

West Kent Clinical Commissioning Group Community Maternity Services Specification

This document sets out a maternity services specification for

The document draws on national documents, published evidence and locally available data and information and was a collaborative document produced with input from local CCG commissioners of maternity services from across Kent and Medway as well as service providers, healthcare professionals and service users.

With thanks to the North East London Strategic Clinical Network and local maternity networks and providers for sharing their maternity service specifications.

DRAFT

Maternity Services Specification

Contents

1 Background	Page
1.1 Introduction	
1.2 The purpose of the service specification	
1.3 Outcomes	
1.4 Equality and diversity	
1.5 Policy and guidance	
1.6 Workforce standards	
1.7 Tariff and payment	
1.8 Existing reporting	
2 Schedule 2 - The services	Page
2.1 Aims and objectives	
2.2 Basic commissioning principles	
2.3 Service Description / Care Pathway	
2.4 Pre-conception advice and care	
2.5 Under 20 years conceptions	
2.6 Antenatal Care	
2.7 Screening	
2.8 Intrapartum care	
2.9 Postnatal care	
2.10 Workforce standards	
2.11 Service user agreement	
2.12 Population covered	
3 Acceptance and exclusion criteria	Page
3.1 Whole system relationships	
4. Applicable Service Standards	Page
4.1 Applicable national standards	
4.2 Applicable local standards	
5. Applicable quality requirements and CQUIN goals	Page
5.1 Applicable Quality Requirements and CCG Outcomes Indicators	
5.2 Other specific quality monitoring	
5.3 Applicable CQUIN goals	
6. Location of provider premises	Page

1 Background

1.1 Introduction

This service specification sets out the model and requirements for a pilot with a community midwifery provider commissioned by West Kent Clinical Commissioning Group (WK CCG) / sub contract with Maidstone and Tunbridge Wells NHS Trust. This specification draws on evidence, best practice and contributions from clinicians, the CCG, Public Health, and service leads and service users.

WK CCG, Maidstone and Tunbridge Wells NHS Trust (MTW) along with an out of area CCG- High Weald Lewes Havens (HWLH), were awarded *Better Births* Maternity pioneer status in May 2016. Key elements of the pioneer work include:

- Widening choice across CCG boundaries - clusters of CCGs working together to establish service specifications and qualify new providers to offer maternity services across their combined localities, offering women more choice of providers to meet their needs and preferences.
- Empowering women to take control - developing and implementing arrangements for women to take control when deciding who provides the services they wish to access.
- Enabling women to make decisions – developing and implementing additional ways of enabling women, from all sections of society, to make decisions and choices about their maternity care.

This pilot is part of the pioneer work and has been commissioned solely by WK CCG and follows recommendations from the 2016 Maternity Review.

The aim is to provide a safe, accessible and personalised service for local women, babies and their families in planning pregnancy, throughout pregnancy, during labour, and in the period following the baby's birth.

1.1.1 The National Context

The Five Year Forward View for Maternity '*Better Births*' was published in 2016 and outlined the need for Maternity Services to work through local transformation to become safer, more personalised, kinder, professional and family friendly. The key areas identified were:

1. Increased personalisation care
2. Increased continuity of care
3. Safer care
4. Better postnatal and perinatal mental health
5. Better multi-professional working
6. Working across boundaries – including service and geographical
7. Reformed payment system

Better Births also outlined the need for the establishing and development of Local Maternity Systems that are co-terminus with STP footprints. These have brought together a range of

stakeholders including: commissioners, maternity providers, public health, maternity voices partnerships, social care and ambulance trusts, to work collaboratively on a local maternity transformation plan to deliver the vision and requirements from *Better Births*. These requirements will be referenced throughout this document.

1.1.2 The Context of Maternity Services in Kent and Medway

In 2015 there were approximately 22,930 live births in Kent and Medway, with just under 6,000 of these being delivered at Maidstone and Tunbridge Wells Trust. Across Kent and Medway, there are 4 maternity providers working over 5 sites, with 1 freestanding midwifery led unit and 4 alongside midwifery led units.

In WK CCG there is 1 established maternity provider working from 1 acute site and 1 freestanding birth centre. The maternity provider, Maidstone and Tunbridge Wells Trust (MTW) also works from another freestanding birth centre outside of the area in Crowborough.

The introduction of a community provider would consequently create a second provider in the system and an additional choice for women, albeit of solely midwifery services.

Key Kent and Medway information:

The population of Kent and Medway is approximately 1.5 million with a mixed socio – economic picture. There is a mixture of urban and rural geography with many women living in villages which are relatively isolated from the main population centres. These women and families have further distances to travel in order to access services.

There are significant health inequalities across Kent and Medway. In the Thanet CCG area, one of the most deprived areas of the county, a woman living in the best ward for life expectancy can expect to live almost 22 years longer than a woman in the worst. Each district within Kent and Medway has areas with poor health outcomes and there are also areas with high deprivation, poor levels of educational attainment and high crime rates.

The general fertility rate (GFR) is the number of live births per 1,000 women aged between 15 and 44 years. The GFR across Kent increased between 2006 and 2012, from 56.4 births per 1,000 population to 65.1. Since then the rate has decreased, and was 62.2 live births per 1,000 females aged 15 to 44 in 2015.

Data for 2015, shows that across Kent, there were 62.2 live births per 1,000 females aged 15 to 44. This ranged from 43.8 in Canterbury and Coastal CCG to 69.7 in Swale CCG. Ashford (66.9), Dartford, Gravesham and Swanley (68.1), Swale and Thanet (69.1) CCGs had a significantly higher GFR than Kent, while Canterbury and Coastal had a significantly lower rate.

The general fertility rate in Medway in 2015 was 65.2 births per 1,000. This value is higher than South East region and England averages (61.7 and 62.5 births per 1,000 respectively). In Medway, the general fertility rate varies considerably between electoral wards, ranging from around 48 in Rainham Central to 79 in Luton and Wayfield.

Number of live births by Trust (2010-2015)

Trust	2010	2011	2012	2013	2014	2015
Dartford and Gravesham NHS Trust	3861	4934	5187	4751	5014	5091
East Kent Hospitals University Foundation Trust	7444	7346	7504	7022	6976	7049
Maidstone and Tunbridge Wells NHS Trust	5388	5580	5723	5432	5735	5868
Medway NHS Foundation Trust	4836	4887	5205	4930	4911	4922

Data provided by Trusts

- In the CQC survey of 2015 Maidstone and Tunbridge Wells NHS Trust was rated as requires improvement
- There were 4 maternal deaths in Kent and Medway during 16/17.
- The UK stillbirth rate in 2014 was 4.16 stillbirths per 1,000 live births and although this rate is falling it remains higher than many other comparable European countries
- The Kent and Medway Local Maternity System aims to ensure that high quality, safe and sustainable maternity services are accessible to women.

1.1.3 Local Demographics

The Kent and Medway population is set to grow rapidly and surpass Office of National Statistics (ONS) predictions. There are ambitious housing expansions planned throughout the STP footprint. The population is expected to grow by 90,000 people (5%) over the next 5 years; 20,000 of these people will be housed in the new town being built in Ebbsfleet. The Ebbsfleet Garden City will develop over the next 15 years as up to 15,000 homes are built.

The Kent and Medway Growth Infrastructure Framework (KMGIF) has predicted 188,200 new homes and 414,000 more people (by 2031) incremental to ONS predictions. It is expected that the new population will put pressure on Maternity and paediatric services especially. This will also not be evenly distributed across Kent and Medway, consequently putting more pressure on some units than others.

When considering the projected population increase particularly as a result of the housing development in some parts of Kent, this will need to be accounted for in order to ensure that maternity services are able to cope with the likely increased demand in the future.

The below population projections are produced by the Office for National Statistics (ONS), and do not take into account planned housing developments:

Projected female population aged 15 to 44

	2014	2020	2025	2030	2035	2039
NHS Ashford	22731	22968	23802	24304	24624	24827
NHS Canterbury and Coastal	40577	39497	40235	41396	41625	41944
NHS Dartford, Gravesham and	50001	51246	53372	54669	55617	56407
NHS Medway	55235	56621	58572	60322	61639	62460
NHS South Kent Coast	34022	32566	32951	33020	33085	33097
NHS Swale	20513	20739	21539	21978	22393	22640
NHS Thanet	24045	24195	25140	25644	26080	26308
NHS West Kent	85385	85215	87898	89301	90484	91224
Kent & Medway	332509	333045	343509	350635	355547	358906

Source: ONS population projections, prepared by KPHO (RK), 8/17

Key Factors Affecting Maternal Health

The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid down in pregnancy and early childhood. The physical and mental wellbeing of the mother, fetal exposures in the womb and early childhood experience have lifelong impacts on many aspects of health and wellbeing (The Marmot Review, 2010) (Wave Trust, 2013).

Some of the key factors affecting women and their babies include:

- Poverty, deprivation, overcrowded housing and homelessness
- Birth outside marriage/sole registration
- Maternal age (under 20 years and 35 years+)
- Domestic violence, including female genital mutilation (FGM)
- Recent migration (including asylum seekers and refugees)
- Low literacy and difficulties in speaking or reading English
- Consanguinity
- Diabetes
- Hypertension
- Mental health
- smoking
- Infectious diseases
- Long Term Conditions
- Obesity

1.1.4 The Community Midwifery Pilot:

Women historically within Kent and Medway are only offered their closest local maternity provider and consequently lack choice within maternity services. This pilot was commissioned to offer an alternative choice to local women.

The model that will be piloted is based on a case loading model, in which one midwife follows a woman across the care pathway, offering continuous support and care throughout pregnancy, birth and the postnatal period. This model of service delivery is based on the key concepts of individualised care, continuity of carer and normalising pregnancy and childbirth; key concepts of the Maternity Review. The importance of these concepts is rooted in evidence that illustrates, mothers who receive continuity of care throughout pregnancy and birth from a single or small group of midwives were more satisfied with their care, less likely

to give birth pre-term, require fewer interventions, whilst having higher rates of normal birth and breast feeding*.

The provider will therefore provide antenatal, intrapartum and postpartum midwifery care for up to six weeks to low risk WK CCG women, on the standard antenatal pathway, using a case-loading midwifery model in order to improve the experience of choice and continuity of carer.

The service will be available to women who reside in WK CCG, who are at low risk of complications, and access will be by **self-referral or GP referral**. At the point of referral the provider will screen the woman for suitability for their care. Women who meet the criteria will be booked and communications made as required to the woman's GP and local provider MTW.

If a woman accessing the service experiences any unforeseen complications at any point in the pathway, her Midwife will refer the woman to MTW / appropriate provider and, where possible, accompany her to any consultation, including attending the birth in a supportive capacity if not at home. This will allow review of any risk factors and planning for ongoing care.

The service will therefore provide women with easy access to supportive, high quality and safe maternity services, designed around their individual needs and those of their babies and family.

*Sandall J. Soltani H. Gates S. Shennan A. Devane D. (2013) Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews (8):CD004667

1.2 The purpose of the service specification

The purpose of this service specification is to inform commissioners, providers, service users and other stakeholders of the standards expected for Maternity services in WK CCG. It does this by:

- Describing at a high level the requirements for a reliable, effective and efficient maternity service
- Describing the standards expected at each stage of the maternity pathway
- Providing a benchmark for identifying specific local areas for improvement in line with best practice
- Informing the development of action plans for achieving specific outcomes
- Provides a structure for monitoring and measuring performance
- Facilitates the planning, implementation and evaluation of changes

1.3 Outcomes

Maternity care is recognised specifically in both the public health outcomes framework 2013 - 2016; with indicators such as:

- Under 16 conceptions,
- Low birth weight
- Smoking and

- Breastfeeding at birth
- Infant mortality
- Screening

And the NHS CCG Assurance Outcomes for Maternity:

- Improve women’s experience of maternity services
- Increase choice’s in maternity services
- Decrease maternal smoking at delivery
- Decrease neonatal mortality and stillbirths

Maternity is also part of the NHS Outcomes Framework of 2016/17:

Domain 1	Preventing people from dying prematurely 1a Potential years of life lost (PYLL) from causes considered amenable to healthcare Adults Children and Young People 1.6 Reducing mortality in children (Infant mortality (PHOF 4.1))	X
Domain 2	Enhancing quality of life for people with long-term conditions 2. Health related quality of life for people with long term conditions	
Domain 3	Helping people to recover from episodes of ill-health or following injury	
Domain 4	Ensuring people have a positive experience of care 4.5 Improving women’s and their families experience of maternity services	X
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm 5a Deaths attributable to problems in healthcare. 5b Severe harm attributable to problems in healthcare. 5.5 Admission of full term babies to neonatal care. 5.6 Patient safety incidents reported.	X

Futhermore there are now the national requirements of all Local Maternity Systems to ensure:

- All women have a personalised care plan
- All women are able to make choices about their maternity care, during pregnancy, birth and postnatally
- More women receive continuity of care
- More women are able to give birth in midwifery led settings
- Reduce the rates of stillbirth, neonatal death, maternal death, and brain injury during birth by 20% by 2020/21 and be on track to reduce by 50% by 2025
- They are investigating and learning from when things go wrong in maternity and sharing that work
- They are fully engaged with the development and implementation of the NHS improvement and Neonatal Quality Improvement programme

1.3.2 Locally defined outcomes – Kent and Medway

The overarching aim of reducing variation in outcomes, improving safety and improving the experience of care for women and their babies is key.

The Kent and Medway Local Maternity System is a key vehicle for the delivery of these national and regional aims and has developed a transformation plan. This will ensure there is access to a consistent Maternity Local Offer across our footprint, regardless of where service users live in Kent and Medway. The LMS will work together across organisational boundaries in a large place based system, to ensure that women, babies and families are able to choose and receive the services they need within their communities, near their homes. Women will be offered an informed choice and a better experience through personalised care. This will reduce variation and inequity across the STP footprint.

The main aims will be:

- Improving quality, safety and outcomes for local women and families
- Improving women's experience
- Implementation of the Maternity Better Births Pioneer programme
- Improving transitional care
- The aims of the Maternity Pioneer Programme
- Reduction in mortality and morbidity of pregnant women
- Reduction in stillbirth rates
- Improvement in women's and families experience of maternity care
- Improving earlier identification of perinatal mental health issues
- Early access to maternity services
- Increasing the number of women accessing midwifery-led settings
- Developing a Kent and Medway model to Continuity of care

1.3.3 Provider Outcomes

In line with these national and regional outcomes and the policy and guidance outlined in section 1.5 the following local outcomes have been identified for the service. Namely that it will:

- Deliver care that is woman-centred, responsive to local need, characterised by compassion, kindness and respect for those using the service and their right to make informed choices about their care.
- Deliver safe and effective care to women, babies and their family.
- Work continuously to improve outcomes for mothers and babies, reducing morbidity and mortality, stillbirth, low birth weight and infant mortality.
- Deliver care that is appropriately compliant with national reviews, standards and evidence based practice.
- Deliver care that engages women as partners in shaping the maternity service so that it best reflects their needs and priorities, leading to improved access and choice.
- Increase the number of 'eligible' (defined as healthy women with uncomplicated pregnancies entering labour at low risk of developing intrapartum complications) women enabled and supported to access midwifery led settings

- Increase the number of women receiving continuity of midwife care, with the midwife acting as the key point of co-ordination for on-going care.
- Promote and increase the numbers of 'normal' births (defined as without induction, without the use of instruments, not by caesarean section and without general, spinal or epidural anaesthetic before or during birth). Ensuring services are adapted to meet the increasing demand.
- Promote the work of public health teams in local authorities to improve public health outcomes such as early access to maternity services, breastfeeding initiation, healthy eating, and reducing smoking in pregnancy and pregnancy planning for women with pre-existing conditions.
- Ensure that all women and their babies have timely access to appropriate level maternal, fetal and neonatal medicine services, with clear pathways of care that are provided within a network.
- Embed safeguarding across the pathway in line with local safeguarding procedures; this would include responsibilities for Female Genital Mutilation (DH safeguarding women and girls FGM)
- Ensure easy access to translation, interpreting and advocacy services based on an assessment of need.
- Bring equity between physical and mental health.
- Maintain strong communication links to other maternity services, relevant health professionals such as health visitors and the woman's GP throughout the pregnancy and following birth.
- Encourage an open and transparent environment where staff are able to raise concerns and challenges and create an environment of learning from incidents and user feedback supported by a robust clinical governance framework.
- Develop a framework around training to support staff and address poor performance or poor attendance ensuring training analysis is conducted for all key staff groups, and use lessons gained from clinical incidents to aid and inform training sessions.
- Reduce where possible, the Kent and Medway maternal death rate.

1.4 Equality and Diversity

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

It is also important that local areas actively engage with women with complex social factors who may be less likely to access or maintain contact with maternity services which can affect outcomes for mothers and babies. The pilot should reach out where appropriate to these groups using local community networks.

1.5 Policy and Guidance

Maternity Services are delivered within the context of national, regional and local policy, research and guidance taking account of individual and population need. Examples of key documents from the last 10 years are given below. Note this list is not exhaustive and as such it is expected that providers update service provision appropriately in line with new standards as they are published:

1.5.1 National Policy, Guidance & Reports

- British Association of Perinatal Medicine (BAPM) Optimal arrangements for neonatal intensive care units in the UK including guidance on their medical staffing – A framework for practice (June 2014)
- DfE (2017) Working together to safeguard children
- DH (2007) Maternity Matters: Choice, access and continuity of care in a safe service
- DH (2007) National Service Framework for Children, Young People and Maternity Services
- DH (2007) Making it better for mother and baby: clinical case for change
- DH (2009) Healthy Child Programme
- DH (2010) Equity and Excellence: Liberating the NHS
- DH (2012) Preparation for Birth and Beyond
- DH (2015) Female Genital Mutilation risk and safeguarding guidance for professional
- DH (2016) Safer Maternity Care. Next steps towards the national maternity ambition
- Fathers Direct – Now Fatherhood Institute (2007) Including New Fathers: A Guide for Maternity Professionals
- HM Government (2015) Working Together to Safeguard Children
- Kings Fund (2008) Safe Births: Everybody's business.
- Kings Fund (2016) User Feedback in Maternity Services
- Institute for Innovation and Improvement (2007) Focus on caesarean sections
- MBRRACE- UK reports and audits into maternal death, perinatal mortality and other morbidity
- NCT, RCM & RCOG (2006) Modernising Maternity Care: A commissioning Toolkit for England (book)
- NHS Commissioning Board (2013) E12/S/a NHS Standard contract for fetal medicine
- NHS Commissioning Board (2012), Everyone Counts: Planning for Patients 2013/14
- NHS England Patient Safety Domain Serious Incident Framework (2015)
- NHS England (2016) The National Maternity Review: Improving outcomes of maternity services in England. A five year forward view for maternity care.
- NHS England (2016) Spotlight on maternity.
- NHS England (2017) A-EQUIP a model of clinical midwifery supervision
- NHSE (2017) NHS Outcomes Framework Indicators 2017 -18
- NHSE (2015) NHS Public Health Functions Agreement 2015 - 16 (links to NHS National ANNB Screening Service Specifications)
- NHS England (2015) NHS Public health functions agreement 2017-2018
- NHS England (2016) Saving Babies' Lives. A care bundle for reducing stillbirth
- NHS England (2016) Leading Change Adding Value: a framework for nursing, midwifery and care staff

- NHS England (2017) Implementing Better Births. A resource pack for Local Maternity Systems. Five Year Forward View.
- NHS England (2017) Next steps on the NHS Five year forward view
- NHS Improvement (2015) Improving access to perinatal mental health services in England – A review
- NICE guidance – see table below
- NICE Collaborative Tuberculosis strategy: commissioning guidance 2015
- PHE (2014) Public Health Outcomes Framework 2013 -16
- PHE guidance on immunisations
- Public Health England (2015) Getting maternity services right for pregnant teenagers and young fathers
- RCOA (2011) Providing equity of critical and maternity care for the critically ill pregnant or recently pregnant woman
- RCOA (2015) Guidelines for the provision of anaesthetic services
- RCOG Green top guidelines and other guidance papers
- RCOG Each baby counts report (2015) and ongoing reporting
- RCOG, RCM, RCOA, RCPCH (2007), Safer Childbirth Minimum Standards for the Organisation and Delivery of Care in Labour
- RCOG, RCM, RCOA, RCPCH (2008) Standards for Maternity Care
- Royal College of Midwives guidance
- Sands (2016) Pregnancy loss and death of a baby: Guidelines for professionals. 4th Edition.
- Tamba & NCT (2015) Maternity Services and multiple births
- The WI & NCT Support Overdue: Women's Experience of Maternity Services
- UNICEF Baby Friendly resources
- World Health Organisation (2007) Recommended Interventions for Improving Maternal and New born Health
- The UK National Screening Committee Programme standards and Guidance

1.5.2 NICE guidance

Some of the key relevant NICE guidance and quality standards that have informed and are referred to in this specification are below. It should be noted that this list is not exhaustive and as such it is expected that providers update service provision in line with new standards as they are published:

NICE Guidance and Quality Standards	Publication Date
Antenatal and Postnatal Mental Health	November 2017
Antenatal Care (CG62) (QS 22)	March 2008 / September 2012
Caesarean section (CG132) (QS32)	November 2011 / June 2013
Diabetes in Pregnancy (NG3) (QS109)	February 2015/January 2016
Donor breast milk (CG93)	February 2010
Ectopic pregnancy and miscarriage (CG154) (QS69)	December 2012/September 2014
Fertility (CG156) (QS73)	February 2013 /

	October 2014
Hypertension in Pregnancy (CG107) (QS35)	August 2010 / July 2013
Induction of Labour (CG70) (QS60)	July 2008 / April 2014
Intrapartum care (CG190) (QS105)	December 2014/December 2015
Jaundice in newborn babies under 28 days (QS57) (CG98)	March 2014/May 2010
Maternal and Child Nutrition (PH11) (QS98)	March 2008/July 2015
Multiple Pregnancy (CG 129) (QS46)	September 2011 / September 2013
Neonatal specialist care (QS4)	October 2010
PIGF based testing to help diagnose suspected pre-eclampsia	May 2016
Postnatal Care (QS37)	July 2013
Pregnancy and Complex Social Factors (CG110)	September 2010
Preterm labour and term (NG25)	November 2015
Quitting smoking in pregnancy and following childbirth (PH26)	June 2010
Safe midwifery staffing for maternity settings (NG4)	February 2015
Smoking cessation in secondary care: acute, maternity and mental health services (PH48)	November 2013
Weight management, before, during and after pregnancy (PH27)	July 2010
NICE support for commissioning	
NICE support for commissioning for fertility problems (SFCQS73)	October 2014
Weight management before, during and after pregnancy (CMG 36)	March 2011

1.5.3 Kent and Medway / Local Policy

- Kent County Council (2013) Every Day Matters: Kent's Multiagency Strategic Plan for Children and Young People 2013-2016, Maidstone: Kent County Council.
- Kent County Council (2014) Kent Joint Health & Wellbeing Strategy; Outcomes for Kent 2014-2017, Maidstone: Kent County Council.
- Care Quality Commission (2013 & 2015) Maternity services surveys
- NHS, Kent County Council, Medway County Council. Transforming health and social care in Kent and Medway. Sustainability and Transformation Plan. NHS, Kent County Council, Medway County Council, 2016.

Other areas for consideration include the use of local dashboard data and CHIMAT data.

1.5 Tariff and payment

The maternity pathway payment system was mandated in 2013/14 and most maternity care delivered by the NHS is paid for on an activity basis, through national prices set annually. It is split into three stages; antenatal, delivery and postnatal. The level of the payment that the provider receives depends on factors that will affect the level of care that the woman is expected to require. Where women receive some of their care from a different provider due to choice or clinical need, managing the cost of this care is to be co-ordinated by the CCGs / providers.

Included in the payment system are all routine antenatal appointments, maternity ultrasound scans, and all relevant maternal and new-born screening which is part of National Screening Programmes.

For the purposes of this pilot, the provider will be paid on a Payment by Results tariff in partnership with Maidstone and Tunbridge Wells Trust as the Prime Provider.

1.6 Data and Reporting

Maternity services are subject to significant monitoring and reporting a range of data including the National Maternity Services Dataset (MSDS). Providers should ensure that they take a strategic approach to data that includes ensuring they can respond to such requests, and how data may be optimally used to support service delivery and development both in the service itself and in the context of the Local Maternity System. This may include identifying trends in outcomes and performance, allowing self-assessment against peers and identifying areas for improvement.

The provider must regard the reporting listed below as mandatory, and respond promptly to further reasonable requests for information.

This information together with data set out in the quality framework will form part of the performance and quality monitoring of any contract. It is paramount that information systems and staff are able to accurately collect and record data across all settings whilst ensuring data is transferable if care is transferred at any point. There should be a robust action plan for addressing any difficulties with this requirement.

If the provider wishes to alter any aspect of their reporting to the CCGs they must formally consult with all relevant CCGs and agree any changes proposed prior to implementation

Organisation responsible	Data collection	Frequency
Antenatal & Newborn Screening Programmes (Public Health England)	KPIs for all screen programmes: AN Sickle Cell & Thalassaemia (SCT) Down's Syndrome Screening Anomaly screening (FASP) Infectious Diseases in Pregnancy (IDP) Newborn Hearing Screening (NHSP) Newborn Infant Physical Examination (NIPE)	Quarterly

	Newborn Bloodspot screening (NBBS)	
CCG Commissioners	Never events such as – Retained swab, following vaginal birth Retained instruments/swabs following caesarean section	As occur within agreed timescales
CCG Commissioners	Serious Incidents Acts or omissions in care which caused or contributed towards the outcome (see Serious Incident Framework 2015)	As occur
CCG Commissioners	Performance data – see section 5	Monthly and Quarterly as determined
Child Death Overview Panels	All child deaths under 18 years old for any reason	As occur
Local Maternity Networks		As agreed with networks
Local Maternity System	Kent and Medway Maternity Dashboard	As agreed-when developed
Maternity Transformation Metrics	TBC – Currently out for consultation	TBC
MBRRACE	Maternal & fetal loss and early neonatal death	As occur
National Perinatal and Maternity Audit	As required	As determined
NHS Digital	Maternity Services Data Set Routine data	Quarterly
PHE Screening Quality Assurance Services and Screening and Immunisation teams.	Incidents within any of the ANNB screening pathways in line with current guidance: Managing safety incidents in NHS screening programmes (DH 2015)	Case by case reporting
RCOG – Each Baby Counts	Stillbirths, neonatal deaths and brain injuries occurring due to incidents in labour. All UK units to submit data.	As occur

SCHEDULE 2 – The Services

Service specifications

Service Specification Number	
Provider Lead	
Commissioning Leads	
Period	

2.1 Aims and Objectives

Maternity services commissioned should be safe, woman-centred, evidence based and of high quality, delivered at the right time, in the right place and by a planned, educated and trained workforce.

This pilot is an innovative model of care which increases the choice options for eligible women. The provider will aim to demonstrate that the care provided in this way via an NHS contract is safe and that the service is sustainable, both for the midwives working and for the families who receive their care through the model.

This will be achieved by ensuring that:

- The transition from pregnancy to parenting and family life is supported through high quality services that are woman and family centred, with all staff treating women and families with kindness and compassion.
- Women and their families are able to access midwifery led antenatal, intrapartum and postnatal care, taking account of individual choice and clinical need.
- Women and their families are given unbiased evidence based information and advice about all stages of their pregnancy that includes the risks and benefits of different options, in a range of formats and languages.
- Continuity of care is delivered across the maternity pathway. This should be for all women seen by the provider. Women should see no more than two midwives from their first booking appointment in addition to their named midwife, who should deliver the majority of the woman's care and not less than 60%.
- Maternity care provision is personalised, flexible, appropriate and accessible to women, placing a significant emphasis upon the need to engage women from disadvantaged and marginalised groups, those from high risk environments and other families with complex social needs.
- There is access to a clear and supportive bereavement pathway that includes the provision of suitably trained midwives, and access to dedicated rooms and facilities. Such a service will ensure women have easy access to local services such as funeral directors, charities, and support groups. All women experiencing bereavement will be able to access should they wish appropriate counselling or therapeutic services.
- Service providers work in partnership to deliver community based multi-professional care across organisational and geographical boundaries to deliver seamless services, based on excellent communication and information sharing.
- Providers adhere to the antenatal and newborn screening programme guidance and reporting – see section 2.7
- Actively engage with Maternity Voices Partnerships so that providers and commissioners work in partnership with women and their families, to co-design, co-develop, improve and deliver services which meet local need.

2.1.1 Transformation and the Local Maternity System (LMS)

The provider will:

- Actively support the transformation of maternity services both across all stages of the woman's pathway within their own services and within the Kent and Medway, in partnership and co-production with local women and families.
- Actively engage and contribute positively towards the development and implementation of the Local Maternity System and its required outcomes including the Local Maternity Offer, Sustainability and Transformation Plan and Better Births pioneer programme and in particular the continuity of carer work.
- Work collaboratively with other providers both within the Kent and Medway LMS and neighbouring Local Maternity Systems to innovate, break down barriers and ensure a flexible approach to place of birth that facilitates increased access to midwifery led places of birth and continuity of care.
- Ensure that there is strong multi-disciplinary clinical leadership at all levels of the maternity service that allows a culture of learning and openness to flourish and that this leadership has access to and is well represented at the Trust board.
- Continue to develop a robust multi-disciplinary training and development programme for all staff.

2.2 Basic commissioning principles:

- The provider will provide data that contributes to the planning and improvement of Maternity Services within WKCCG and enables benchmarking of services, see section 5.
- Regular activity reports will be provided as agreed. These will include antenatal & newborn screening, early booking and antenatal, birth and postnatal pathway data, and the maternity services data set.
- The provider will produce an exception report in line with agreed timescales in respect of this data
- Additional data may be required for key national data sets and public health indicator's
- Payment will be made in line with the national maternity tariff payment system.

2.3 Service Description / Care Pathway

The following sections, describe the services required for each stage of the maternity pathway:

- Antenatal care
- Screening
- Intrapartum care
- Postnatal care for mother and baby

It is expected that the national and local standards of practice, principles and equality and diversity considerations outlined in Section 1 are applied to the pathway.

2.3 Antenatal Care

For the purposes of this pilot all women will have scans undertaken at MTW and MTW will analyse all blood results.

Processes consequently need to be in place between the provider and MTW to ensure access to results.

The provider will:

- Deliver antenatal care in accordance with NICE antenatal care guidance (including number of appointments, timing, comprehensive medical social and obstetric history taking and risk assessment at booking).
- Facilitate and encourage early referral and work with CCGs to ensure that the booking appointment is offered as quickly as possible (should be less than 10 working days) from receipt of the referral, with the ability to fast track referrals for later referrals (after 20 weeks of pregnancy) and to ensure timely access to screening services. This will ensure delivery of the NHS standard for early access to services (access to maternity care by 10 weeks of pregnancy).
- Enable women to be able to self-refer to a midwife for antenatal care. The information regarding how to access and contact the service and access midwives should be easily available within local settings and the process simple and quick. **Services and GPs should be using the MTW referral form.**
- Provide all women with hand held records containing the results of their antenatal tests
- **Offer at the first appointment a variety of participant-led antenatal classes across WK CCG including breastfeeding workshops with evidence based information given on infant feeding and classes that support the importance of bonding and attachment.**
- Assess risk of gestational diabetes and mental health concerns at the booking appointment using risk factors, testing and questioning as appropriate and in line with the NICE guidance.
- Offer antenatal care in a variety of community and primary care settings including GP surgeries, outreach clinics, community centres, midwife-led units and children's centres, regardless of the complexity of pregnancy.
- Work towards the development of community hubs for the provision of care.
- Ensure that care is also provided by a midwife in an obstetric setting for women who are categorised as high risk.
- Ensure that women should be advised of and cared for by their 'named midwife' for the majority of their antenatal and postnatal care (see section 2.1 and the maternity clinical network toolkit).
- Ensure that there are clear means for women to contact their named midwife and team, for both urgent and non-urgent matters that enable her concerns to be addressed promptly
- If women choose to see their GP for antenatal care as a shared care arrangement, the provider will work collaboratively with GPs to support this choice. GPs should have access to relevant maternity guidelines, and be kept up to date with both operational and clinical changes in the service.
- Ensure information is transferred to Child Health Record Departments about all booked women to facilitate health visiting contact with women in the antenatal period.

- Ensure that there is effective integration between primary, secondary, community (health visiting) and tertiary care services and a seamless journey is achieved for women and their families. Medical and social information relating to a woman's pregnancy, baby and family must be shared between maternity services and the woman's GP and other relevant agencies as needed. There must be direct and clear communication and collaboration between primary and acute services, with a proactive approach taken for vulnerable women.
- Be proactive about communicating appointments, for example by sending reminders using multimedia.
- Provide information to women, on their antenatal care including gestation specific advice and information on antenatal appointments, lifestyle advice, screening tests and managing common problems, signposting to good sources of information.
- Discuss and deliver health promotion information on healthy diet, folic acid, alcohol vitamin D, refer to local Healthy Start Programme and promote healthy start vitamins to eligible families, as per local arrangements.
- Discuss the benefits of seasonal flu vaccine and whooping cough vaccine and deliver a vaccination service where an appropriate service plan exists.
- Offer all women who smoke referral to smoking cessation services and all women, carbon monoxide (CO) testing to assess exposure to tobacco smoke at booking and at 36 weeks gestation.
- Provide and/or sign-post to, specific antenatal support for all women particularly those with additional needs, for example non-English speakers or those with a BMI of 30 or more; ensuring that women with a BMI of over 35 are offered referral to the specialist midwives.
- Promote pregnancy and birth as a normal life event and support women to have a birth plan in place by 36 weeks gestation and ensure that women have multiple opportunities to discuss their decisions with a health care professional.
- Offer women the choice of type and place of birth supported by personalised, evidence based information regarding the relative risks, outcomes, potential benefits and consequences in relation to her health, obstetric and social care needs in differing places of birth. The information on places of birth should include home, alongside midwifery birth centre, freestanding birth centre and obstetric unit and enable her to make a personalised care plan.
- Ensure all women receive a personal maternity choice booklet highlighting all options and information relating to place of birth.
- Actively promote midwifery led settings to 'eligible' women
- Demonstrate a strategy for detecting babies with fetal growth restriction (FGR) and follow MTWs protocol.
- Have access to multidisciplinary care for medically complex/high risk women and pathways defined for access to tertiary care.
- Ensure that a network of care for women with mental health issues is provided, and women with existing or previous mental health issues (especially including previous illness during the perinatal phase), are provided with information about how pregnancy and childbirth might affect their mental health problem, including relapse. Providers should ensure that women are referred to appropriate mental health support services as early as possible and provision meets the Kent and Medway Pathways for Perinatal Mental Health. Provider should also attend networking meetings / events where appropriate.

- Ensure that the service delivery model meets the needs of pregnant women with complex social factors.
- Ensure that pre-birth multi-agency protocols are in place to safeguard unborn babies where vulnerability and risk indicators are identified. The protocol should provide an agreed process between Health, Children's Social Care and relevant other agencies on the planning, assessment and actions required to safeguard the unborn baby.

2.4.1 Under 20 years conceptions

- A pathway should be in place to support teenage and young women who are pregnant using a flexible model of care tailored to the needs of the local population including antenatal care and education in peer groups and in a variety of settings, and antenatal education offered at the same time as antenatal appointments.
- Provider should link in with teenage pregnancy team from MTW to ensure consistent approach is offered to teenage mothers and their families.
- Young women should be encouraged to use antenatal care services and services should be age-appropriate. Information should be provided about; help regarding transport and access to appointments, antenatal care offered in the community and opportunities provided for the partner / father of the baby to be involved, if appropriate, in the young woman's antenatal care, with her agreement. Information should be provided that is suitable for the women's age – including information about care services, antenatal peer group education or drop-in sessions, housing benefit and other benefits – in a variety of formats.
- The provider must work with the Family Nurse Partnership teams and others providing targeted interventions for women and families to ensure that information can be appropriately shared and referrals offered in a timely manner.

2.7 Screening

The provider will:

- Offer antenatal and newborn screening in line with the recommendations of the National Screening Committee. This includes specifications for:
 - Antenatal Sickle Cell & Thalassaemia
 - Infectious Diseases in Pregnancy
 - Down's Screening
 - Fetal Anomaly Screening
 - Newborn Infant Physical Examination
 - Newborn Hearing screening
 - Newborn Bloodspot screening

The provider will also:

- Ensure delivery of antenatal and newborn screening programmes is monitored within the central support team, with policies & protocols reviewed regularly, care pathways sustained

in line with NSC standards, training and education delivered, audits undertaken and timely data collection and submission for monitoring programmes.

- Ensure that the local coordinator produces an annual screening report to for PHE.
- Ensure screening arrangements are subject to robust governance
- Ensure timely reporting and management of alerts and incidents
- Provide quarterly KPIs.
- Provide cohort tracking to ensure all women and babies are offered timely screening
- Ensure failsafe systems are operating across the screening care pathways.
- Ensure electronic system in place for safe transfer of women / babies.
- Ensure robust referral pathway in place for timely follow up.
- Ensure maternal and newborn screening test result data is transferred electronically to Child Health Record Departments (CHRDs) Hepatitis +’ve; NIPE; Newborn Hearing Screening.
- Offer all pregnant women clear information regarding the full range of screening tests and the consequences of these including screening for consanguinity.

2.8 Intrapartum Care

The provider will:

- Deliver Intrapartum Care in line with the NICE Intrapartum Care guidelines (increasing the number of births at home and in midwifery led units toolkit), Increasing Continuity of Care toolkit, Minimum Standards for The Organisation and Delivery of Care in Labour (RCOG, RCM, RCA, and RCPCH 2007).
- Ensure workforce planning, team structures and staffing rotas support and enable all places of birth and the delivery of the standards and toolkits as above.
- Work within networks to provide choices in settings for labour (also see Antenatal care section above), and during labour including choice of pain relief.
- Promote normality and provide safe, welcoming, homely birth environments that promote privacy and dignity for mother and companions.
- Ensure staff and environments are able to support both pharmacological and non-pharmacological approaches to pain management including immersion in water.
- Provide 1:1 midwifery care in established labour (NICE defines established labour as ‘when there are regular and painful contractions, and the cervix has opened to at least 4 cm’).
- Ensure there are appropriate levels of care and support available for women who may not be in established labour but are requesting assistance, advice or guidance.
- Ensure that there are robust protocols in place for transfer of care between settings and clear pathways for dealing with obstetric or medical emergencies, and for women requiring critical care.
- Ensure that they have a robust evidence based programme of teaching and assessing staff with fetal heart monitoring in labour.
- Use booking data to plan capacity and have robust responses to fluctuations in demand that ensure acute and midwifery led pathways are sustained in busy periods.

2.9 Postnatal Care

The provider will:

- Undertake a full health and social care needs assessment following birth and offer women and their babies, postnatal care based on NICE Postnatal Care guidance.
- Ensure all women are assessed immediately after giving birth by a suitably qualified member of the birth team (doctor or a midwife) and again prior to transfer to community care and/or within 24 hours of giving birth, by a midwife.
- Ensure that all women are monitored for signs of post-delivery physical and mental ill health and are given written advice on health promotion, advice and health warning signs for mother and baby prior to discharge, including ensuring access to the child health record 'Red Book'.
- Assess the mental and physical health and social needs of mothers and babies at each postnatal contact, and enable specialist advice to be sought as appropriate (NICE Postnatal Care guidance).
- Make sure that an individualised postnatal care plan is in place for all women and their baby, and it is reviewed and documented at each postnatal contact.
- Ensure that the initial new-born physical examination is carried out prior to discharge or within 72 hours of birth.
- Ensure postnatal contact on day 5 (counting day 0 as day of birth) to undertake new-born bloodspot test.
- Ensure that subsequent postnatal contact takes place within the first week of birth. This can take place either in the home or in an appropriate community setting.
- Ensure that an externally evaluated, structured programme that promotes and encourages breastfeeding is implemented, using the Baby Friendly Initiative as a minimum standard.
- Ensure safe and secure transfer of patient information between organisations for women at any stage of pregnancy and the postnatal period.
- Ensure that continuity of care is carried into the postnatal phase with seamless handover to other healthcare professionals such as GPs and health visitors. Written hospital and community discharge letters should be completed for all women with copies passed to the health visitor and GP.
- Offer postnatal care in a variety of settings including the woman's home, postnatal clinics, children's centres, health centres and ensure support is provided from a community-based co-ordinating health professional.
- Provide appropriate immunisation for mother and baby, in line with the NICE Post Natal Care guidance, including anti-D immunoglobulin and ensuring women who reside in high TB prevalence areas have access to vaccination at birth for their babies or are signposted to community provision.
- Provide information to both mothers and fathers on healthy lifestyles, reducing the risks of sudden infant death and unintentional injury, the benefits of breastfeeding and where this is not possible, bottle feeding and access to local services to support parents and children in adapting to family life.
- Ensure women with significant medical disorders or who have experienced significant obstetric events are offered obstetric follow-up.
- Ensure staff, policies and protocols recognise the high risk status of women readmitted in the postnatal period.

- Ensure all women are given information about, and offered a choice of, all contraceptive methods by their midwife within 7 days of birth.
- Encourage women to provide feedback on their experience of care and service.
- Ensure access to specialist bereavement support and counselling for women and their families who experience neonatal or maternal death, or stillbirth.
- Follow the local maternity process for reporting and investigating direct and indirect maternal deaths in Kent and Medway.
- Ensure that safeguarding remains a priority in the postnatal period and that all relevant information is shared with other agencies and organisations as required, including the completion of the mother and baby form for looked after children.

2.10 Workforce standards, planning and development

The support and development of the workforce is an essential component of delivering both current services and the transformation agenda. Providers will need to ensure that they have robust workforce development plans in place that take into account, the needs of the local population, the transformation agenda with particular reference to safety, continuity of care, and choice and the needs of the staff. Providers will need to work collaboratively across the Kent and Medway Local Maternity System to ensure a 'joined up' approach is developed.

In addition the provider must ensure that staff have the time and opportunities to maintain professional standards and meet revalidation requirements. Part of this approach should include access to multi-disciplinary training.

The standards below provide guidance for the development of high quality and safe services and they should be used as a tool for planning and quality assuring maternity services. The provider should produce a workforce report including training delivered for the CCG every twelve months.

2.10.1 Midwifery

- Providers must have a system in place for determining how many midwives are required at all times to safely care for and support women and their babies (see NICE Safe midwifery staffing for maternity settings guidance).
- Midwifery staffing levels should be determined every 6 months for each part of the maternity service (for example, antenatal, intrapartum and postnatal services) and a systematic process undertaken to calculate the midwifery staffing establishment.
- Providers should review staffing and skill mix, including the percentage of non-permanent staff used to ensure they are appropriate to meet the needs of mothers and their babies (see NICE Safe midwifery staffing for maternity settings guidance).
- Procedures must be in place for monitoring and responding to unexpected changes in midwifery staffing requirements. This should take account of the particular needs of women and their babies being cared for on that day or during the shift (see NICE Safe midwifery staffing for maternity settings guidance).

- Providers should develop escalation plans to address demand for maternity services and variation in the risks and needs of women and babies in the service (see NICE Safe midwifery staffing for maternity settings guidance).
- The provider will generally work to an annual ratio of 1 midwife to 35 Births and will monitor this via referral and booking data.
- The provider will have a robust policy for managing the number of hours midwives will work, ensuring that there are checks and controls to prevent excessive tiredness in midwives.
- Any woman booked with the community provider will have two midwives allocated to her at the start of care and she will be provided with 1:1 care during established labour at home from either her first or her back-up midwife. If she needs or wants to transfer into hospital one of her midwives will usually accompany her as a birth partner.
- The provider will ensure all midwives have access to a Clinical Coordinator 24/7 for their midwives.

2.10.2 Midwifery Supervision and the A-EQUIP Model

- The provider must ensure that arrangements are in place for all midwives to receive the new national model of clinical midwifery supervision” (Standard NHS Contract 2017/18).
- In accordance with DH guidance (DH 2016a) the provider must nominate the staff members who will become PMAs replacing supervisors of midwives.
- The number of PMAs required to deploy the A-EQUIP model should be determined by the provider in accordance with the DH guidance
- Providers must ensure that practitioners have the appropriate qualifications, experience, skills and competencies to perform the duties required of them (NHS Standard Contract 2017/18).
- The provider must ensure that the nominated PMA attends a preparation course, as specified in this guidance

2.11 Working with local women

Service user experience and engagement is an essential component in reviewing, developing and continuously improving maternity services and providing effective healthcare.

The provider should consider areas of best practice being undertaken across the NHS and wider health arena and strive to provide the best possible experience of maternity care.

The provider will:

- Demonstrate active engagement with local maternity services forums such as a Maternity Voices Partnerships (formerly known as Maternity Services Liaison Committees).
- Gain feedback from service users via the Friends and Family Test and support other local initiatives for gaining a better insight into the experiences of users and quality of services.
- Provide feedback to users on how maternity user feedback has been used by the organisation including action plans and outcomes.
- Ensure that the women’s, baby’s and family needs are central to service improvement.

- Engage with service users in the development and review of services including changes in policies, protocols, guidelines and innovations, taking the approach of co-production

2.12 Population covered

The services outlined in this specification are for women resident or registered with a GP within West Kent CCG. (Crowborough?)

3.0 Acceptance and Exclusion Criteria

All eligible women requiring antenatal, intrapartum and postnatal care, including fathers / partners or other appropriate family members.

Eligibility will be partially dependent on where the woman lives.

The eligibility criteria will be shared with all referrers including GP's and local Trusts and the information will be sent to all community based groups to enable appropriate self-referral into the project.

3.1 Whole System Relationships

This specification cannot be successfully delivered without effective relationships and collaborative working arrangements between partner organisations, services and associated professionals. The maternity service working relationships include:

- The Community Midwifery Service Provider
- The Kent and Medway Local Maternity System
- The South East Clinical Maternity Network
- Neonatal Services and related network
- Family Nurse Partnership
- Perinatal Mental Health Services
- Local Authorities including public health and social services
- Relevant community services providers e.g. smoking cessation, breastfeeding support
- Clinical Commissioning Groups
- Health Visiting Services
- GPs and primary care teams
- Children's Centres
- Safeguarding children and vulnerable adult services
- Maternity Voices Partnerships and other service-user organisations
- Local Screening midwives
- NHS England Kent and Medway ANNB Screening Commissioners
- Link Universities to Maternity/Medical services
- Health and Wellbeing Boards
- ANNB Quality Assurance Public Health England (PHE)
- PHE Heath Protection Area Team
- Child Health Record Departments (CHRDs)
- Newborn Hearing Screening Services
- Newborn Blood Spot Laboratories

- Down's Screening Laboratories
- Sickle Cell Centres
- PHE National Screening Committee (NSC)
- National Congenital Anomaly Register
- Kent Ambulance Service

4. Applicable Service Standards

4.1 Applicable national standards

See section 1.5

4.2 Applicable local standards

See section 1.5

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements and CCG Outcomes Indicators

CCGs Improvement and Assessment Framework 2016/17

Better Health:

- 101a: Maternal Smoking at Delivery

Better Care:

- 125a: Neonatal mortality and Stillbirths
- 125b Women's experience of maternity services
- 125c Choices in maternity services

5.2 Other specific Quality Monitoring

Neighbourhood Midwives must prepare and complete a local Maternity Dashboard which should reflect current network arrangements and those agreed with commissioners.

Organisation responsible	Data collection	Frequency
Kent and Medway Maternity System	Kent and Medway Maternity Indicator set	Quarterly

As part of the specific quality monitoring the provider will prepare and complete a Maternity Dashboard to be submitted to commissioners on a monthly basis to include: **See schedule 6**

An exception report will be provided monthly to the relevant CCG highlighting key issues.

The provider will also provide indicative activity on a monthly basis to assist monitoring of activity against plan

The dashboard will be sent to:

5.3 Applicable CQUIN goals (See schedule 4 Part [E])

Please refer to Schedule 4E of Contract Particulars.

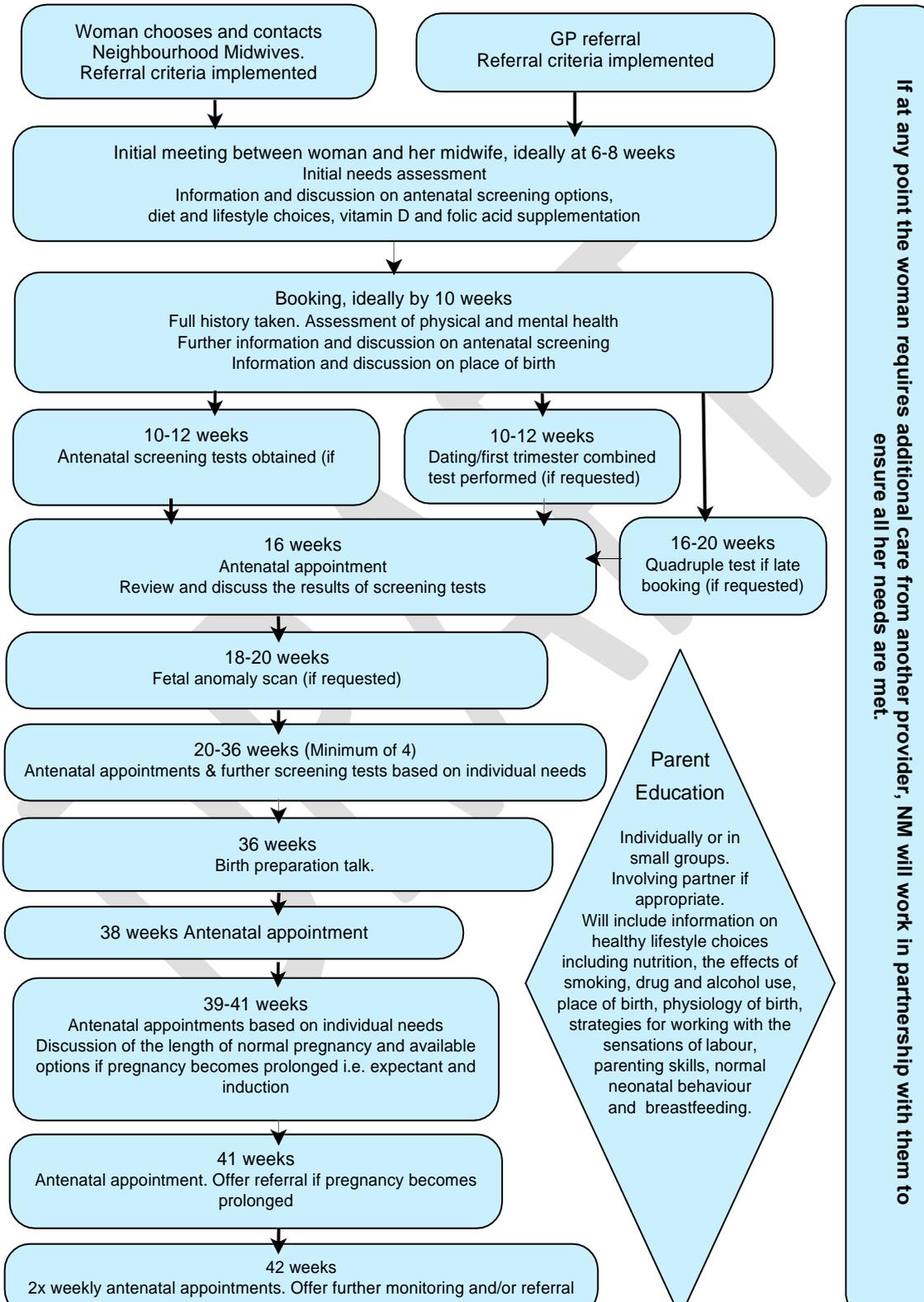
6. Location of Provider Premises

The provider's premises are located at: XXXXXXXXXX

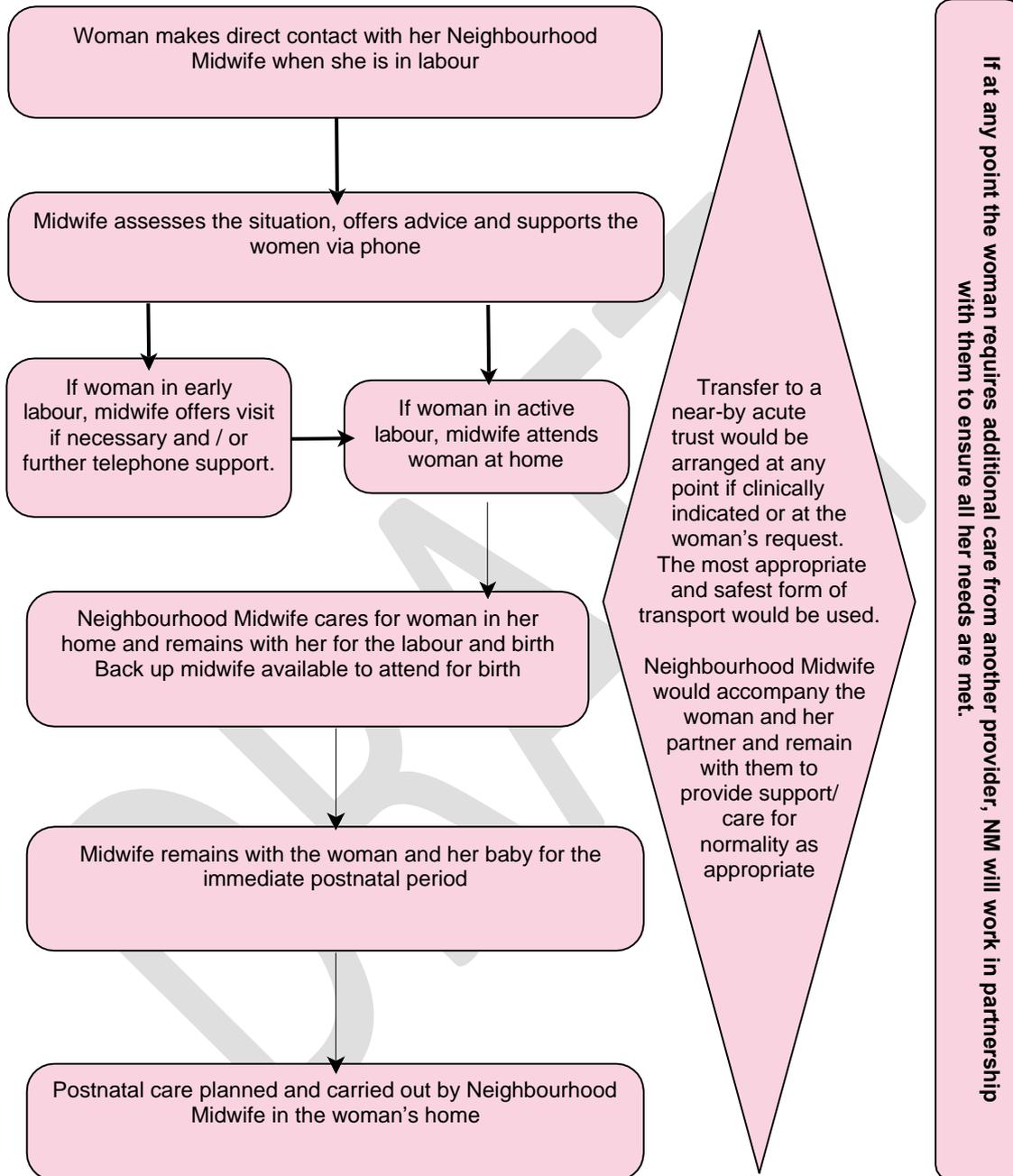
6.2 Days/Hours of operation

- To support women, the provider will be available 24/7 by phone. They also are available for additional visits when needed. Community-based intra-partum care for home births will be available as a 24-hour service.
- Community-based antenatal and postnatal services will normally be available 7 days a week
- Any closure or suspension of any part of the service should be notified to the appropriate CCG within 72 hours

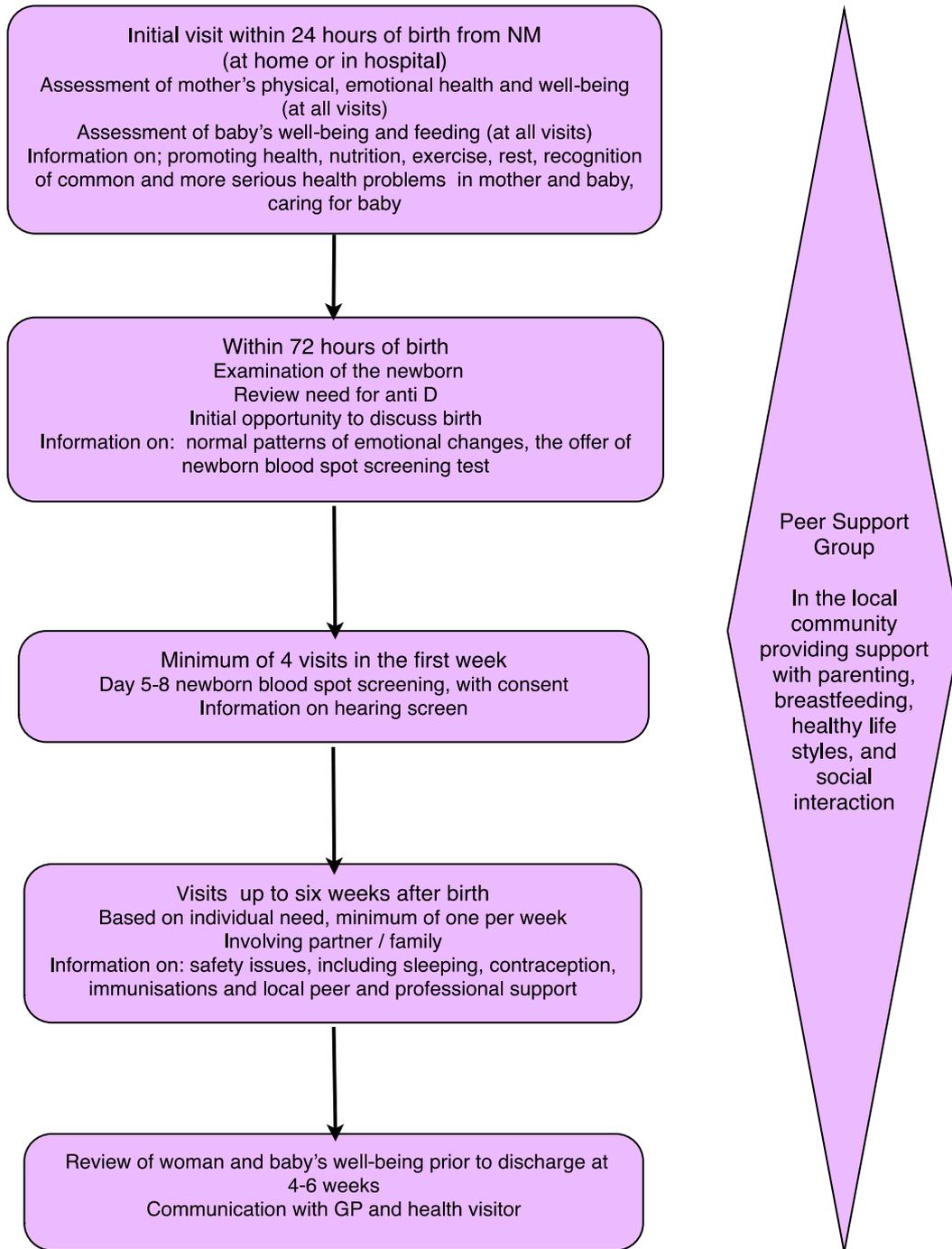
Neighbourhood Midwives: Pregnancy Care Pathway



Neighbourhood Midwives: Home Birth Pathway



Neighbourhood Midwives: Postnatal Care Pathway



Neighbourhood Midwives: Breastfeeding Care Pathway

