Service specification

National service specification for the care of women who are pregnant or post-natal in detained settings (prisons, immigration removal centres, children and young people settings)

NHS England

Service specification: care of women who are pregnant or post-natal in detained settings (prisons, immigration removal centres, children and young people settings)

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Disclaimer

This service specification covers a wide range of circumstances, so a term that feels appropriate to one audience may not suit another. We have therefore tried to use language throughout this document, which is widely recognised and respectful towards patients/individuals.

Background

Introduction

National context

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 as a whole 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 problems.

Population needs – women who are pregnant / post-natal in the detained estate

We know through research that people in prison have multiple complex health and social care needs and face significant health inequalities (Anders, 2017). Rates of poverty, debt, unemployment, poor education and homelessness are higher, and this group generally struggle to access health services. Women offenders are often even more affected and have disproportionately higher levels of mental health problems, substance misuse, suicide, and self-harm compared to men in prison (Public Health England, 2018a). Evidence also suggests that most women in contact with the criminal justice system come from socioeconomically marginalised backgrounds and a large proportion have experienced complex trauma – resulting in increased rates of drug dependence, psychological problems and mental illness (PHE 2018b). Female imprisonment is associated with increased risk of maternal hardship, poorer perinatal outcomes and childhood behavioural and developmental problems (Dumont et al, 2014).

Female prison population in the UK

The female prison population in the UK makes up 5% of the total prison population, which translates to around 12,000 women every year (Mulligan 2019, Abbott 2016). Around half are estimated to have been victims of domestic abuse, and 30-40% have experienced abuse or neglect as a child[9]. One study[8] estimates that 53% of women prisoners reported being abused sexually, emotionally or physically as a child. Around 80% have a mental health condition and around 70% have issues with substance abuse (Abbott, 2016; Albertson et al, 2019). A Stepped Care Model for Mental Health Services is used in the detained settings with most of the care delivered under Primary Care Mental Health Services for mild to moderate illness. 80% of women are in prison for non-violent offences, and 25% have no prior convictions. It is estimated that around 600 women receive antenatal care, and at least 100 babies are born to women in prison in England and Wales each year. Around 66% of female prisoners in the UK are mothers. The rate of suicide is 58.6 times higher in the UK prison population than it is in the general population (this applies to both male and female prison populations) (Lieser, 2019).

Caring for the health of women in the detained estate has many challenges due to issues such as: pre-sentencing lifestyles, risky behaviours, access to services and higher levels of medical need compared to women in the community - many women have a history of substance misuse and mental illness (HM Chief 2018); and there is also a higher proportion of unplanned pregnancies.

Maternity context

In December 2020, NHS Trusts in England were required to provide a response to the immediate and essential actions (IEAs) requested in the Ockenden report to improve safety in maternity services. Accordingly, prison/detained setting maternity 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, ensuring women and their families have access to the personalised services and support they need during pregnancy, childbirth and postnatal period and into early childhood. The providing trust must ensure that this is regularly reviewed, and the

prison maternity service model adapted as needed to support the best and safest possible care.

Meeting the health needs of pregnant and post-natal women within the criminal justice system can help to achieve reductions in crime, reduce offending and improve the individual woman's health. Pregnancy has also been recognised as a unique window of opportunity to work preventatively with families; and lays the foundations for the child's future physical, emotional, social and cognitive development (APPG, 2015). To facilitate the delivery of policy and recommendations set out in the NHS Long Term Plan for maternity care, NHS England (2016) recognises that, to ensure equity, women with multiple disadvantages and complex social needs will require extra support to ensure they receive high quality personalised care and feel empowered to make choices.

This specification outlines what should be included in a trauma informed, detained setting based maternity service; providing support for women who are pregnant and in the post-natal period. Maternity care should be integrated with wider health, psychological and social support services and services provided by the voluntary sector. It includes desired objectives and outcomes concerning the multiple complex needs of perinatal women who reside in prison, and recommendations for users of this service specification to consider. It is because of the complexities for women in detained settings that **all pregnancies must be classed as high risk.**

Aims and objectives of the detained estate pregnancy and post natal service specification

This is a specification for a new service model and sets out what the maternity service provider, in conjunction with Her Majesty's Prison & Probation Service (HMPPS), should include to address the needs and improve pregnancy/postnatal outcomes for women in detained settings. This specification is to inform commissioners, providers and other relevant stakeholders of the standards expected for maternity services across the detained estate in England. It is anticipated that the specification will be amended for local need but should be the minimum requirements to represent current best practice.

The aims of the service specification are to:

- Provide a consistent and equitable approach to the delivery and monitoring of maternity service provision in the detained estate
- To reduce unwarranted variation and improve quality outcomes for women
- Set out the standards expected of maternity service providers.
- Describe at a high level the requirements for effective, efficient, safe, and reliable maternity services for women in the detained estate.
- 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.

A system wide approach is required, in recognition of the importance of collaboration with other services involved in the care of pregnant/post-natal women in detained settings. Inclusion of the collaborative approach outlines how this impacts on short and long-term patient outcomes and experience.

There are numerous clinical guidelines and best practice documentation available that describes clinical practice and processes. This document does not aim to

replicate these guidelines, but to provide a description of the minimum service requirements for a prison/detained setting Maternity Service. For specific clinical interventions refer, to the appropriate clinical guidance.

Maternity services commissioned for the detained setting will be based on the Better Births vision for maternity services across England. They should become safer, more personalised, provide continuity of carer, kinder, professional and a more family friendly approach. Every woman must have access to information to enable her to make decisions about her care, including where she and her baby can access support that is joined up and centred around their individual needs and circumstances. Additionally, all staff should 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.

This specification encompasses all elements of the services regardless of location of service delivery and covers the following aspects of maternity provision for women who are detained:

- Antenatal care
- Infant feeding – including support with lactation and breastfeeding
- Information relating to Public Health intervention and prevention
- Intrapartum care
- Postnatal care for mother
- *Post-natal care for the baby (if residing in a detained setting Mother and Baby Unit)
- Pre-pregnancy care
- Screening

* If the baby is residing in the community the care will be provided by universal community midwifery services.

The objectives for this service which will be delivered using a trauma-informed approach includes:

- Personalised care, centred on the woman, her baby and her family, based around their needs and their decisions informed by unbiased information – also considering where they have genuine choice.
- Continuity of carer, to ensure safe care based on a relationship of mutual trust and respect, in-line with the woman's decisions.
- 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.
- Better primary care perinatal mental health service, which can have a significant impact on the life chances and wellbeing of the woman, baby and family.
- Multi-professional working, breaking down barriers and ensuring there is good communication between midwives, obstetricians, nurses, prison officers, health visitors, Mother and Baby Unit staff, social care, voluntary sector provision and other professionals, to deliver safe and personalised care for women and their babies.
- Working across boundaries to provide and commission maternity services for the detained estate which offer flexibility, support personalisation, safety and choice, with access to specialist care and support whenever/where-ever needed.
- Opportunities to listen to women and their families, developing a robust mechanism for gathering service user feedback.
- Visible leadership in the form of an establishment-based specialist midwife who will also cover other aspects of the detained estate in the locality.

This document outlines the service and quality indicators expected by NHS England (the commissioner) from the maternity service provider, to ensure that a high standard of service is provided to NHS England's responsible population. It therefore sets out the specific policies, recommendations, and standards that the commissioner expects the service provider to meet.

Basic commissioning principles

- 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 commissioners, 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 maternity pathways. This includes the knowledge, skills and experience of staff, 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.

Equality and diversity

Equity means that all mothers and babies will achieve health outcomes that are as good as the groups with the best health outcomes. Services should explicitly target inequalities in health, including mental health, and aim to meet the needs of vulnerable and socially disadvantaged groups. Many groups of the population are known to have poorer health outcomes across their life-course, and this includes pregnancy outcomes. This can include higher risks of stillbirth, restricted growth, fetal abnormalities and in some cases maternal deaths. Women from a Black, Asian or Minority Ethnic background have been highlighted by Public Health England (2020) as likely to have poorer health outcomes for mothers and babies. Similarly, there are other marginalised groups who have higher risks of poor health and services are expected to know their population to ensure the care is provided to meet any additional needs. This includes ensuring information about treatment and care is culturally appropriate and that women have access to spiritual and religious support they require during their pregnancy and at the birth of their baby. In addition,

should there be difficult outcomes such as the baby being unwell or dying pre-existing measures should be in place for the immediate access to ‘Chaplin’ / faith or other wellbeing services for the mother. Information 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 detained estate population.

The service should be inclusive and tailored to meet the needs of patients with any protected characteristics, taking into account where multiple protected characteristics being present could impact on health and wellbeing outcomes.

It is essential that maternity services respond and actively engage using a trauma-informed approach with women in the criminal justice system. They will need to ensure that there is specialist support for women, many of whom have ‘complex social factors’ and may have been less likely to access/maintain contact with maternity services in the community. Health inequalities can broaden further because women are detained but this is also an opportunity to make a difference and positively affect outcomes for mothers and babies. This is in line with ‘Equity and Equality: Guidance for Local Maternity Systems’ (2021) which reviewed the MBRACE reports to identify where there are areas for improvement.

Policy context

The provider must be aware of, consider and refer to the national and local policy context and drivers in the development, design and delivery of healthcare services for pregnant/post-natal women in the detained estate. The key documents are referred to in Appendix One and the provider should keep abreast of subsequent and updated policies, taking into account any relevant policies not listed.

Maternity and perinatal care in the detained estate is influenced by a wide spectrum of policy areas and developments. This includes a range of policies, frameworks and documents which have been developed by HMPPS – see Appendix three. These will need to be considered when developing the specialist clinical service which, as a

priority must meet the expected health outcomes for this group of women. The provider will deliver services to meet the objectives and outcomes of the various clinical frameworks and priorities and will be expected to develop and implement measures to monitor these outcomes.

The clinical frameworks include but are not limited to:

NHS Outcomes Framework

The NHS Outcomes Framework sets out the framework and indicators used to hold NHS England and commissioned services to account for improvements in health outcomes. The expected service outcomes should be aligned to the NHS Outcomes Framework (NHSOF) 2016-17, CCG Improvement and Assessment Framework (CCG IAF) 2017-19 and the Public Health Outcomes Framework (PHOF) 2013-16. Those related to this specification include:

Domain and description	NHS Outcomes Framework	CCG Improvement and Assessment Framework	Public Health Outcomes Framework
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	
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 ill-health or following injury	Overarching indicators: 3a - Emergency admissions for acute conditions that should 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	5a - Patient safety incidents reported		

people in safe environment and protecting them from avoidable harm	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		

Prison maternity service description

The aim of the commissioned service is to provide maternity care to pregnant and newly delivered women who are resident in prison/detained estate. The service will be provided within the prison/detained estate by dedicated specialist midwives using an enhanced model of care – the traditional community midwifery approach is not suitable for this group of women as **all pregnancies within the detained estate are classified as high risk** ([12]PPO, 2021 Baby A). The service will include antenatal and postnatal care to those women identified as being pregnant or in the postnatal period. Where possible this named professional should follow those women in their care into an acute Hospital setting for delivery of the baby as part of promoting continuity of care. Arrangements should be in place to ensure competencies can be maintained for the wider work of a midwife.

Access principles

The maternity service providers will:

- Deliver core services related to pregnancy, birth and emergency assessment and care 24/7, 365 days of the year and provide clearly identified 24/7 direct telephone access.
- Have in place a robust escalation policy around managing capacity and acuity which is monitored and reported.
- Offer routine assessment and care throughout pregnancy and the post-natal period – in the absence of the specialist midwife there must be the availability of visits seven days per week by an allocated community midwifery team.

- Provide information about the service and care in a way that is accessible to all service users including those with learning disabilities, communication difficulties or where English is not their primary language. All methods of communication must be in line with the NHS England Accessible Information Standard. Where interpreting services are required this must be for the full pregnancy and post-natal pathway (within the prison and for all hospital appointments) – note that interpreting services includes the use of British Sign Language as well as language specific.
- Work in partnership with other local units to proactively manage any ward/service closures.

Population covered

The services outlined in this specification are for women resident in prisons and immigration removal centres. The specific establishments covered will be detailed by the local NHS England commissioner. For children and young people's detained services, the principles in this service specification will be used to develop a bespoke specification adapted to meet the needs of young women.

Acceptance and exclusion criteria

All women residing in the specified detained settings requiring antenatal, intrapartum and postnatal care.

No exclusion criteria.

Interdependencies on other services

- Fetal Medicine Specialist Centres
- HMPPS
- Local authority services including safeguarding children and adults
- Maternity networks/maternity services liaison committees – co-operation through maternity networks to ensure local patterns of services meet women's needs and expectations for themselves and their babies
- Neonatal networks
- Voluntary sector services which may be available locally

Preconception care

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

- Minimising alcohol intake
- Not smoking during pregnancy and having a smoke-free environment (all HMPPS estate is smoke-free)
- Pre-conceptual folic acid
- Pre-pregnancy flu, pertussis and rubella immunisation – guidance from NHS England (NHS England pertussis vaccination in women 2020/21). This should now also include information around the COVID-19 vaccination.
- Seeing a healthcare professional as early as possible in pregnancy.

Women with relevant clinical conditions should have access to preconception advice from relevant healthcare professionals. The conditions include (not an exhaustive list):

- Diabetes
- Epilepsy
- History of mental health problems
- Personal or family history of congenital or chromosomal anomalies
- Previous poor obstetric history
- Women who are at high risk of developing pregnancy complications

This will ensure that they can make informed decisions about their care and treatment, in partnership with their healthcare professionals. In the detained estate this information may also be available from the wider primary care team, GP and sexual health services.

Obstetric consultant support should be easily available and pathways for referral should be clearly defined. Joint clinic and assessment appointments between the consultant, specialist midwife and the woman should be available as an option.

Antenatal care delivery model

The maternity service provider will ensure that antenatal care is provided in line with the following areas:

- Women-focussed
- Clinical
- Partnerships
- Pathways
- Education and information
- Health and well-being

Women-focussed

- Promote a culture that is trauma informed across all partner agencies.
- Have in place specialist midwife roles to coordinate care around the needs of the individual.
- Offer antenatal services in a range of detained settings appropriate to the nature of the type of intervention being delivered and the needs of the woman, taking into consideration questions of equity, efficiency, and trauma-informed principles.
- Ensure a flexible approach is taken when making appointments with the specialist midwife, considering the requirement for enhanced and ad-hoc visits where there is immediate need or additional support is required.
- Where appropriate, promote pregnancy and birth as a normal life event and in-line with the principles outlined in Better Births.
- Screening of mental health and current emotional wellbeing is required. This will be flexible but as a minimum should take place at booking and between 26 and 30 weeks of pregnancy – this is in-line with CG192 Antenatal and Postnatal Mental Health Guidance. However, due to impact of being detained whilst pregnant and the associated physical, emotional and social changes that occur during this period, the recommendation is that women should be asked about their emotional wellbeing at all contacts.
- Provide all women with a personal maternity record that is accessible to all professionals providing maternity care.

- Ensure that the woman is kept informed of any plans around her care.
- Work with other maternity units for women already booked for delivery elsewhere – depending on the gestation of the pregnancy and expected length of stay in the detained setting, care may remain with the service the woman originally booked with. This will be decided based on individual circumstances and practicality of attending any hospital appointments.
- Support all women to have an individualised birth plan in place by 36 weeks gestation – this is the standard in relation to equivalence of care but the reality may be that this is in place much sooner given the high risk nature of the women and their pregnancies. The plan needs to be developed with the woman and be individualised and personalised.
- 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 provision of enhanced antenatal care.
- Perform domestic abuse routine enquiry at the earliest opportunity and at all routine antenatal and postnatal contacts – considering the nature of the detained environment and the different factors which could occur (bullying, harassment, intimidation).
- Prepare women for parenthood via antenatal education programmes or 1:1 sessions where required. It is recommended that the Solihull Parenting Programme should be offered to all perinatal women in detained settings; this is a nationally recognised parenting system and seen as best practice. Consider how the woman's partner can be involved in ante-natal education if relevant.
- Where necessary, ensure a 'Separation Plan' is formulated in partnership with the woman and the multi-disciplinary team. This needs to be developed using a trauma-informed approach to ensure the mental health and well-being of the woman is considered. The Separation Plan is likely to be required in the following situations:
    - The woman is not applying for a Mother and Baby Unit place.
    - An application for such a place at Mother and Baby Unit will not be resolved before the birth.

- The woman's Mother and Baby Unit application has been unsuccessful.
- The baby is going to stay with family members.
- The local authority social care are seeking an Interim Care Order to place the baby with foster carers.

Clinical expertise

- Deliver antenatal care in accordance with NICE guidelines, including Quality Standard 22 and NG201 (2021).
- Promote early access to all Maternity Services to facilitate prompt referral and appropriate screening to meet national targets.
- Offer antenatal screening in-line with the UK National Screening Programme.
- Identify age as a risk factor for women in receipt of care.
- Named Obstetrician to lead and determine the care, investigations and procedures which may be needed for women who have complex pregnancies or a complex medical history. The pregnancy of all women in the detained settings must be treated as high risk and the care planned according to need.
- Pregnant women who have a disability or long term condition e.g. diabetes; high blood pressure; a mental health condition; learning disability autism or both, should be identified at the start of their care pathway so that suitable provision is put in place and health risks are managed early on in the care pathway.
- Access to Specialist Neonatal Services if there are concerns about the impact of medical/obstetric complications to ensure there is a clear plan in place before the expected date of delivery.
- Manage women with complex fetal conditions within a recognised and agreed fetal-maternal medicine pathway.
- Providers should have expertise available for women who have had female genital mutilation in relation to supporting and safeguarding. All care must be provided 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 amongst women, healthcare and prison staff about the importance of detecting and reporting reduced/altered fetal movements.
- Provide the option of cardiotocograph (CTG) monitoring within the detained estate using clear Standard Operating Procedures to manage this care and any follow up required.
- Ensure a standardised approach and management to the identification of the growth restricted baby, which involves appropriate referral to the acute maternity team.

Partnerships

- Ensure there is good partnership working between the detained setting Healthcare Provider, HMPPS/Detained Setting and hospital services to facilitate all appointments where attendance at hospital is required.
- Hospital appointments and scans – working with health/detained partners to organise appointment bookings. This will require good communication between prison/detained setting and hospital and understanding of the limitations due to prison/detained escort availability and security risks.
- Contribute to the Multi-Disciplinary Perinatal Meeting for the establishment to share information about the women on the caseload. The specialist midwife may be the Lead Professional for some aspects of the perinatal pathway.

Pathways

- Supporting primary care perinatal mental health and psychological wellbeing throughout all maternity pathways.
- Have in place an explicit process of direct access to the specialist midwife as a first point of contact when pregnancy is confirmed. This avoids delays and will help ensure early antenatal screening can be discussed with the woman and associated standards are met.
- Deliver continuity of care across the maternity pathway; units should be working towards continuity of carer as set out in Better Births.

- Ensure that safeguarding (children and adults) is embedded across the pathway following local Safeguarding Board procedures.
- Referral pathways to Specialist (secondary care) Perinatal Mental Health Services should be in place and accessed where required (up to 24 months after the end of a pregnancy).
- Have in place pathways and provision to support women with any Neurodisability including learning disabilities in-line with recommendations from Hidden Voices of Maternity (2015). Women with any disability must be involved in the development of an individualised care plan.

Education and information

- Make information available to women, with clear explanations of the roles of healthcare professionals involved in their care, to help them understand the services provided and make informed choices. This should include information about the purpose and timing of appointments and an individualised programme of appointments to be agreed based on the clinical need of the woman, and in-line with NICE guidance.
- To provide unbiased information to inform decision-making.
- Promote breastfeeding and UNICEF Baby Friendly principles.
- To promote access to the same information as women in the community which is often available via electronic applications (apps) – to work with HMPPS/Governor to find ways to make that type of information available.

Health and well-being

- Consider testing for Chlamydia and Hepatitis C as part of the pathway of antenatal care.
- Offer all women carbon monoxide testing to assess exposure to tobacco smoke at the first booking appointment. All women who smoke will be offered opt-out referral to smoking cessation services and risk assessed and managed accordingly, in-line with prison/detained estate policy.
- Deliver and discuss appropriate health promotion information on healthy diet, folic acid, vitamin D and pregnancy supplements – organise prescription with prison/detained estate GP.

- Discussion about contraception and sexual health during pregnancy, prior to release from prison (including Release on Temporary Licence – ROTL) and linked in to the 6-week postnatal GP check. Evidence shows that women in prison have higher rates of HIV, Hepatitis, and Sexually Transmitted Infections (STI) such as chlamydia infection, gonorrhoea and syphilis – therefore it is vital that information is based not only on prevention of pregnancy, but also on STI prevention.
- Promote and offer all pregnant women immunisations in line with The Green Book. This includes: Pertussis (ideally at 20 weeks up to 32 weeks but can be offered from 16 weeks and after 32 weeks), annual seasonal flu vaccination (any gestation) and Covid-19 vaccine.

Other specific requirements in the ante natal period

Reception into the detained estate – antenatal services and advice provided in collaboration with the specialist midwife

- Upon receiving the woman into custody, as part of the prison/detained estate induction by Healthcare, all women should be offered a pregnancy test. It is acknowledged that this may not be appropriate on immediate arrival at the detained setting. Using a trauma-informed approach and explaining the benefits of being aware of her pregnancy status should be used. It is recommended that a pregnancy test is repeated/offered after 28 days in custody.
- For women who are already aware that they are pregnant **and** there are no issues/concerns they must be seen by the specialist midwife within 72 hours. To be seen sooner if there are any concerns - this could include discussions with the local maternity unit – local arrangements to be agreed and set out within a standard operating procedure (SOP).
- Local arrangements in place regarding community midwifery cover in cases where specialist midwife not available within the above timescale (for example, due to absence or leave).
- Early pregnancy assessment referrals – for example, if any history of vaginal bleeding, injury/trauma, history/signs of ectopic pregnancy (as per local policy).

- Assist with referral to termination of pregnancy (TOP) service if requested, provide local information leaflet to aide decision-making.
- Support with referral to Sexual Assault Referral Centres if there is disclosure of a sexual assault (follow the local pathway that is in place).
- Access to folic acid, vitamin D and pregnancy supplements within five working days of arrival.
- Referrals and collaboration with local multi-agency prison/detained setting and community services, e.g. substance misuse, mental health, psychiatry, social care, voluntary sector services etc.
- Personalised care planning including the expected appointments with the specialist midwife and overview of hospital care (without compromising security).
- Liaise with any health and social care professionals that have been involved in the woman's care prior to coming into prison.

Antenatal education

It is essential that women who are in the detained estate have the same access to ante-natal/parenting education as those within the community. This will be assessed on an individual basis depending on circumstances and plans for the baby post pregnancy. Opportunities must be found to doing joint parenting education with the woman's partner/family if they are to be taking over the care for the baby after delivery. Use of tele-health/Visionable could be considered if joint parenting education sessions would be beneficial.

The role of the health visitor is outside of the scope of this service specification, but a recommendation has been made to health and justice commissioners to review that aspect of care.

NICE and Public Health England recommend the use of evidence-based parenting programmes and there is the drive for all maternity units in England to have staff trained in the Solihull Approach. The Solihull Approach aims to increase emotional health and well-being through both practitioners and parents. It does this through resources and training across the child and family workforce, including midwifery providers. It provides a theoretical framework for working with emotional and behaviour difficulties. It has a strong and growing evidence base, with over 35

published papers, and The Solihull Approach is included in the UK Department of Health's Healthy Child Programme. As a nationally recognised parenting system and best practice, The Solihull Parenting Programme should be offered to all perinatal women in prison/detained settings by the specialist midwife.

Access to early pregnancy unit

Women who commence a custodial sentence or are detained during early pregnancy should be provided with access to an early pregnancy unit which they are able to access for advice free of charge. Any women up to 18 weeks pregnant should be made aware of how to access such services. HMPPS are required to ensure the women have access to this advice when they need it – in-cell telephony is an option for some but not all establishments.

The provider should ensure that women have access to early pregnancy services by speaking to the specialist midwife or the Healthcare Team. If attendance is required at the Early Pregnancy Units then this will need to be prioritised for escort by HMPPS.

All staff working with women in detained settings should have an awareness and brief training on actions to take if a woman is concerned about the heaviness of bleeding or pain in early pregnancy (consider miscarriage and Ectopic Pregnancy). The specialist midwife should provide support to other healthcare and prison staff working in the setting to build awareness of the signs of pregnancy which may help ensure undetected pregnancies are identified.

Access to 24hr pregnancy assessment service

All women should be able to contact a Midwife by telephone, free of charge through in-cell telephony (or alternative if this is not available within an establishment) – the specialist midwife will ensure processes are in place to facilitate this, being aware that this may need to be a supervised call for security reasons.

Pregnancy/Maternity Assessment Units provide emergency and follow-up antenatal care for women over 18 weeks gestation with specific pregnancy-related problems. It is midwifery-led, with support from an Obstetrician (doctor who specialises in the care of women during pregnancy) when needed.

Common reasons for attendance at Pregnancy / Maternity Assessment Units, include, but not exhaustive of:

- An urgent problem such as vaginal bleeding or abdominal pain.
- Baby is less active than usual.
- Maternal blood pressure is raised or there is concern around this.
- Onset of early labour.
- Severe itching during pregnancy.
- Spontaneous rupture of membranes.

During the agreed hours of contact for the specialist midwife, many of these concerns can be addressed and a clinical assessment made on site within the prison/detained setting. However, there must be a robust referral pathway for healthcare/prison/detained staff for times when the Midwife is not on site.

On-site antenatal services

The following services must be provided **on site** by the provider trust commissioned to deliver the services outlined in this service specification:

- Specialist midwife.
- 'Birth Reflections' service (for example, if previous traumatic pregnancy/birth).
- Blood glucose monitoring.
- Blood pressure monitoring.
- Cardiotocograph (CTG) monitoring.
- Facilitation of additional monitoring required for complex medical conditions in pregnancy (e.g. Obstetric Cholestasis), to be agreed locally.
- Glucose tolerance testing.
- Outpatient induction of labour (if this is a service available to women in the local community).

Depending on local need, commissioners may add other services that they expect to be delivered on site to the list above.

There will be no planned 'home' deliveries within a detained setting.

Intrapartum care

This will be provided at the local hospital maternity unit – or specialist centre if there are maternal or fetal complications. There should be no planned deliveries at any detained setting. The hospital staff will be familiar with all the policies and procedures to follow when caring for a woman who is from the detained estate and have access to the birth response plan/safeguarding processes. If there is a plan for elective procedures (induction of labour, planned Caesarean Section etc) the specialist midwife may be able to provide continuity of care but only if this does not disadvantage or cause unsafe services for other women on the caseload within the detained estate.

The specialist midwife will contribute to the development of standard operating procedures that may be required at each detained setting to outline steps to take when labour starts or there is an unplanned birth/delivery/emergency. It is the responsibility of HMPPS to have processes in place for unplanned births in line with the [11]HMPPS Pregnancy, Mother and Baby Unit Policy Framework. There should be local relationships with the Ambulance Trusts to ensure the right type of response is received – each establishment should already have these partnerships in place to ensure the right level of response is dispatched depending on the incident that is happening.

Postnatal care delivery model

The following principles include guidance for both women who are transferring to a prison Mother and Baby Unit, ***and*** women who are returning to the prison/detained setting without their baby. This must be taken into account when considering each point.

The maternity service provider will:

- Ensure all women on the hospital postnatal ward have access to their allocated midwife as required after having had their baby.
- Ensure a smooth transition from hospital midwife, obstetric, and neonatal care, including appropriate liaison with the prison/detained setting healthcare team. Ongoing support will be coordinated by the specialist midwife, who will

work collaboratively with the health visitor, GP, prison/detained setting primary care mental health team and any other service involved in the woman's care.

- Follow the plans made during the women's pregnancy and ensure only visitors approved by HMPPS are given access to the ward.
- Offer all women an enhanced level of postnatal contacts, in addition to the minimum number of visits as set out in local/national guidelines. Contacts should be in the most appropriate prison/detained setting environment and in-room/wing visiting should be provided wherever required. Flexible postnatal visits are to meet the individual needs of the woman (and her baby if present).
- Undertake a needs assessment on health, social, and environmental factors to provide a personalised postnatal birth plan for all women. This should be shared with the prison/detained setting healthcare department and all other professionals who are providing care.
- Facilitation of pre-discharge planning meeting prior to leaving hospital, to discuss any concerns and ensure a robust plan of care is in place – a member of the prison/detained setting primary care mental health team (preferably perinatal mental health practitioner) should be included, and any other detained setting health service involved in perinatal care (e.g. drug and alcohol recovery team, psychiatrist, GP).
- Ensure women and infants are discharged post-birth following handover to and engagement of appropriate services as per care plans – including details of any prescribed medication, follow-up appointments and care arrangements for baby (if not suitable for transfer to Mother and Baby Unit).
- When the baby is being discharged into the community, including for Foster Care, ensure arrangements are in place for post-natal care by the local Community Midwifery Team.
- Ensure that all women are monitored for signs of post-delivery physical and mental ill-health and given advice on warning signs prior to discharge from hospital.
- Assess Perinatal Mental Health and current emotional wellbeing in line with CG192 Antenatal and Postnatal Mental Health Guidance.
- Ensure new mothers 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 and screening programmes.
- Provide post-delivery contraception and sexual health advice to all women.
- Promote UNICEF Baby Friendly principles for breast feeding and bonding/attachment.
- Promote principles for safe sleeping UNICEF Baby Friendly and NICE CG37.
- Ensure a separation plan is in place and is followed if not transferring with baby to a prison/detained setting Mother and Baby Unit.
- Provide additional support and monitoring of emotional wellbeing with referral to specialist services/counselling if required.
- Education and support around perinatal and infant mental health.
- If separated, facilitate contact with baby (if appropriate and in accordance with any safeguarding plans in place).
- Reinforce postnatal non-smoking messages.
- Public health information:
    - Advice about contraception and sexual health
    - Pelvic floor and bladder care
    - Offer cervical screening
    - Maintenance of smoking cessation
    - Vaccinations if required (e.g. Mumps, Measles and Rubella)
- Ensure that newborn screening tests are offered and undertaken for all babies, in-line with UK National Screening Programme.
- Postnatal care of baby (if residing on Mother and Baby Unit) provided by the specialist midwife. Local arrangements must in place for community midwifery provision in the absence of the specialist midwife.
- Specialist midwife to brief community and hospital midwifery teams in case of unplanned need outside normal working hours (e.g. weekends/ evenings).
- Robust referral mechanism in place for urgent postnatal care (e.g. maternal or neonatal infection; heavy vaginal bleeding).

Prison/detained setting reception – postnatal services and advice provided in collaboration with the specialist midwife (women received into prison during the postnatal period).

- To be seen by specialist midwife at soonest opportunity.
- Appropriate referrals and collaboration with local multi-agency and prison services, e.g. substance misuse, primary care perinatal mental health, psychiatry etc.
- If mother and infant are separated, work with children's social care to facilitate contact with baby (if appropriate and in accordance with any safeguarding plans in place).
- Liaise with any health/social care professionals and any voluntary agencies that have been involved in the woman's care prior to coming into prison.
- Local arrangements in place regarding community midwifery cover in cases where specialist midwife not available (for example, due to absence or leave).
- Personalised care planning and assessment of risks.
- Support and advice regarding lactation and/or expression of breastmilk.

Infant feeding and breastfeeding

The specialist midwife will lead on the development of local guidance relating to infant feeding for women who reside in the prison/detained setting, considering the increased complex needs associated with this patient group. It is essential that hospital grade breast pumps are available all women who are breast feeding but especially those who are separated from their babies as it allows for good establishment and continued milk production. The breast pumps will belong to the healthcare provider (general healthcare provider and not the Maternity Services Provider). It is anticipated that there will be at least one hospital-grade breast pump available on site and more are likely to be required for establishments with Mother and Baby Units or due to the size/layout of the establishment. The specialist midwife will be required to ensure all equipment is available to establish and maintain breast milk production and advise the healthcare provider on the type of pump and consumables that are required. Maintenance, upkeep and provision of consumables linked to the breast pumps are the responsibility of the Healthcare Provider. The

Midwife should be familiar with how to use the equipment and provide support to women and any peers who are available to assist the women within their accommodation.

The following is minimum standard and should be used alongside a personalised infant feeding plan:

- Pregnant women in the custodial setting must be given the same information and support in order to make infant feeding choices relevant to them, and all women will be given verbal and written information in-line with local and national guidelines.
- Post-natal women in detained settings must be given the same information and support to breastfeed or provide expressed breast milk for their infants as women in the community (Birth Charter, 2016). If they are having full care of the baby in hospital following delivery, feeding should be encouraged responsively and in-line with local infant feeding guidelines.
- There are good examples of women being separated from their babies who continue to provide breast milk for the carer of the baby to use. This must be reflected in any infant feeding policies for women in detained settings.
- Following joint discussion with the woman, an infant feeding plan will be developed by the specialist midwife and shared with maternity and prison/detained setting healthcare teams, perinatal multidisciplinary team (MDT) and appropriate detained setting staff. This will be developed in collaboration with the Obstetric Consultant/Neonatal Team and any other health professionals involved in the woman's care (for example, where the woman is being prescribed treatment for mental illness, substance misuse or other medical condition).
- If a woman chooses to formula feed her baby, she will be asked at delivery to select her chosen brand and this will then be provided by the hospital during her stay.

Perinatal mental health and psychological wellbeing

Maternity services have a unique role in supporting pregnant and post-natal women in detained settings. This period can be a challenge for women due to the associated physical, emotional, and social changes that occur which can be worsened by being in the detained setting. it is important that the maternity service strives to limit the development or recurrence of mental health difficulties through this period using a trauma-informed approach. This should include:

- Continuity of carer – specialist midwife and named consultant obstetrician. Women value seeing the same member of staff at antenatal appointments; establishing trust can help to identify emerging stress and mental health difficulties at an early stage
- The specialist midwife will continue to support the woman and assess mental, emotional and general wellbeing throughout pregnancy and the postnatal period.
- Ensure that all pregnant women in detained setting have a comprehensive perinatal mental health assessment by a primary care perinatal mental health practitioner.
- Ensuring maternity and neonatal staff are adequately trained in Perinatal Mental Health and communication skills, to enable them to effectively address the sensitive topics of psychological wellbeing and mental health, and to provide trauma-informed care.
- Working collaboratively with the detained setting's Mental Health Team, Primary Care Team, Prison Staff, Pregnancy Mother and Baby Liaison Officer, voluntary sector etc.
- Ensuring good communication and information-sharing with the detained setting GP.
- Specialist midwife representation at the regular detained setting perinatal multi-disciplinary team meeting – the name, format and frequency of the meetings will be determined by the establishment in line with the [11]HMPPS Pregnancy, Mother and Baby Unit Policy Framework.

- Ensure there are robust referral and care pathways in place for access to specialist perinatal mental health services (secondary care).
- Co-ordinating care in preparation for release (including release on temporary licence – ROTL), by ensuring good communication between detained setting Maternity Services and the receiving health service/s (e.g. GP, community midwife, health visitor, GP).
- Co-ordination will also be required across prison and probation services for women being released or transferred.
- Where there are integrated specialist perinatal mental health professionals within the maternity service, they should work collaboratively with the detained setting mental health team and any other specialist mental health services involved.
- Follow clear pathways of care and ensure they have a clear referral pathway in place for any health or social care assessments and interventions needed.
- Provision of information about relevant services that the woman can access, including (where appropriate) third sector, peer support and community organisations.
- Peer mentor programmes may be available in the detained setting and the specialist midwife can work with this group of women to support those who are pregnant/post-natal where this is appropriate.
- Provide women who are due for release with copies of letters and appointments.

Links with health visiting service

There is a growing body of evidence which suggests that parental imprisonment can impact on children and young people's health and wellbeing, and that the effects – particularly the emotional impact – can follow children through into adulthood.

The Healthy Child Programme was initiated by the Department of Health in 2009. It aimed to produce a unifying framework around the provision of health services for children and young people aged 0-19 in the community. There are three components of the programme:

- Pregnancy and the first five years of life
- The Healthy School Child Programme
- The Adolescent Health Programme.

The aim of the programme is that it should lead to a range of positive health outcomes for children. These include strong parent-child attachments, identification of factors that can affect health and wellbeing, and better outcomes for children at risk of social exclusion (DH and DCSF, 2009)

Whilst the role of the health visitor is out of scope for this service specification there is a recommendation for commissioners to review local arrangements in place with health visiting services. This is to ensure that mothers and babies have access to the care the health visitor provides to pregnant women and their babies in detained settings – the high risk pregnancy and potential health outcomes will contribute to the agreed level of support from the health visiting team. Where there is a Mother and Baby Unit, there needs to be consideration of commissioning a specific specialist role with the health visiting services to ensure that children have access to the same enhanced care as they would at home.

For estates where no Mother and Baby Unit exists, Providers are recommended to make links to Health Visiting Services and to ensure that:

- Pregnant women are given a copy of ‘Red Book’.
- Provided with ‘The Little Orange Book’.
- A Family Health Needs Assessment is completed.
- Ante-natal assessments are completed.
- Information about Healthy Child Programme is delivered for all women, including those who are separated from baby.

It is recommended that in those instances commissioners should make links with local health visiting leads to discuss how this provision can be delivered in the most efficient and effective way for all parties involved. This is to promote and ensure safety of the child, application of a child focus, whilst being sensitive to the needs of maternal mental health and the separation of the mother and baby.

Discharge and release planning

The provider must participate in the overall discharge planning for women who are pregnant or in the post-natal period and being released from detained settings. This includes those returning to the community, release on temporary licence, attending court or being transferred to another establishment. On leaving the detained estate suitable stable accommodation should be made available to all leavers - the specialist midwife will contribute to supporting the detained settings, local authority and social services to ensure safe discharge of women and children to reduce the risk of harm. The prison are responsible for ensuring the women have access to the right benefits and care packages as they leave the detained setting.

Where other health needs have been identified such as ongoing substance misuse, the specialist midwife will work with the substance misuse team prior to discharge from the estate. They will ensure the women have the details for ongoing care in community services and, with consent their contact details shared with services for follow-up (after permission from the client).

To support re-settlement, the specialist midwife will provide an enhanced pregnancy/post-natal discharge service upon the woman's release or transfer from the detained setting. This will allow for a period of continuity where practical and include:

- Comprehensive handover of care to community midwife and safeguarding midwife (if required), including any information relating to her history that may impact upon her pregnancy (for example: domestic violence, substance misuse, mental illness, adverse childhood experiences (ACE), homelessness). This is vital in reducing the amount of times the woman has to repeat her story and reduce the risk of re-traumatisation and will also contribute to engagement being maintained/improved, making sure women's needs are met throughout the transition.
- Depending on the geography and where the woman is being released to, the specialist midwife will consider a joint appointment with the community midwife taking over the care of the woman. This is to act as an introduction to

the community midwife, promoting confidence and trust for the woman through the transfer of care.

- Continued involvement with safeguarding children meetings and reports – to represent the period of care whilst the woman is in the detained setting.
- Post-transfer visit to Mother and Baby Unit – this increases the woman's feelings of trust, value, and respect. It also enhances safety, effectiveness and quality of care.
- Postnatal visit to Mother and Baby Unit if woman has transferred directly from hospital after birth.
- Ensure that any follow-up with consultant obstetrician/neonatologist is arranged (if needed) and the woman has appointment details.
- Postnatal home visit if woman released into local community (consider joint visit with the woman's health visitor).
- Specialist midwife to signpost and liaise with primary care to ensure follow-up appointments are in place and the woman is aware (e.g. 6-week GP postnatal check).
- Ensure that assessment of eligibility for the Healthy Start Programme and advise the woman on how to access this.
- The maternity service provider should enable women to take a copy of their hand-held maternity notes (whether paper or digital) when released from detained settings, ensuring that all information is also shared with the woman's community midwife.

Ongoing care

The role of the specialist midwife is in line with the Nursing and Midwifery Council: Standards for Proficiency (2019). This means they care for pregnant mothers and those in the post-natal period – where babies are included this covers the newborn period of up to two months.

As part of the HMPPS Pregnancy, Mother and Baby Policy Framework each detained setting will have regular (weekly in many cases) perinatal multi-disciplinary team meetings. at this meeting, a decision will be made as to who will be the woman's allocated lead professional following discharge from the specialist midwife.

Typically, this will depend on what is the most critical issue with the woman, and this will be agreed by the MDT. At the point of discharge from midwifery care, the specialist midwife will provide a comprehensive handover to the professional who will lead ongoing perinatal care.

Following discharge from midwifery care, the specialist midwife will provide:

- Ongoing attendance at weekly perinatal multi-disciplinary team meetings.
- Maternity service representation at relevant safeguarding children's meetings (e.g. Review Child Protection Conference or Looked-After Child Review). This will provide a vital overview of the woman's parenting capacity and any strengths/risks identified during the early stages of parenthood.
- Midwifery advice regarding pregnancy and postnatal-related matters where they arise within the multi-disciplinary team forum (in situations where the midwife is not the lead professional).
- Pre-conception advice for perinatal women.

Perinatal care pathway for women in prison

As noted above, HMPPS have a Policy Framework for Pregnancy, Mother and Baby which includes the same definition of the perinatal pathway as being used by health of up to 12 months post pregnancy outcome. The pathway and MDT approach are to ensure that all perinatal women are cared for and supported. There is recognition that being pregnant or having given birth (or other pregnancy outcome) within the previous 12 months can add to the stress of being in custody, which also contributes to further risks for the woman's pregnancy, birth and early motherhood. The maternity services provider is a vital partner in the delivery of the care pathway across the detained settings. The provider will work collaboratively and in partnership with a team of multi-disciplinary professionals to develop a pathway which is specific to that setting.

The perinatal pathway will outline the local processes to be followed to ensure the wellbeing of women while in custody, both during pregnancy and after the birth of the baby/end of the pregnancy. It will also include guidance on the care of all women

coming into custody who have given birth, suffered pregnancy loss within the last 12 months (this includes miscarriage, ectopic pregnancy, stillbirth and neonatal death or termination of pregnancy within the previous twelve months) or separated from their baby/child.

The specialist midwife will contribute to the development and ongoing review of the local perinatal care pathway, providing midwifery leadership within the wider multi-disciplinary team. The provider will support the specialist midwife in the development of a 'Maternity Care Pathway for Women who are Pregnant or in the Post-natal in Prison' – to be used by the maternity service's acute and community staff. This will provide clear guidance that is specific to the providing NHS trust, in-line with local policies and referral mechanisms/criteria. The provider will ensure that this guidance is shared with all staff who provide maternity care in hospital, assessment centres and community.

The specialist midwife is a key member of the detained setting perinatal multi-disciplinary team which includes partners from: primary care, mental health (including primary care perinatal mental health), HMPPS/pregnancy mother and baby liaison officer/family liaison officer, voluntary agencies (such as those who advocate for women or work with families etc), probation, social care, children's services, public health etc.). The collaborative approach is to:

- Draw together a cohesive plan of care and support which is coordinated by a named individual for a consistent approach, regardless of changing circumstances during pregnancy and after birth.
- Provide clear updates to the woman about the discussion and any outcomes from the perinatal meeting.
- Share information in a multi-disciplinary forum.

Specialised services/partners

Throughout the processes described, there will be a need for services, provided in partnership with other agencies to manage cross-cutting issues or relatively rare events. This includes identifying pathways to access specialised services including specialised fetal medicine, specialist perinatal mental health (secondary care), drug

and alcohol services, the management of complex pregnancies and appropriate levels of neonatal care.

Maternity service providers should work with local services, including social care and third-sector agencies that provide specialist services for pregnant/post-natal women in detained settings. This will be to coordinate antenatal/intrapartum/postnatal care by, for example:

- Co-locating services – this is further enabled by having a prison/detained setting-based specialist midwife.
- Including information about complex needs (e.g. opiate replacement therapy) in care plans.
- Jointly developing care plans across agencies – for example: plans for birth; separation plans; breastfeeding; release from prison; re-settlement.
- Offering women information about the services provided by other agencies such as birth partner support, advocacy etc (this must be in conjunction with HMPPS to ensure there is no risk to the woman, her family, security arrangements etc).

Equipment

The provider will ensure the specialist midwife has the equipment required to fulfil her role – this must be agreed with the governor/director/The Home Office depending on the type of detained setting. The provider trust is responsible for the purchase/replacement schedule, maintenance and consumables required. The equipment and consumables to be provided by the provider trust include:

- Doppler
- Cardiotocograph machine with remote connection to the maternity unit/ante-natal assessment
- *****Normal delivery pack (as per trust policy)
- *****Infant resuscitation bag - as per trust policy but expected to include:
  - 1 Laryngoscope and 1 disposable blade
  - 1 AMBU bag 500mls
  - Airways - 1 each of O, OO

- Silicon face mask size O/O
- Silicon face mask size O/1
- 1 mucous extractor/filter
- 4 size 1.5 v batteries
- 1 paediatric stethoscope
- Two surgical gowns
- Two fit masks

***** It is essential that only the specialist midwife has access to this equipment. The delivery pack and infant resuscitation bag must be kept in a locked cupboard when the midwife is not on site. It is for the sole use of the midwife should an unplanned delivery happen while they are on site. it is not to be used by any other professional as the midwives will be fully trained in neonatal resuscitation. This is in line with community midwives who may get called to unplanned deliveries during their shift. The specialist midwives are responsible for routine checking of all the equipment in line with the trust policy.

The specialist midwife will work with the healthcare provider to ensure the breast pumps are available when required, including access to consumables. A standard operating procedure should be in place for health and detained staff to follow when a woman is using the breast pump – this will cover access to the pump, storage of milk, transfer of milk etc.

Public health outcomes

The provider is required to support the delivery of the full range of public health programmes appropriate to the needs of pregnant/post-natal women.

The provider will deliver a localised service using nationally recognised values and behaviours. Information will flow between local and national teams contributing to the key outcomes and improvement areas:

- Ensuring services are integrated.

- Reducing health inequalities and ensuring equal access to programmes.
- Reducing health risk factors.

The provider will ensure that a multidisciplinary approach is in place working in collaboration with key stakeholders within the prison/detained setting to address the following areas of health prevention and promotion:

- Health promotion and prevention
- Healthy eating and nutrition
- Healthy lifestyles, including relationships
- Mental health promotion and wellbeing
- Screening and immunisations
- Sexual health
- Smoking cessation

Screening programmes

The provider will work with the detained setting to ensure that the following services are supported and facilitated:

- Antenatal and new-born programme (ANNB): inclusion of antenatal ultrasound screening.
- Antenatal blood borne virus screening.
- Screening for inherited conditions such as Sickle Cell Anaemia and Thalassaemia.
- Screening for Down's syndrome, Edwards' syndrome or Patau's syndrome.
- Blood group and antibody screening.
- New-born bloodspot.
- New-born infant physical examination (NIPE).
- New-born hearing screening.

Women should also have access to evidence-based information prior to consenting to inclusion within the screening programme, and this should be provided to them in an accessible format that suits their own needs. The provider will ensure this is

provided within the appropriate timescales, ensuring that national standards are met in-line with National Screening Committee recommendations.

The provider must work with their local antenatal and new-born screening team to ensure that compliance to these standards are met and that this is evidenced through robust data collection and governance processes.

Vaccination and immunisations

The provider will ensure that all guidance from Public Health England's (PHE) 'Green Book' (PHE, 2013/updated 2020) is followed for vaccinations and immunisations, also maintaining up to date training for all vaccinators. The provider will ensure that:

- All principles of vaccination delivery are followed, and that women are provided the opportunity to remain within the healthcare department following vaccination to ensure she does not experience an adverse reaction.
- All women are made aware of, and fully understand, the benefits of vaccination in pregnancy.
- An immunisation register is maintained.
- Vaccination details are recorded in the individual's clinical electronic record (including decline of offer), data is submitted as per national requirements and uptake rates reviewed and reported to support high levels of compliance.
- Vaccines are administered within the detained setting's healthcare department in a controlled and safe manner.
- Women in detained settings have the same access to vaccination programmes as women in the community.

Health promotion and prevention

The provider must work in partnership with all of the healthcare and detained setting services to ensure that there is effective coordination and delivery of health promotion activities and interventions.
This will include but not be limited to:-

- Delivery of antenatal/parent education, promotion and preventative care programmes.
- Liaising with voluntary sector organisations to support delivery of health promotion activities.
- Training of all staff in the detained setting to raise awareness of:
    - The needs of the pregnant/post-natal woman
    - Associated risks to the mother and unborn baby (if pregnant) and/or infant (if residing in a Mother and Baby Unit) whilst in custody
    - Needs and risks of the mother associated with separation with her baby.
- Training and support for maternity and neonatal staff to raise awareness of the complexities associated with perinatal women in contact with the criminal justice system.
- Support the delivery of consistent perinatal health improvement messages, programmes and interventions across the prison/detained setting. This will include group and individual support.

Smoking cessation

Smoking in pregnancy is the main modifiable risk factor for a range of negative outcomes for both mother and baby. Women who smoke during pregnancy are twice as likely to experience a stillbirth; up to 32% more likely to experience a miscarriage; and babies born to smokers are three times more likely to suffer from Sudden Infant Death Syndrome. Smokers who access behavioural support to quit, combined with stop smoking medication, are 3 times as likely to quit as those without support. However, women from priority populations (especially those from lower socio-economic groups) are less likely to seek or access this support. Women who smoke at booking and who are unemployed, have complex social factors, or who misuse substances, are more likely to continue to be smokers at delivery (PHE, 2021).

The provider must be aware and adhere to both local and national policy for ‘Stop Smoking Services and Support in Custody’ in adult establishments, in-line with HMPPS smoke-free prisons policy. All prisons/detained settings are expected to meet this minimum service offer. The provider must acknowledge their role in the

delivery of this, in conjunction and agreement with NHS England, Public Health England and HMPPS. There is a breadth of guidance already in place that complies with NICE and Public Health England guidance, and the provider should seek to understand the policy that is in place within their local establishment.

The provider will ensure that:

- All women who smoke on reception to detained settings are opportunistically advised to quit and those motivated to do so are referred to the Stop Smoking Service. Further details of this will be obtained from the detained setting's healthcare team.
- Motivated smokers seeking support are offered an evidence-based intervention. Interventions should follow the National standard of 'Making Every Contact Count' (MECC) and adopting an Ask, Advise, Act approach.
- Smoking status is reviewed at each contact throughout the maternity care pathway and documented in both SystmOne (at specialist midwife contacts within the detained setting) and the woman's maternity record. The current national measure of maternal smoking is the rate of women smoking at time of delivery (SATOD); data held in maternity records play an essential role in the audit and assurance of data around the stop smoking measures in pregnancy that have been implemented. Providers must have a robust strategy in place to ensure this is submitted accurately, as set out in the maternity services data set requirements (MSDS)

The provider must ensure that they comply with their local smoking cessation in pregnancy guidelines and staff should be advised to seek supervision and support from a trained stop smoking advisor employed by their organisation. The provider must ensure they provide evidence-based information to women about the risks of continuing to smoke poses to the health of their unborn, and the longer-term health risks to themselves. This must be re-visited throughout the episode of care provision.

Workforce

The provider must ensure that the workforce is able to provide high quality, safe, effective, caring, responsive and well led care for women. It is essential that "the

right staff, in the right place and at the right time" are available to achieve better outcomes, better patient and staff experiences, and effective use of resources.

The service must be delivered by specialist midwives who are employed directly by an NHS trust who deliver maternity services for women with high risk pregnancies – this will usually be the maternity unit that is closest to the detained setting. This is to ensure that the midwives are part of established robust governance and risk management processes to support the specialist interventions and care required by women in the detained estate. The midwives should not be directly employed or part of any sub-contract of a detained setting healthcare provider. The specialist midwives will be based within the detained setting supported by consultant obstetrician, fetal medicine, neonatologists and any other specialism required to meet the maternity and health needs of the women and their babies. Depending on the type of establishment there may also be maternity support staff to compliment, but not replace, the role of the specialist midwife. The provider will ensure that all maternity and neonatal staff involved in the care of women in custody have access to adequate, dedicated time for training and supervision.

Specialist midwife role

The required workforce of specialist midwives will vary depending on the type of establishment and if there is a Mother and Baby Unit as part of the detained setting. It is expected that the role will be Agenda for Change Band 7 due to the specialism, level of autonomy and complexity of the caseload. It is essential that the Midwife is a visible part of the health and detained setting team.

The commissioned service will provide a minimum of 0.8 WTE (30 hours per week) specialist midwife role for each women's prison without a Mother and Baby Unit. Additional hours/multiple posts are recommended for detained settings with Mother and Baby Units/Perinatal Mental Health Units – suggested minimum of 1.2 WTE specialist midwife hours and the possibility of support roles if required. This is not to replace or duplicate the resources employed by HMPPS as part of the Mother and Baby Unit but is part of the enhanced specialist midwifery care offer for women in detained settings. Using a cluster approach for establishments which are close

geographically may be explored but it is vital that the role of the specialist midwife is not diluted due to the need to travel between sites. This will be agreed with the responsible health and justice commissioner.

The hours required for immigration removal centres and children and young people detained settings will be agreed by the responsible health and justice commissioner.

The provider is expected to ensure cover is in place for annual leave, study leave and other absences to avoid there being a gap in service delivery.

The specialist midwife must:

- Be registered with the Nursing and Midwifery Council under the midwives part of the register.
- Access and maintain all required mandatory training, professional midwifery advocate support and clinical and safeguarding supervision from within providing trust.
- Be trained and supported to use the Solihull Approach to parenting/ante-natal education programme.
- Ensure that the identified cohort of women have the appropriate maternity care, with referrals to specialist services as required (e.g.: referral for additional ultrasound scans, consultant appointments etc.).
- Maintain continuous professional development through attendance at educational and training opportunities which are relevant to this work (eg: Royal College of General Practitioner Management of Drug Misuse, Part 1).
- Maintain her core midwifery skills by also working alongside / as part of existing community midwifery teams for a minimum of 352 hours per year in addition to the hours spent doing the role within the detained setting.
- Participate in healthcare liaison/training/education – this will include any awareness raising or training for prison, maternity, and healthcare staff.

The provider will ensure the specialist midwife:

- Has access to regular clinical supervision in line with trust policies, also recognising that additional supervision may be required from a specialist mental health professional who has an appropriate level of expertise – this will provide the clinical and personal support necessary to maintain psychological wellbeing.
- Has completed the security vetting required to work within a detained setting (the detained setting will arrange this once a Disclosure and Barring Certificate dated within the previous 12 months has been presented).
- Has full professional registration with the Nursing and Midwifery Council and discharge their professional responsibilities in line with 'The Code: Professional standards of practice and behaviour for nurses, midwives, and nursing associates'.
- Has the equipment required to undertake the role of the specialist midwife within the detained setting. This will need to be agreed with the governor/director/Home Office depending on the type of detained setting.
- Has the knowledge, skills and experience to work autonomously in a detained setting.
- Have a recognised mentorship qualification with annual updates.
- Have a right to work in the UK.
- Is supported and actively encouraged to attend regional/national meetings and seminars/events in relation to the care of perinatal women in the criminal justice system. This may include HMPPS/NHS England board meetings and networking events.
- Is trained in neonatal life support and associated updates/refreshers.
- Is using a compassionate and trauma-informed approach to the care provided to women and their babies.
- Maintains the competencies required for the delivery of this role and maintenance of core skills.

Specialist midwife key responsibilities

The specialist midwife will:

- Ensure that there is appropriate assessment and planning in place in order to safeguard the woman and child with effective communication.
- Collaborate with prison/detained setting health and the wider partner agencies to develop, implement, and embed multidisciplinary pathways of care.
- In collaboration with partner agencies develop and deliver robust training and education to affect understanding of the impact of being held within the judicial system during the perinatal period.
- Participate in the provider trust's children and adult safeguarding group, ensuring feedback to the maternity service via established communication networks.
- Ensure effective communication and appropriate information-sharing between the maternity service, other services throughout the providing trust, primary care and social care in relation to care arrangements for the mother and the baby.
- Ensure all documentation relating to care is: appropriate, accountable and defensible; available and accessible to the identified staff both within the detained setting and within the maternity service.
- Develop, with other members of the multidisciplinary team, information leaflets and forms for specific use by, parents/legal guardians/families and staff.
- Ensure that there is robust data collection pertaining to interagency referrals and outcomes.
- Facilitate and participate in the review and evaluation of practice through the use of standards and audit within the maternity service and partner agencies.
- Deliver parenting education using the Solihull Approach.
- Guide and coach ward team leaders, midwives, medical staff and other designated key staff in developing and strengthening knowledge and skills in caring for perinatal women within the criminal justice system. This will include how to meet the responsibilities for delivering the appropriate care and support.

- Liaise with other maternity units across England as required to provide the care for women from outside the immediate geographical area of the detained setting.
- Ensure the trust's safeguarding arrangements and services comply with the Data Protection Act 1998, the Human Rights Act 1998 and within the Code of Confidentiality.

Recruitment, induction, and retention of staff

The specialist midwife should be an externally advertised post, following all recruitment policies of the provider. Upon appointment the specialist midwife must have a planned induction programme, specific to the role which is implemented within the first two weeks of employment. This will incorporate placement in acute and community settings located within the maternity service provider's facilities. This must be followed by a robust induction delivered by HMPPS. As part of the induction process, the specialist midwife will be expected to complete SystmOne training relevant to pregnancy/post-natal care. A competency framework will be in place to support the roles linked to this specification.

All specialist prison midwives will be required to undertake the RCGP Certificate in the Management of Drug Misuse Part 1.

The provider will inform the commissioners in writing of any staffing issues, cautions, and convictions identified that may place the service / patients at risk. The provider will liaise with the commissioners in order to establish whether the risk can be managed. This will depend upon the nature and length of the caution / conviction as described in the Rehabilitation of Offenders Act 1974, and any human resources advice which has been sought depending upon the complexity of the situation. HMPPS may also need to be informed depending on the situation due to potential security implications.

Clinical governance

All healthcare provision is regulated by the Care Quality Commission (CQC) and all care must be provided in-line with the fundamental standards:

- Regulation 9: Person-centred care
- Regulation 10: Dignity and Respect
- Regulation 11: Need for consent
- Regulation 12: Safe care and treatment
- Regulation 13: Safeguarding service users from abuse and improper treatment
- Regulation 14: Meeting nutritional and hydration needs
- Regulation 15: Premises and equipment
- Regulation 16: Receiving and acting on complaints
- Regulation 17: Good governance
- Regulation 18: Staffing
- Regulation 19: Fit and proper persons employed
- Regulation 20: Duty of candour
- Regulation 20A: Requirement as to display of performance assessments

The provider is required to have a clear Governance Framework that covers all aspects of the maternity and neonatal service. There should be internal clinical oversight and assurance with robust operational processes in place for the delivery of care and services under this specification. The governance framework will detail the meetings / forums which form part of the governance arrangements and provide clarity of group membership / quoracy from the multidisciplinary team, partners, and key stakeholders. Policies, guidance and standard operating procedures for the provider trust may need to be amended or created to incorporate the specialist service for women in the detained settings.

Governance includes but is not limited to:

- Audit
- Complaints
- Evidence based practice, including adherence to NICE guidelines or equivalent specialist guidelines

- Incident management
- Infection, Prevention and Control
- Open and transparent processes/Duty of Candour
- Patient and public participation/compliments
- Policies and procedures, including standard operating procedures (SOP)
- Quality assurance
- Record keeping
- Risk management

The specialist midwife should undertake Root Cause Analysis (RCA) training and is expected to lead and participate in the process should this be required for any event affecting a patient in their care. The specialist midwife must also be compliant with any requests for data and information required for the Health Service Investigation Branch (HSIB) process (when relevant), or Nursing and Midwifery Council investigation.

Quality assurance and audit

Clinical audit is a key activity for health providers and professionals in England. The clinical audit process is a cycle of steps that includes making changes in practice and reviewing the effectiveness of processes in place. A quality assurance process includes the identification, assessment, correction, and monitoring of healthcare services within available resources. In order to demonstrate quality assurance relating to the care provided to women within detained settings, the provider should ensure that the specialist midwife is aware of quality assurance processes and working to a level where they are able to participate and report accordingly on such activities. The specialist midwife should have knowledge and understanding of the Governance and reporting processes of both HMPPS and the NHS provider trust and must report and comply with both systems in tandem.

Record keeping

All staff are expected to comply with good record keeping practice, as defined by their professional body and the provider must undertake regular record keeping audits. The results of audits must be shared in writing with the commissioner as part of the quality monitoring process. The provider must adhere to standard record keeping practices mandated by NHS England, including the use of standard electronic templates where appropriate. The specialist midwife will use the clinical records utilised within the provider trust but must also apply updates to the detained estate healthcare electronic record (eg: SystmOne) – remote access to the detained estate healthcare electronic record must be available. This will ensure that all healthcare team members are aware of the ongoing care being provided across disciplines.

The provider trust must have systems and processes in place to aid good record keeping practice which includes:

- Agreed arrangements and time scales for multi-agency audit of record keeping including data quality.
- Clear guidance on confidentiality of records in line with legislation and professional codes of practice.
- Clear polices in place which detail the management of subject access requests, taking into account the impact some detail may have if/when shared with a patient.
- Having robust polices in place which cover storage, retention and destruction of records in accordance with current NHS standards.
- Maintenance of individual electronic records for each woman.
- Patient's consent to create a record of the services provided, who this could be shared with, how long the record will be retained and the date of planned destruction.
- Retention and storage of records which allows audits to be completed as requested or required by Commissioners.
- Training for staff to ensure they understand their responsibilities and legal obligations in relation to person identifiable records.

Policies and guidance

The specialist midwife will follow and participate in the development of all policy and guidelines within maternity services, set by the provider trust in which they are employed.

They will be actively sought as an expert in their field by HMPPS staff, demonstrating leadership and expert knowledge in the care of perinatal women in detained settings. The specialist midwife will contribute to the development of guidelines and policies that affect the women in their care.

The specialist midwife should ensure that they work at all times within the Nursing and Midwifery Council: 'The Code', and remains accountable to the NHS provider by working to their standards, policies and guidance at all times. Failure to do so would constitute a reason for investigation into the specialist midwife's practice. Reasons for failure to follow policy must be clearly documented within the women's handheld records.

Risk and incident management

It would be expected that as part of continuous professional development requirements, the specialist midwife will be an active and participating member of the Provider's risk management team. They will be responsible for liaising with HMPPS where there is relevant learning to be actioned and shared. The specialist midwife should be actively encouraged to participate in the NHS provider's risk management structure and process, contributing to the patient safety agenda and applying this knowledge into practice.

The provider must adhere to the current NHS England Serious Incident Framework/Patient Safety Incident Framework.

Complaints and compliments

The provider should encourage all women in the care of a specialist midwife to submit compliments and complaints via the NHS procedures in place. If a complaint is received regarding the conduct of the specialist midwife, then the employer (being

the NHS provider) will investigate. The complaint should be answered accordingly, including by reference to the records made by the specialist midwife during the care episode. For transparency, the provider is also encouraged to forward any complaints directly to the commissioner for their review and acknowledgement.

Compliments should be shared according to internal NHS and HMPPS policies and procedures and be logged in a manner which can ensure feedback to the relevant staff member or team.

Listening to women and families

Supporting the delivery of the Better Births' vision; of greater service user engagement and feedback is essential to inform service improvements. Providers should ensure that all pregnant/post-natal women presenting for care whilst in detained settings are asked about their satisfaction with the services provided. Providers are expected to:

- Demonstrate active engagement with service users in the planning and development of services.
- Participate in the net promoter programme (Friends and Family Test) and additional mechanisms as necessary.
- Put in place mechanisms to gain feedback from service users
- Record and monitor feedback provided.
- Respond to complaints proactively.
- Support participation in the CQC national maternity services survey to inform the NHS System Oversight Framework.
- Use both positive and negative feedback to drive and evidence continuous service improvement to best meet mothers and family's needs.
- Use Maternity Voices to ensure the voice of the women are heard.

Gathering anonymised patient stories could help develop the evidence of the difference being made by the targeted approach to caring for pregnant/post-natal women. Peer mentors may also be able to provide feedback on behalf of the women.

Infection, prevention and control

The provider will ensure there are clear processes in place to meet the standards of infection, prevention and control (Health and Social Care Act, 2008 and NHS Standards for Infection Control, 2012), and the cleaning/decontamination required to minimise transmission of infection. The specialist midwife will need to adhere to any additional requirements when working in detained settings.

Safeguarding

Staff training

Staff training programmes should be underpinned by the Local Authority Training Strategy relevant to the area in which the detained setting is located. These should be designed to support Commissioners and practitioners to embed good practices, in relation to the safeguarding of adults, children and young people.

The Provider must ensure that staff members working with vulnerable women and children have annual access to specific training in relation to the safeguarding of adults, children and young people. This should form part of the annual appraisal discussion.

Providers must ensure that the training provided is in line with the Intercollegiate Document, relevant to the role and provided to a high standard. Training should be followed up with the opportunity to access regular safeguarding supervision, with an allocated Named Nurse for Safeguarding. This should be facilitated by the provider on a 3-monthly basis (as a minimum) alongside a local arrangement with the Provider's Safeguarding Team to ensure that this is in place.

Safeguarding vulnerable adults

The aims of safeguarding a vulnerable adult are to ensure their lives are free from neglect and abuse, encourage or help individuals to make decisions about their own lives and care, and create a risk-free environment.

There are many forms of abuse and neglect, including sexual abuse, physical abuse, psychological abuse, domestic abuse, discriminatory abuse, financial abuse and neglect.
When taking steps to safeguard vulnerable adults, it is crucial that the Mental Capacity Act is followed - this process will determine whether an adult is capable of making choices for themselves. Only where this process has been followed and it has been decided that they are unfit to choose for themselves, can any decisions about care be made without the individual's consent. The provider must have policies and procedures in place to be utilised to safeguard vulnerable women.

The specialist midwife must be adequately trained, and have the skills and knowledge required to:

- Identify the need for a Safeguarding Adults Referral.
- Recognise and/or recommend the level of individual need according to local criteria.
- Understand why this is appropriate and have the ability to write this clearly and concisely.
- Make referrals in a timely manner, according to local policies, procedures and timeframes.
- Make clear decisions about the outcome that they require.

Safeguarding children

The Department for Education published Working Together to Safeguard Children in July 2018, replacing the previous guidance issued in 2015. This is a statutory framework that sets out the legislation relevant to safeguarding children.

The provider must ensure that it has all relevant policies and procedures in place to be utilised to safeguard children of women within custody, and that these are available to all maternity staff. The specialist midwife must be trained and able to observe signs which may indicate a child is at risk of being abused or neglected. This should ensure that they use their professional curiosity when performing comprehensive risk assessments in all cases with referrals to children's social care if they suspect that a child is at risk of harm or neglect. They must consider risks in

pregnancy for the unborn baby and risks to child/children that the woman had in her care prior to coming into custody.

The specialist midwife should make sure that they understand and work within the local multi-agency safeguarding arrangements that are in place.

The provider should ensure they follow key principles:

- Children have a right to be safe and should be protected from all forms of abuse and neglect.
- Safeguarding children is everyone's responsibility.
- Children and families are best supported and protected when there is a co-ordinated response from all relevant agencies.

Information governance, data protection, security and confidentiality

Information governance is the mechanism in which organisations 'process' or handle information. It covers personal information, i.e. which relates to patients/service users and employees, and corporate information. It provides a way for employees to deal consistently with regards to how information is handled, including rules as set out in:

- The Common Law Duty of Confidentiality.
- The Confidentiality NHS Code of Practice.
- The Data Protection Act 1998.
- The Freedom of Information Act 2000.
- The Information Security NHS Code of Practice.
- The International Information Security Standard: ISO/IEC 27002: 2005.
- The NHS Care Record Guarantee for England.
- The Records Management NHS Code of Practice.
- The Social Care Record Guarantee for England.

In the UK, the legal frameworks covering how patient data must be looked after and processed are the Data Protection Act (DPA) 2018, which brought the EU General Data Protection Regulation (GDPR) into law, and the Common Law Duty of Confidentiality (CLDC). Data protection legislation requires that the collection and

processing of personal data is fair, lawful and transparent, and this should be adhered to by the Provider. In summary this means there must always be a valid lawful basis for the collection and processing of data, and the provider must be able to evidence that this is the case.

In addition to the statutory requirements the provider must meet prevailing national standards and follow appropriate NHS good practice guidelines for information governance and security, including, but not exclusively:

- Appointment of a Caldicott Guardian.
- Disaster recovery plan to ensure service continuity and prompt restoration on all Information Management and Technology systems.
- Encryption standards in line with guidance from NHSX (formerly Health and Social Care Information Centre).
- Governance arrangements in line with the Data Security and Protection Toolkit.
- Policies on security and confidentiality of patient information.
- Records Management Policies and procedures.
- Risk and incident management system.
- Use of the Caldicott principles and guidelines.

For the avoidance of doubt, obligations apply in respect of information held in all formats including electronically and manually.

The provider must ensure that they have in place, policies which cover all aspects of Information Governance available for the specialist midwife to utilise and adhere to when dealing with care records of women in prison. The specialist midwife should also be aware of the guidelines and standards also set out by HMPPS.

Key policies that the specialist midwife must familiarise themselves with include:

- Confidentiality Code of Conduct
- Data Protection Policy
- Duty of Candour
- Email Policy
- Internet Use Policy

The provider should also ensure that the specialist midwife has access to annual information governance training and that they understand how essential these principles are to their role, thus reducing the risk of information governance incidents and confidentiality breaches occurring.

The specialist midwife must always comply with Nursing and Midwifery Council: The Code (2020). As a nurse, midwife or nursing associate, they have duty of confidentiality to all those who are in their care or accessing care provision. This should always be adhered to, and the provider must ensure that this is the case. The specialist midwife must ensure that they do not breach their Code of Conduct. They should, however, also have an understanding of situations in which information sharing is relevant, for example in cases that are within Child Protection procedures and ensure that women in their care understand the limitations of confidentiality.

Business continuity and contingency planning

This service is seen as business critical and it is essential that the provider has a robust business continuity plan covering a broad range of risks that may affect the delivery of services contained within this service specification. Contingency plans must be in place to minimise disruption to the delivery of services and should clearly describe the escalation procedure and how they will be shared with staff, Commissioners and other key stakeholders. Business continuity plans should include periodic multi-agency testing of the systems and processes that will be used in the event of a failure of a key business function. This must include, but is not limited to, contingencies relating to failure of information systems, electronic clinical records and electronic communication etc.

Quality, performance and activity monitoring

Key performance indicators

To monitor the services provided by the specialist midwives, qualitative and quantitative information needs to be submitted – this will be in line with the Health and Justice Data Strategy. The datasets are subject to reviews and the provider will be required to adapt systems to allow the collation and submission of the information.

The following data (subject to review in 2022) will be submitted to the health and justice commissioning teams on a quarterly basis, broken down into monthly activity:

- The number of pregnant and postnatal women on the specialist midwife's
- Number of new bookings
- Number of ante-natal contacts
- Number of on-site scheduled appointments not attended (including the reason)
- Number of external out-patient scheduled appointments attended
- Number of external out-patient scheduled appointments not attended
- Uptake of antenatal education – number of sessions delivered (group/1:1)
- Number of live births
- Number of live births attended by the specialist midwife (continuity of care)
- Number of unplanned deliveries on the detained site
- Details of other pregnancy outcomes
- Number of post-natal contacts – mother and baby
- Continuity of carer contacts (%)
- Breastfeeding rates
- Smoking status at booking, delivery and postnatal
- Safeguarding meetings and reports
- Outcomes of Mother and Baby Unit applications
- Number of meetings attended broken down into: Perinatal Pathway; Multi-disciplinary health related; safeguarding

Expected outcome measures

The outcome measures are based upon equivalence with the community pathways, current National Institute of Clinical Excellence and The Ockenden Report (2020).

- All pregnant women are seen by a midwife within 7 days of arriving in the detained setting.
- Continuity of care: 75% of contacts throughout antenatal and postnatal period by the named specialist midwife.

- 80% detection rate of fetal growth restriction with actions taken in line with national and local policies.
- Increase breastfeeding initiation rates by 2% from a baseline of the rate on 1st September 2021.
- All women are involved in the decisions made about her care with specialist midwives and local maternity unit. this will include preferences of place of birth, choices linked to birth planning etc.
- All pregnant women will have access to maternity care 24/7 (maternity triage/maternity assessment centre when specialist midwives are not on site).
- Promotion of mental health well-being with prompt referrals to perinatal mental health specialists where required.

Quality measures

The provider will quarterly on the following:

- Compliance with statutory mandatory training.
- Number, themes and learning from incidents, complaints and compliments relating to the service.
- Risk register.
- Audit reports – record keeping and safeguarding as a minimum.
- User involvement and any improvements made linked to this activity.

A quarterly quality and performance report will be submitted to commissioners. This will include the data linked to the KPIs and narrative to demonstrate compliance with the quality and outcome measures outlined above. An annual report will provide a summary of the service delivered.

Appendix One – definitions

In this service specification, the following definitions are used:

- **Detained estate** – covers: children and young people secure estate, immigration removal centres and prisons.
- **Equity** - means that all mothers and babies will achieve health outcomes that are as good as the groups with the best health outcomes. For this, maternity and neonatal services need to respond to each person's unique health and social situation – with increasing support as health inequalities increase – so that care is safe and personal for all.
- **Maternity** – refers to the period from confirmation of pregnancy to six weeks after childbirth.
- **Newborn** – an infant from birth to around two months old (NMC, 2019)
- **Perinatal period** – refers to the period during pregnancy and the year after (RCM, 2019)
- **Perinatal mental health** - refers to primary care perinatal mental health services which are available to women from confirmation of pregnancy and the first 12 months after childbirth or pregnancy loss (including termination of pregnancy).
- **Postnatal period** – refers to the time from birth to six weeks post-natal.
- **Specialist perinatal mental health** – refers to secondary care specialist perinatal mental health which has referral criteria for severe mental illness from confirmation of pregnancy and the first 24 months after childbirth or pregnancy loss (including termination of pregnancy).

Appendix Three – NICE guidance

NICE guidance and standards which apply to this specification, along the pathway of care are outlined below:

NICE guidance*	Publication/updated date
Antenatal Care NG201	2021
Antenatal Care QS22	2012 / 2022
Antenatal and postnatal mental health - clinical management and service guidance CG192	2014 / 2020
Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors CG110	2010
Safe midwifery staffing for maternity settings NG4	2015
Hypertension in pregnancy NG133	2019
Quitting smoking in pregnancy and following childbirth PH26	2010
Smoking: acute, maternity and mental health services PH48	2013
Weight management before, during and after pregnancy PH27	2010
Diabetes in Pregnancy NG3	2015 / 2020
Epilepsies: diagnosis and management CG137	2012 / 2021
Inducing labour CG70	2008
Insertion of a double balloon catheter for induction of labour in pregnant women without previous caesarean section - Interventional procedures guidance (IPG528)	2015
Preterm labour and birth NG25	2015 / 2019
Intrapartum care for healthy women and babies CG190	2014 / 2017

Intrapartum care for women with existing medical conditions or obstetric complications and their babies NG121	2019
Caesarean section CG132 QS32	2011 / 2012
Multiple pregnancy: antenatal care for twin and triplet pregnancies CG129	2011
Jaundice in newborn babies under 28 days CG98	2010 / 2016
Maternal and child nutrition PH11	2008 / 2014
Postnatal Care up to 8 weeks after birth CG37	2006 / 2015
When to Suspect Child Maltreatment in under 18s CG89	2009 / 2017

*Please note that the list above reflects the published guidance in August 2021 and the NICE website should be sourced for amended, updated and new guidance. The provider shall adhere to all guidance.

Appendix Three: HMPPS guidance

HMPPS Women's Team (2018) 'Guidance on Working with Women in Custody and the Community'

(Standard 6.7) Prisons should ensure perinatal care services are in place to support women

"Prisons should ensure there is a perinatal pathway with care services in place to support women during this time. There should be multi-disciplinary membership of the pathway and it should include efforts to improve conditions or care for pregnant women, support during birth, co-residence after births and mental health service provision."

(Standard 6.5) Pregnant women should have access to a (trauma informed) antenatal and screening support programme while in prison.

(Standard 6.1)

(i) *As part of* NHS England's *Saving Babies' Lives* care package, *the following four evidence-based interventions should be available to women in prison to help reduce the risk of stillbirths:*

- *Reducing smoking in pregnancy*
- *Risk assessment and surveillance for foetal growth restriction*
- *Raising awareness of reduced foetal movement*
- *Effective foetal monitoring during labour*

(ii) *In line with the national maternity review, Better Births, each woman in prison should have a personalised care plan and be provided with unbiased information to support their decisions.* Every pregnant woman should also have a clear plan of care should an emergency birth happen. *They should be able to have continuity of carer, to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions.*

(iii) The midwifery team working across the detained estate will lead on ensuring these interventions/services are delivered to women and babies, but close

cooperation between all the stakeholders involved in women's care will be important. For example, prison/security staff will be needed to facilitate timely transfer to hospital if urgent monitoring and additional scans are required.

[11]Ministry of Justice/HMPPS Policy Framework, 2021. 'Pregnancy, Mother and Baby Units (MOTHER AND BABY UNITs), and Maternal Separation from Children up to the Age of Two in Women's Prisons'

Part A: Pregnancy, Birth and Other Pregnancy Outcomes – relates to women experiencing pregnancy and pregnancy outcomes in the 12 months prior to or during their entry into prison.

Part B: Prison Mother and Baby Units - relates to women and children applying to and spending time on Mother and Baby Units.

Part C: Mothers separated from children up to the age of two years old – relates to planned and unplanned separation of mothers from their babies/children up to the age of two years (1001 days).

This framework includes the development of a Pregnancy, Mother and Baby Unit Liaison Officer (PMBLO) role who will need to work in partnership with the services described in this specification.

Appendix Four: Key documents, policies and frameworks/references

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