London Maternity Strategic Clinical Network
- Generic Maternity Services Specification

This document sets out a generic maternity services specification for London.

It draws on national documents, published evidence and locally available data and information. This collaborative document has been produced with input from local CCG commissioners of maternity services from across London as well as service providers, healthcare professionals and service users.

It recommends an approach to local commissioning based on best practice and evidence to support maternity services to reduce unwarranted variation and improve quality outcomes across London. Clinical Commissioning Groups may wish to add further local priorities to the template.

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Prepared by: London Maternity Strategic Clinical Network

With thanks to the East Midlands Maternity Strategic Clinical Network and local maternity networks and providers for sharing their maternity service specifications.
# Maternity Services Specification

## Contents

1. **Background**
   - 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**
   - 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**
   - 3.1 Whole system relationships

4. **Applicable Service Standards**
   - 4.1 Applicable national standards
   - 4.2 Applicable local standards

5. **Applicable quality requirements and CQUIN goals**
   - 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**
1 Background

1.1 Introduction

This document sets out a maternity service specification based on evidence and best practice with input from local CCG commissioners, healthcare professionals and service users.

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

*Maternity services in London: Key Facts*

- Over 130,000 live births in London in 2014
- 1.74 children born per woman in London on average
- Across London there are 21 maternity services providing maternity care over 28 sites; 3 freestanding midwifery units and 21 alongside midwifery units
- Among regions in England, London has the lowest birth rate for women aged under 18 and highest birth rate for women aged over 45 years
- London has the worst perceived maternity care in England, CQC survey 2013
- 25 maternal deaths in 2014/15
- 4.82 stillbirths per 1,000 live births
- Approximately 10% of women in London deliver their baby in one NHS trust but receive postnatal care in another area.
- The London Strategic Clinical Network (SCN) was established in 2013 to reduce variation in outcomes and experience of care for women and their babies in London.
- 5 local maternity networks in London aim to ensure that high quality, safe and sustainable maternity services are accessible to women.

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 London. It:

- Sets out the standards expected of maternity service providers
- Describes at a high level the requirements for a reliable, effective and efficient maternity service
- Provides a benchmark for identifying specific local areas for improvement in line with best practice
- Informs 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 in the NHS Outcomes Framework 15 / 16:

<table>
<thead>
<tr>
<th>Domain 1</th>
<th>Preventing people from dying prematurely</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.6 Reducing mortality in children (Infant mortality (PHOF 4.1))</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 2</th>
<th>Enhancing quality of life for people with long-term conditions</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Domain 3</th>
<th>Helping people to recover from episodes of ill-health or following injury</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Domain 4</th>
<th>Ensuring people have a positive experience of care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4.5 Improving women’s and their families experience of maternity services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 5</th>
<th>Treating and caring for people in safe environment and protecting them from avoidable harm</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5.5 Improving safety of maternity services (admission of full term babies to neonatal care)</td>
</tr>
</tbody>
</table>

**Locally defined outcomes**

Linked to the Outcomes Framework, the programme of work for the Maternity Strategic Clinical Network is focused on three main priorities:

- Reduction in mortality and morbidity of pregnant women
- Reduction in stillbirth rates in London
- Improvement in women’s and families experience of maternity care

As such, the following local outcomes have been identified: to:

- Deliver safe and effective care to mother, child and family.
- Continuously improve outcomes for mothers and babies by reducing the risk of morbidity and mortality, stillbirth, low birth weight and infant mortality.
- Deliver care that is compliant with national reviews, standards and evidence based practice.
- Deliver care that is responsive to local need.
- 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.
- To increase the number of ‘eligible’ (defined as healthy women with uncomplicated pregnancies entering labour at low risk of developing intrapartum complications) women accessing midwifery led settings and increase the number of women accessing continuity of midwife 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 delivery).

• Work with 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, 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 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 relevant health professionals 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.

• Develop a framework around training to support staff and address poor performance or poor attendance and ensure a training analysis is conducted for all key staff groups. Use lessons gained from clinical incidents to aid and inform training sessions.

• Reduce where possible, London’s maternal death rate; including commitment to continuous learning and support for the London-wide review process for severe maternal morbidity and maternal deaths.

1.4 Equality and Diversity

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

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

1.5 Policy and Guidance

Maternity Services are delivered within the context of national, regional and local policy, taking account of individual and population need.
This specification will be delivered to reflect national and local policy and guidance including, but not exclusive to the following:

**National Policy and Guidance**

- 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
- DH (2005) Access to maternity services research report
- DH (2006) Our Health, Our Care, Our Say
- DH (2009) Healthy Child Programme
- DH (2015) Female Genital Mutilation risk and safeguarding guidance for professional
- NHS Commissioning Board (2012), Everyone Counts: Planning for Patients 2013/14
- NHSE (2015) NHS Public Health Functions Agreement 2015 - 16 (links to NHS National ANNB Screening Service Specifications)
- 0NHS England pertussis vaccination in women 2015
- NICE guidance
- NICE Collaborative Tuberculosis strategy: commissioning guidance 2015
- RCOG Greentop guidelines
- RCOG (2007), Safer Childbirth Minimum Standards for the Organisation and Delivery of Care in Labour
- RCM guidance
- UK NSC (2010) NHS population screening: programme standards

**NICE guidance**

NICE guidance and quality standards referred to in this specification are below:
### NICE Guidance

<table>
<thead>
<tr>
<th>Topic</th>
<th>Publication Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal and postnatal mental health (CG192)</td>
<td>December 2014</td>
</tr>
<tr>
<td>Antenatal Care (CG62) (QS 22)</td>
<td>March 2008 / September 2012</td>
</tr>
<tr>
<td>Caesarean section (CG132) (QS32)</td>
<td>November 2011 / June 2013</td>
</tr>
<tr>
<td>Diabetes in Pregnancy (NG3)</td>
<td>February 2015</td>
</tr>
<tr>
<td>Donor breast milk (CG93)</td>
<td>February 2010</td>
</tr>
<tr>
<td>Ectopic pregnancy and miscarriage (CG154)</td>
<td>December 2012</td>
</tr>
<tr>
<td>Fertility (CG156) (QS73)</td>
<td>February 2013 / October 2014</td>
</tr>
<tr>
<td>Hypertension in Pregnancy (CG107) (QS35)</td>
<td>August 2010 / July 2013</td>
</tr>
<tr>
<td>Induction of Labour (CG70) (QS60)</td>
<td>July 2008 / April 2014</td>
</tr>
<tr>
<td>Intrapartum care (CG190)</td>
<td>December 2014</td>
</tr>
<tr>
<td>Multiple Pregnancy (CG 129) (QS46)</td>
<td>September 2011 / September 2013</td>
</tr>
<tr>
<td>Neonatal jaundice (CG98) (QS57)</td>
<td>May 2010 / March 2014</td>
</tr>
<tr>
<td>Pregnancy and Complex Social Factors (CG110)</td>
<td>September 2010</td>
</tr>
<tr>
<td>Quitting smoking in pregnancy and following childbirth (PH26)</td>
<td>June 2010</td>
</tr>
<tr>
<td>Safe midwifery staffing for maternity settings (NG4)</td>
<td>February 2015</td>
</tr>
<tr>
<td>Smoking cessation in secondary care: acute, maternity and mental health services (PH48)</td>
<td>November 2013</td>
</tr>
<tr>
<td>Weight management, before, during and after pregnancy (PH27)</td>
<td>July 2010</td>
</tr>
<tr>
<td><strong>NICE support for commissioning</strong></td>
<td></td>
</tr>
<tr>
<td>NICE support for commissioning for fertility problems (SFCQS73)</td>
<td>October 2014</td>
</tr>
<tr>
<td>Weight management before, during and after pregnancy (CMG 36)</td>
<td>March 2011</td>
</tr>
<tr>
<td>NICE support for commissioning for ectopic pregnancy and miscarriage (SFCQS69)</td>
<td>September 2014</td>
</tr>
</tbody>
</table>

*Please note that the list above reflects the published guidance in August 2015 and the NICE website should be sourced for updated and new guidance.

### London / Local Policy

- Borough Joint Strategic Needs Assessments
- Care Quality Commission (2013) Maternity services survey
- Pan London Safeguarding Procedures
Other areas for consideration include local dashboard data and local CHIMAT data.

**SCN toolkits**

The following best practice toolkits have been produced as part of the London Maternity Strategic Clinical Network’s strategy to identify areas of good practice for implementation across all maternity units in London, ensuring equally good outcomes for all pregnant women and their babies.

<table>
<thead>
<tr>
<th>SCN Guidance</th>
<th>Publication Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early referral of pregnant women for antenatal maternity care</td>
<td>In progress September 2015</td>
</tr>
<tr>
<td>Fetal fibronectin testing in women with threatened pre term labour</td>
<td>January 2014</td>
</tr>
<tr>
<td>Improving outcomes for major obstetric haemorrhage</td>
<td>July 2014</td>
</tr>
<tr>
<td>Outpatient induction of labour in low risk women</td>
<td>April 2015</td>
</tr>
<tr>
<td>Increasing the number of births at home and in midwifery led units</td>
<td>April 2015</td>
</tr>
<tr>
<td>Increasing the number of women who receive continuity of care</td>
<td>April 2015</td>
</tr>
<tr>
<td>Reducing stillbirth through improved detection of fetal growth restriction</td>
<td>November 2014</td>
</tr>
</tbody>
</table>

**1.6 Workforce Standards**

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

**Midwifery**

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

There should be one whole time equivalent (WTE) consultant midwife for every 1:900 normal births (SCN MLU toolkit, RCOG Safer Childbirth London Quality Standards).

All women should be provided with 1:1 care during established labour from a midwife, across all birth settings (NICE guidance, Cochrane Review Continuous Support for Women during Childbirth and London Quality Standards).

Providers should ensure that staffing considerations are taken account of for alongside and freestanding midwifery units in line with the SCN toolkit (see MLU toolkit).

Providers should maintain a Supervisor to Midwife ratio of 1.15 (Nursing and Midwifery Council, Midwives Rules and Standards).

A midwife labour ward coordinator, to be present on duty on the labour ward 24 hours a day, 7 days a week and be supernumerary to midwives providing 1:1 care (The Kings Fund Improving safety in maternity services, NHS Institute for Innovation and Improvement, NHS maternal death review and London Quality Standards).

Medical

Obstetric units should be staffed to provide 168 hours a week (24/7) of obstetric consultant presence on the labour ward (RCOG Safer Childbirth and London Quality Standards).

Obstetric units to have a consultant obstetric anaesthetist present on the labour ward for a minimum of 40 hours (10 sessions) a week (OAA / AAGBI, Guidelines for obstetric anaesthesia services and clinical expert panel consensus).

Units that have more than 5,000 deliveries a year, or an epidural rate greater than 35 per cent, or a caesarean section rate greater than 25 per cent, to provide extra consultant anaesthetist cover during periods of heavy workload (OAA / AAGBI, Guidelines for obstetric anaesthesia services and clinical expert panel consensus).

Obstetric units to have access 24/7 to a supervising consultant obstetric anaesthetist who undertakes regular obstetric sessions (OAA / AAGBI, Guidelines for obstetric anaesthesia services and clinical expert panel consensus).

Consultant-led obstetric units (where anaesthetic care is not primarily consultant delivered) should have a minimum of 12 consultant obstetric anaesthetic sessions (direct clinical care) per week to cover non-elective activity (OAA / AAGBI).

1.7 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, this care is paid to the provider by the lead provider.

The following are included in the payment system:

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

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

1.8 Existing Reporting

Maternity services are subject to significant monitoring and reporting a range of data.

The table below provides an overview of this. It is expected that 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.

<table>
<thead>
<tr>
<th>Organisation responsible</th>
<th>Data collection</th>
<th>Frequency</th>
</tr>
</thead>
</table>
| 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)  
  - Newborn Bloodspot Screening (NBBS) | Quarterly |
| CCG Commissioners | Never events –  
  - Retained swab, following vaginal birth  
  - Retained instruments/swabs following caesarean section | As occur within agreed timescales |
<table>
<thead>
<tr>
<th>CCG Commissioners</th>
<th>Serious Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Acts or omissions</td>
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<tr>
<td></td>
<td>in care which</td>
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<td>caused or</td>
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<td>contributed</td>
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<td>towards the</td>
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<td>outcome (see</td>
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<td>Serious Incident</td>
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<td></td>
<td>Framework)</td>
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<tr>
<td></td>
<td>As occur</td>
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<tr>
<td></td>
<td>Smoking rates (at</td>
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<td></td>
<td>booking and</td>
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<td></td>
<td>delivery)</td>
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<tr>
<td></td>
<td>Breast feeding</td>
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<tr>
<td></td>
<td>initiation rates</td>
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<tr>
<td></td>
<td>Quarterly</td>
</tr>
<tr>
<td>Child Death Overview Panels</td>
<td>All child deaths under 18 years old for any reason</td>
</tr>
<tr>
<td>MBRRACE</td>
<td>Maternal &amp; fetal loss and early neonatal death</td>
</tr>
<tr>
<td></td>
<td>Quarterly</td>
</tr>
<tr>
<td>Health and Social Care Information Centre</td>
<td>Routine data collection for:</td>
</tr>
<tr>
<td></td>
<td>routine booking</td>
</tr>
<tr>
<td></td>
<td>appointment</td>
</tr>
<tr>
<td></td>
<td>activities</td>
</tr>
<tr>
<td></td>
<td>maternity care</td>
</tr>
<tr>
<td></td>
<td>plan</td>
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<tr>
<td></td>
<td>dating scan</td>
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<tr>
<td></td>
<td>antenatal</td>
</tr>
<tr>
<td></td>
<td>screening tests</td>
</tr>
<tr>
<td></td>
<td>structural fetal anomaly screening</td>
</tr>
<tr>
<td></td>
<td>labour &amp; delivery</td>
</tr>
<tr>
<td></td>
<td>newborn screening</td>
</tr>
<tr>
<td></td>
<td>maternal or neonatal death</td>
</tr>
<tr>
<td></td>
<td>Quarterly</td>
</tr>
<tr>
<td>Local Maternity Networks</td>
<td>Dashboards</td>
</tr>
<tr>
<td>Local Supervising Authority</td>
<td>Several datasets relating to supervisory investigations and standards of statutory supervision within maternity services including the supervisor to midwife ratio. Annual maternity service audit and annual report.</td>
</tr>
<tr>
<td>RCOG – Each Baby Counts</td>
<td>Stillbirths, neonatal deaths and brain injuries occurring due to incidents in labour. All UK units to submit data.</td>
</tr>
</tbody>
</table>
2 SCHEDULE 2 – The Services

Service specifications

<table>
<thead>
<tr>
<th>Service Specification Number</th>
<th>Provider Lead</th>
<th>Commissioning Lead</th>
<th>Period</th>
<th>Date of Review</th>
</tr>
</thead>
</table>

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 will be undertaken by ensuring that:

- The transition from pregnancy to parenting and family life is supported through high quality services that are woman and family centred.
- Women and their families are able to access a full range of pre-conception advice, antenatal, intrapartum and postnatal care, taking account of individual choice and clinical need.
- Women and their families are given evidence based information and advice about all stages of their pregnancy.
- Continuity of care is delivered across the maternity pathway.
- Maternity care provision is 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.
- Service providers work in partnership to deliver community based multi-professional care across organisational and geographical boundaries to deliver seamless services.
- Service providers should have failsafe systems in place which operate across organisational boundaries to identify women / babies at risk of not receiving timely screening.
- Providers and commissioners work in partnership with women and their families, predominantly through Maternity Services Liaison Committees (MSLC) to design, develop, improve and deliver services which meet local need.

2.2 Basic commissioning principles:

- The provider will use their local maternity dashboard which will feed into the pan London maternity SCN dashboard to enable benchmarking of services.
- Regular activity reports will be provided as agreed. These will include antenatal & newborn screening, early booking and antenatal, birth and postnatal pathway data, number of births affected and the maternity minimum data set.
- 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:

- Pre-conception
- 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.*

2.4 Pre-conception advice and care

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

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

Women with pre-existing clinical conditions such as diabetes, hypertension, epilepsy, a personal or family history of congenital or chromosomal anomalies, or those at high risk of developing pregnancy complications including women with poor mental health and a BMI of over 30 or more, should be provided with pre-conception information, advice and support as per NICE guidance.

Responsibilities between primary care, maternity services and specialist services such as Mental Health should be clearly defined for the provision of support, and pathways should be in place for the referral to specific pre-conception services and specialist hospital based clinics.

National guidance for tuberculosis is due out at the end of 2015 and there are eligibility criteria for NHS funded latent TB infections testing and treatment *(NICE guidance for TB)*

2.5 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.

Young women should be encouraged to use antenatal care services and services should be age-appropriate, information 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.

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 made in a timely manner.

2.6 Antenatal Care

Providers will:

- Deliver antenatal care in accordance with NICE antenatal care guidance (including number of appointments, timing and risk assessment).
- Facilitate early referral and work with CCGs to deliver the NHS standard for early access to services (access to maternity care by the 10th completed week 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 should be easily available within local settings and the process simple and accessible.
- Assess risk of gestational diabetes at the booking appointment using risk factors in a healthy population and testing 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. Care can also be provided by a midwife in an obstetric setting for women who are categorised as high risk.
- Women should be advised of their ‘named midwife’ for their antenatal care (see SCN toolkit). They may continue to see their GP for antenatal care in a shared care arrangement, if they choose to do so and their GPs provide this service (if shared care processes are in place in that area). GPs who provide shared ante-natal care are required to maintain their competence in caring for low risk women.
- Providers should ensure information is transferred to Child Health Record Departments of all booked women to facilitate health visiting contact with women antenatally.
- 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 there should be direct and clear communication and collaboration between primary and acute services.
- Ensure all pregnant women with diabetes Type 2 are referred in early pregnancy to the Diabetic Eye Screening Programme National Standards.
- 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.
- Provide and/or sign-post to, specific antenatal support for women with additional needs, for example non-English speakers or those with a BMI of 30 or more.
- Provide evidence based information and advice about all available settings (home, freestanding midwifery unit, alongside midwifery unit or obstetric unit) when the woman is deciding where to have her baby, so that she is able to make a fully informed decision. This includes information for the woman and her baby about outcomes, risks, benefits and consequences for the different settings.
- Give the woman evidence based information including local statistics about all local birth settings, including access to midwives and medical staff, access to birthing pools, active birth equipment, Entonox, other drugs and epidural analgesia and the likelihood of being transferred (see section 1.5 regarding formats and languages).
- Offer women the choice of type and place of birth appropriate to her health, obstetric and social care needs, this will include midwife led and obstetric led units.
- Actively promote midwifery led settings to ‘eligible’ women (see SCN toolkit).
- Develop the capacity of the midwife-led and home birth services to meet the needs of the local population.
- Provide all women with hand held records containing the results of their antenatal tests and offer participant-led antenatal classes including breastfeeding workshops.
- Discuss and deliver health promotion information on healthy diet, folic acid, alcohol, vitamin D, refer to Healthy Start Programme and promote healthy start vitamins to eligible families.
- Discuss the benefits of seasonal flu vaccine and whooping cough vaccine.
- Promote pregnancy and birth as a normal life event and support women to have a birth plan in place by 36 weeks gestation and reconsider birth place of choice.
- Demonstrate a strategy for detecting babies with fetal growth restriction (FGR) (See SCN toolkit).
- Follow the principles in the Fetal Fibronectin toolkit (SCN) for fibronectin testing in women with threatened preterm labour and the Outpatient Induction of Labour toolkit (SCN) for low risk women.
- Have access to multidisciplinary care for medically complex/high risk women and pathways defined for access to tertiary care. Providers will ensure they are part of a network that includes all levels of neonatal care (BAPM NICU framework for practice), a tertiary level fetal medicine service that meets NHS England service specifications (NHS England fetal medicine service specification) and multidisciplinary maternal medicine services. Pathways will ensure timely referral, including in utero transfer as necessary for those at the highest risk of preterm birth, to optimise outcomes for mother and baby. Networked providers will develop service level agreements (SLAs) to fund these complex pathways.
- Ensure that a network of care for women with mental health issues is provided, and women with existing or previous mental health issues (including perinatal phase, defined from conception, during pregnancy and the first year after childbirth) 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 and provision meets the London Standards and Pathways for Perinatal Mental Health (Draft Pan-London perinatal mental health pathways).
• 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.
• Refer women with a BMI of over 35 to an obesity pathway
• 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.

2.7 Screening

Providers 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

• Have a dedicated screening coordinator / midwife (LCO) and a deputy to oversee delivery of antenatal and newborn screening programmes. Ensuring policies & protocols are reviewed regularly, care pathways are sustained in line with NSC standards, training and education is delivered, audits undertaken and there is timely data collection and submission for monitoring programmes.
• Ensure that the local coordinator produces an annual screening report to Trust Boards and PHE.
• Ensure Trust Screening Steering Group meets quarterly and has robust governance arrangements.
• Ensure timely reporting and management of alerts and incidents
• Provide quarterly KPIs.
• Ensure robust commissioning processes with Service Level Agreements for specific screening services: Newborn Hearing; Down’s Laboratories.
• Provide cohort tracking to ensure all women and babies are offered screening timely
• 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.
- Ensure all pregnant women with Type 2 diabetes are referred to the Diabetic Eye Screening Programme.
- Offer all pregnant women clear information regarding the full range of screening tests and the consequences of these.
- Use booking data to plan capacity.

<table>
<thead>
<tr>
<th>Screening and Pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Before you get pregnant</strong></td>
</tr>
<tr>
<td>Start Folic Acid</td>
</tr>
<tr>
<td>Week 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56</td>
</tr>
<tr>
<td>Pre-screening Info</td>
</tr>
<tr>
<td>Booking Now</td>
</tr>
<tr>
<td>Antenatal Care</td>
</tr>
<tr>
<td>2.8 Intrapartum Care</td>
</tr>
</tbody>
</table>

**Providers will:**
- Deliver Intrapartum Care in line with the NICE Intrapartum Care guideline, Increasing the number of births at home and in midwifery led units toolkit (SCN), Increasing Continuity of Care toolkit (SCN), London Quality Standards and Minimum Standards for The Organisation and Delivery of Care in Labour (RCOG, RCM, RCA, and RCPCH 2007).
- 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 ‘homely’ birth environments.
- 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 that there are robust protocols in place for transfer of care between settings and clear pathways for dealing with obstetric or medical emergencies.
- Follow the Improving Outcomes for Major Obstetric Haemorrhage toolkit (SCN).
- Use booking data to plan capacity.
2.9 Postnatal Care

Providers 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 advice on warning signs prior to discharge. See London Quality Standards and use of the MEOWS chart.
- Provide specialist bereavement support and counselling for women and their families who experience neonatal or maternal death, or stillbirth.
- Follow the SCN process for reporting and investigating direct and indirect maternal deaths in London.
- Ensure that the initial newborn 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 newborn 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.
- 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 an externally evaluated, structured programme that encourages breastfeeding is implemented, using the Baby Friendly Initiative as a minimum standard.
- Ensure that the transfer of postnatal information between Trusts is done so securely and safely.
- 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.
- Assess the mental and physical health and social needs of mothers and babies at each postnatal contact, and specialist advice sought as appropriate NICE Postnatal Care guidance.
- Provide immunisation including anti-D immunoglobulin, MMR and rubella in line with the NICE Post Natal Care guidance and the Green Book.
- Follow the London Neonatal Operational Delivery Network protocol for the readmission of jaundice babies.
- 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.
- Offer post-delivery contraceptive advice to all women.
• Encourage women to provide feedback on their experience of care and service.

2.10 Workforce standards

See section 1.7

2.11 Service user engagement

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

Organisations 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.

Providers will:

• 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, such as ‘walk the floor’.
• Provide feedback to users on how maternity user feedback has been used by the organisation including action plans and outcomes.
• Participate in a local maternity services forum such as a Maternity Services Liaison Committee.
• Ensure that the mother’s, baby’s and family needs are central to service improvement.
• Engage with service users in the development and review of services (see SCN toolkit).

2.12 Population covered

The services outlined in this specification are for women resident or registered with a GP within the geographical area covered by [INSERT]

3.0 Acceptance and Exclusion Criteria

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

No exclusion criteria.

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:

• Neighbouring Maternity Service Providers / Networks
• Neonatal Services/networks
• Family Nurse Partnership
• Perinatal Mental Health Services
• Local Authorities including public health and social services
• Clinical Commissioning Groups
• Health Visiting Services
• GPs
• Children’s Centres
• Safeguarding children and vulnerable adult services
• MSLCs and other service-user organisations
• Local Screening midwife
• NHS England London ANNB Screening Commissioners NHS E London
• Link Universities to Maternity/Medical services
• Health and Wellbeing Board
• ANNB Quality Assurance Public Health England (PHE)
• PHE Health 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

4. Applicable Service Standards

4.1 Applicable national standards

See section 1.6

4.2 Applicable local standards

See section 1.6

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements and CCG Outcomes Indicators

<table>
<thead>
<tr>
<th>DOMAIN 1: Preventing people from dying prematurely</th>
<th>Outcome Measure</th>
<th>Threshold</th>
<th>Method of Measurement</th>
<th>Consequences of Breach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in perinatal mortality rates (neonatal mortality and stillbirths)</td>
<td>Actual figures</td>
<td>Reported to NHS England and SCN core dashboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality requirement</td>
<td>Number of women seen by a midwife or maternity healthcare professional, before 10 completed weeks of pregnancy. Or within 2 weeks of referral if this is</td>
<td>90%</td>
<td>Service reporting Quarterly</td>
<td></td>
</tr>
</tbody>
</table>
received after 10 completed weeks of pregnancy.

**DOMAIN 4: Ensuring that people have a positive experience of care**

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Threshold</th>
<th>Method of Measurement</th>
<th>Consequences of Breach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friends and Family Test</td>
<td>Actual figures – 40% response rate</td>
<td>Reported to NHS England and SCN core dashboard</td>
<td></td>
</tr>
</tbody>
</table>

**Quality requirement**

| % of women completing the Friends and Family test | Friends and Family Test at key points in the pathway and submit data as required including SCN dashboard |                        |
| % of women who had a positive experience of care | Friends and Family Test at key points in the pathway and submit data as required |                        |

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

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Threshold</th>
<th>Method of Measurement</th>
<th>Consequences of Breach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in the number and percentage of full term babies admitted to neonatal intensive care</td>
<td>Actual figures</td>
<td>Reported to NHS England</td>
<td></td>
</tr>
</tbody>
</table>

**Quality requirement**

| Midwife to birth ratio | Working towards 1.29 | Maternity dashboard |                        |
| % of women to have received 1:1 midwife care during established labour | 100% | Maternity dashboard |                        |
| Number of hours of consultant cover on labour ward | Minimum of hours per week in each unit. To be agreed locally – work towards achieving London Quality Standard. | Maternity dashboard |                        |
### 5.2 Other specific Quality Monitoring

Providers must prepare and complete a local Maternity Dashboard which should reflect current network arrangements.

<table>
<thead>
<tr>
<th>Organisation responsible</th>
<th>Data collection</th>
<th>Frequency</th>
</tr>
</thead>
</table>
| Strategic Clinical Network | Pan London maternity dashboard, including:  
- Major PPH rate  
- Friends & family test uptake rates  
- Maternal Death rate  
- Neonatal HIE (grade 3) rate  
- Neonatal death rate  
- Stillbirth rate | Quarterly |

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

To be completed locally

### 6. Location of Provider Premises

The provider’s premises are located at:

- To be completed locally