforce standards

- The provider will work towards having a 1:29 birth to midwife ratio. (Birthrate Plus) and follow recommendations of NICE Guidance NICE NG4
- Ensure levels of obstetrician and anaesthetic cover on the labour ward meet the standards of care guidance based on numbers of deliveries and complexity of caseload or have a plan to be working towards the appropriate level of presence. (RCOG, Safer Childbirth 2007)
- The provider will ensure that any statutory changes to the supervision of midwives are adopted
- Provider organisation boards should promote a culture of learning and continuous improvements to maximise quality and outcomes from their services, including multi professional training.

3.2.9 Service user engagement

Supporting the delivery of the Better Births vision of greater service user engagement and feedback is essential to inform service improvements. Providers are expected to:

- Put in place mechanisms to gain feedback from service users to inform service user experience
- Participate in the net promoter programme (Friends and Family Test) and additional mechanisms as necessary
- Support participation in the CQC national maternity services survey to inform the CCG IAF indicator 125b experience of maternity services and choice in maternity services 125c.
- Actively participate in and promote a local maternity services forum which may be an existing maternity Services Liaison Committee (MSLC) or alternative joint forum including, commissioners, users and provider services
- Use both positive and negative feedback to drive and evidence continuous service improvement to best meet mothers and family's needs
- Demonstrate active engagement with service users in the planning and development of services

3.2.10 Data

NHS England's *Better Data, Informed Commissioning, Driving Improved Outcomes: Clinical Data Sets* states that all NHS funded providers (including independent sector) are required to comply with data collections that have been approved by the Information Standards Board. The Maternity and Children's Data Set is one of the approved data collections and providers are required to put in place mechanisms to collect and submit this data electronically in line with data quality standards and the reporting schedule which are based upon fixed period reporting. The provider is expected to maintain a level of continuity in the timeliness of their submissions.

Information is also required by the health and local authority commissioners in relation to specific areas including: - Teenage pregnancy, female genital mutilation (FGM), maternal mental health, breastfeeding initiation and access to maternity services by 10 weeks and 12 weeks +6 days. Smoking in pregnancy (SATOD), note that women of unknown status will not be included in the not smoking group. All information will need to be available on a CCG basis.

Service providers will be expected to produce and share their quality dashboard. Dashboard data requirements are set out in Section 5.0 the quality improvement framework.

3.2.12 Tariff Payment

The antenatal and post-natal tariff elements will be paid to the provider based on information

supplied. The pathway provider will be paid for each module of the pregnancy. Fetal medicine is included in the maternity tariff. Where a woman receives care from a different pathway provider due to choice or the need to transfer the subsequent provider will be paid by the commissioned pathway provider under recharging arrangements.

3.3 Population covered

The services outlined in this specification are for women resident within the geographical area covered by ***the commissioning CCG***

3.4 Acceptance and exclusion criteria

All women requiring antenatal, intra-partum and postnatal care, including fathers/partners or other appropriate family members.
No exclusion criteria

3.5 Interdependencies on other services

- Maternity Networks - Cooperation through maternity networks to ensure local patterns of services meet women's needs and expectations for themselves and their babies
- Neonatal Networks

3.5.1 External

The Provider will make appropriate links with **0-19 health services** which play an important role in identifying and supporting pregnant women with complex social issues that may impact on the health of themselves and their baby.

The Provider will engage with **healthy child programme** through **health visiting services** to facilitate an antenatal visit and then work with and have in place effective communication with the health visiting service throughout pregnancy, delivery and on transfer in the post-natal period. Transfer to health visitors shall be made as part of an integrated care plan which identifies and highlights any vulnerability within the family and will be facilitated by hospital midwives in high risk cases.

In addition the provider should ensure there are pathways in place for referral to fetal medicine, neonatal care, perinatal mental health services, drug and alcohol services, domestic abuse support services and appropriate communication with GP's, social care services, prison services and antenatal and newborn screening services.

A robust system will be in place for notification of birth and the woman's midwife should liaise closely with obstetric, neonatal, general practice, health visiting and FNP, and other services including confirming contraceptive plans where possible. This is essential to ensure women get the care they need and that it is joined up with care they are receiving in the community and primary care.

3.5.2 Internal

The provider shall ensure that full support services are available including anaesthetics, radiology, paediatrics, access to high dependency or Intensive care, with appropriate midwifery and obstetric support.

The provider will designate a board level lead for maternity services. The board should routinely monitor information about quality, including safety and take necessary action to improve quality.

4. Applicable Service Standards

4.1 Applicable national standards e.g. NICE

Maternity Services have been the subject of high political and public profile in recent years and there have been a succession of reviews, strategies and best-practice guides providing an evidence base

for commissioning care that is safe, woman centred and cost effective. Services provided shall be in accordance with the most current minimum standards set out within these and other documents and current national and local policy. Where possible the Provider shall be working towards achieving more than minimum standards.

Providers will ensure services reflect the current national context for local planning of maternity services including, but not exclusive to those set out in the following documents:

4.1.1 Department of Health (DH)

DH (2014) *Giving all children a Healthy Start in life*
DCSF (2013) *Sure Start Children's Centre Statutory Guidance, update on 2006*
DH (2009) Promoting the health and wellbeing of looked after children – revised statutory guidance
DCSF/DH (2008) *Getting maternity services right for pregnant teenagers and young fathers*
DH (2007) *Maternity Matters: Choice, access and continuity of care in a safe service*
DH (2007) *National Service Framework for Children, Young People and Maternity (NSF)*
DH (2007) *Making it better for mother and baby: clinical case for change*
DH (2007)*You're Welcome quality criteria; Making health services young people friendly*
DCSF/DH (2007) *Teenage Parents Next Steps: Guidance for Local Authorities and Primary Care Trusts*
DfES/DH/Royal College of Midwives (2007) *Multi-agency working to support pregnant teenagers: a midwifery guide to partnership working with Connexions and other agencies*

4.1.2 NICE Guidance and subsequent revisions:

See section 1.5

4.2 Applicable standards set out in guidance and/or issued by a competent body (e.g. Royal Colleges)

4.2.1 College standards:

- Royal Colleges of Obstetricians & Gynaecologists, Midwives, Anaesthetists and paediatrics and Child Health (2008) *Standards for Maternity Care*
- Royal Colleges of Obstetricians & Gynaecologists, Midwives, Anaesthetists and paediatrics and Child Health (2007) *Safer Childbirth: Minimum standards for the organisation and delivery of care in labour*
- NCT, RCM & RCOG (2006) *Modernising Maternity Care: A commissioning Toolkit for England*

4.2.2 Other national guidance:

- Saving Babies' Lives. A care bundle for reducing stillbirth, NHS England 2016
- Working Together to Safeguard Children. HM Government (2013)
- Preparation for Birth & Beyond 2011
- King's Fund (2008) *Safe Births: Everybody's business.*
- The UK National Screening Committee (2008) *Newborn and Infant Physical Examination Standards and Competencies*
- NHSLA (2007) *CNST Maternity Clinical Risk Management Standards*
- Fathers Direct (now Fatherhood Institute) (*2007) Including New Fathers: A Guide for Maternity Professionals*
- Saving Lives, Improving Mothers' Care, UK EMBRRACE 2015 National Perinatal Epidemiology Unit, University of Oxford
- Focus on: Caesarean Sections. Institute for Innovation and Improvement (2007)
- Recommended Interventions for Improving Maternal and Newborn Health. World Health Organisation. (2007)
- Infectious diseases in pregnancy screening: programme handbook 2016 to 2017
- Fetal anomaly screening programme (FASP): care pathway for Down's (T21), Edwards' (T18) and Patau's (T13) screening

- Fetal anomaly screening programme (FASP): care pathway for ultrasound screening
- National Screening Documents
- Spotlight on Maternity. Contributing to the Government's national ambition to halve the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries by 2030. March 2016

4.3 Applicable local standards:

- East Midlands Clinical Network Raised BMI standards 2015
- Local safeguarding children's board (LSCB) safeguarding manual
- Submit maternity data set in accordance with the national requirements and meet mandated data quality requirements.

5.Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4 Parts [A-D]) – FRAMEWORK FOR QUALITY IMPROVEMENT

Based on applicable national outcomes frameworks, plus other specific quality monitoring as identified below.

Any variation or deviation in the quality of the service provided, as specified in this service specification, must be notified in writing to the CCG as soon as identified, together with proposed remedial action

Threshold details need to be agreed with local providers.

CCG IAF indicators

Indicator	Measure
Neonatal mortality and Stillbirth	Stillbirths and neonatal deaths per 1000 births.
Women's experience of maternity services	Score out of 100 based on six survey questions
Choices in maternity services	Score out of 100 based on six survey questions

5.1.1 Specific Quality Monitoring

As part of the specific quality monitoring the provider will undertake the outcome and quality monitoring detailed below

Quality Requirement	Method of Measurement
Maternity Dashboard to be submitted to commissioners with (see section 5.1.2)	Quarterly or bi monthly
Maternity Dataset: Antenatal Pathway tariff and Postnatal Pathway tariff	Quarterly
Monitor care around women with complex social factors (NICE guidance CG62): – Attend for booking by 10 weeks, at 12 +6 weeks and 20 weeks	Annual audit
Contributing to the national dashboard when finalised	

5.1.2 Local Maternity Dashboard

Outcome Measure	Threshold	Method of Measurement	Consequences of breach
Number of live births	Actual figures	Reported via Maternity Data Specification Quarterly	
Reduction in perinatal mortality rates – Neonatal mortality – Infant mortality	Actual figures	Reported to NHS England	
Friends and Family Test (Net Promoter/Patient Reporting Outcomes Measures – specific to maternity services)	Actual figures 20% women respond	Reported to NHS England	
Reduction in the number and % of full term babies admitted to neonatal intensive care	Actual figures	Reported to NHS England	
Low birth weight of term babies: Number and % of babies born at term < 2.5 kg.	Actual figures	Reported to NHS England	
Number and % of women who initiate breastfeeding	2% increase *(year-on year improvement)*	Reported locally by maternity data specification	
Access to non-cancer screening programmes	See NHS England Screening Programmes Key Performance Indicator Data	Reported to NHS England	
No. of women seen by a midwife or maternity healthcare professional, and % by: - 10 weeks - 12 weeks and 6 days - 20 weeks	90% for 12 weeks 6 days	Service reporting Quarterly	
Number and % of women who initiate breastfeeding	2% increase (year-on year improvement)	Reported via Maternity Data Specification Quarterly	
The number, and %, of home births (where clinically appropriate)	Activity to be baselined in Q1 2017/18 Target to be agreed locally	Reported via Maternity data specification Quarterly	
The number, and % of women who have midwifery led care at delivery	Activity to be baselined in Q1 2017/18 Target to be agreed locally	Reported via Maternity data specification Quarterly	
Number and % of routine antenatal	Activity to be	Service reporting	

	visits undertaken by a woman's named midwife.	baselined in Q1 2017/18 Target to be agreed locally	Quarterly	
	% of women who are notified to Health Visiting Service by 16 weeks of pregnancy	National spec states 1 to 1 visit by 28 weeks		
	Midwife to birth ratio.	Working towards 1:29	Reported via Maternity Dashboard on a quarterly basis	
	Hours of consultant cover on delivery suite by site:	Minimum of hours per week in each unit. To be agreed locally	Reported via Maternity Dashboard on a quarterly basis	
	Community midwifery caseload. (Average case load of >98 women per WTE)	Actual average caseload per WTE	Reported via Maternity Dashboard on a quarterly basis	
	WTE vacancies	Target to be agreed locally	Reported via Maternity Dashboard on a quarterly basis	
	Sickness rates by: Community Acute	Target to be agreed locally	Reported via Maternity Dashboard on a quarterly basis	
	Number and % of routine postnatal visits undertaken by a woman's named midwife	Activity to be baselined in Q1 2017/18 Target to be agreed.	Reported via Maternity Dashboard on a quarterly basis	
	Number of Unit closures and diversions to be reported	Target to be agreed locally	Reported via Maternity Dashboard on a quarterly basis	
	Instrumental deliveries	Target to be agreed locally		
	Caesarean section elective and emergency (incl. for maternal request)	Target to be agreed locally		
	Number of post-partum haemorrhage	Target to be agreed locally		
	Number of 3rd and 4th degree tears	Target to be agreed locally		
	Number of infections	Target to be agreed locally		
	New SI's reported to STEIS	Target to be		

	agreed locally		
Never events	Target to be agreed locally		
Activity: referrals and deliveries	Target to be agreed locally		
Normal birth numbers - Primigravidas - Subsequent	Target to be agreed locally		
% of Emergency Readmissions within 28 days post delivery	Target to be agreed locally		
Reducing Stillbirth Care Bundle – outcome indicators			
Number and % of women that have smoking status recorded at time of booking Number and % of women that have smoking status recorded at time of delivery (SATOD) % of women that are offered CO reading at: • Booking • 28 weeks • 36 weeks • Post delivery	11% by 2018 (or year-on year reduction) 99% 100%	Reported via Maternity Data Specification Quarterly Reported nationally (UNIFY)	
Low birth weight of term babies: Number and % of babies born at term < 2.5 kg.	Actual figures	Reported to NHS England	
Small for gestational age (SGA) birth rates: Antenatal detection rate: False Positive False Negative		Reported via Maternity Data Specification Quarterly	
Rate of stillbirths with SGA: With antenatal detection Without antenatal detection	Rate	Reported via Maternity Data Specification Quarterly	
Stillbirths	Number and rate	Reported via Maternity Data Specification Quarterly	
Induction of labour rates	Activity to be baselined in Q1 2017/18 Target to be agreed locally	Reported via Maternity Data Specification Quarterly	
Number of cases of severe brain injury – diagnosis in the first 7 days of life	Increases/ decreases	Reported via Maternity Data Specification	

		Quarterly	
Intrapartum stillbirths	Increases/ decreases		

5.1.5 Governance

The provider will regular undertake clinical audit and perinatal risk review in relation to the services and provide details of completed audits and findings together with any related action plans to commissioners.

The provider will report all Serious Incidents to the XXX *CCG's* including recording on STEIS and will ensure multi-disciplinary review of all incidents. Investigations, reports and lessons learned will be shared with the CCG's.

6. Location of Provider Premises

The Provider's Premises are located at:

To be completed locally