SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	**01/MRFH/0033**
Service	Maternity Pan Dorset
Commissioner Lead	Clinical Commissioning Programme for Maternal & Reproductive Health
Provider Lead	
Period	1 September 2014 to 31 March 2016
Date of Review	September 2015

1. Population Needs

1.1 National/local context and evidence base

Maternity services in Bournemouth and Poole and Dorset face some specific challenges, in terms of the increase in overall activity levels predicted, the increase in complexity and vulnerability in the population and in the unacceptably poor caesarean section rate.

Caesarean section rates have been increasing year on year and can not continue in this upward trend. The rates for Bournemouth and Poole and Dorset are in the top fifth percentile for the SHA and the top decile nationally.

Evidence base

Maternity is well served by evidence base and national guidance. NICE, RCM and RCOG guidance can be found in section 4. In addition the following policy documents are applicable:

- Department of Health (2009) *Healthy Child Programme pregnancy and the first five years of life*
- Health Care Commission (2008) *Towards Better* Births
- Department of Health (2007) *Implementation Plan for reducing Health Inequalities in Infant Mortality: A good practice guide: review of the health inequalities infant mortality PSA target*
- CEMACH (2007) *Saving Mothers' Lives*
- Department of Health (2007) *Maternity Matters: Choice, Access and Continuity of Care in a Safe Service*
- UK National Screening Committee UKNSC (2007) http://www.screening.nhs.uk/./
- Department of Health (2004) *Maternity National Service Framework*
- Department of Health (2009) *Getting maternity services right for pregnant teenagers and young fathers*
- The Marmot review, Fair society, healthy lives 2010
- Maternity Matters, Choice, access and continuity of care in a safe service, DH 2007

- Midwifery 2020: delivering expectations, DH 2010
- Preparation for birth and beyond, DH 2012
- Supporting families in the foundation years, DH (2011)
- NICE Public Health Guidance 48: Smoking cessation in secondary care: acute, maternity and mental health services (November 2013)
- Smoking Cessation in Pregnancy: A Call to Action. ASH et al (2013)
- NICE PH Guidance 26: How to stop smoking in pregnancy and following childbirth (June 2010)

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	*
Domain 2	**Enhancing 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**	*
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	*

Public Health Outcomes

Domain 1	**Improving the wider determinants of health**	*
Domain 2	**Health improvement**	*
Domain 3	**Health protection**	
Domain 4	**Healthcare public health and preventing premature mortality**	*

2.2 Local defined outcomes

The service provider shall deliver the following outcomes working in partnership with the local health economy where appropriate:

- The majority of women (in line with the KPI) shall present for a first booked appointment with a midwife within 12 completed weeks gestation
- Women shall have an informed choice about the most clinically appropriate care for them
- Reduced rates of medical or surgical intervention in births
- Fewer women or babies presenting with complications following birth
- Increased number of service users involved in service planning
- Increased satisfaction of service users and fewer complaints
- Increased rates of breastfeeding initiation
- Reduce the number of women smoking during pregnancy
- Reduce the proportion of women smoking at time of delivery

- All women are continuously risk assessed throughout their pregnancy and provided with appropriate care.
- Increased staff satisfaction
- All women and babies receive the required screening during pregnancy
- All women fully counselled on vaginal birth after caesarean section and women are advised on how to maximise chances of a normal birth and discuss a plan of care for labour
- Ensure obese mothers are given practical advice and encouragement to lose weight before and after pregnancy, including access to specialist help if they need it
- Fathers and partners shall be engaged with the woman's consent as part of the preparation for parenthood

3. Scope

3.1 Aims and objectives of service

Aims

- To provide accessible, safe and high quality maternity services to meet the needs of the local population.
- To provide maternity services that meet core national standards for pre-conceptual, antenatal, intrapartum and postnatal care and aligned neonatal and newborn services.
- To improve access to maternity services based on clinical need and individual choice
- To reduce inequalities by improving outcomes for women and babies
- To provide the best possible start in life for children
- To contribute towards the reduction of infant mortality rates
- To provide consistency of service commissioning and provision across Bournemouth and Poole and Dorset

Objectives

The objectives of the maternity services are:

- Improved access to maternity services
- Promotion of normality in pregnancy and the birthing experience
- Reduced caesarean section rates
- Safe midwifery and obstetric care adhering to national best practice guidelines
- Improved continuity of care for service users
- Increased focus of care closer to home
- Increased choice and control for service users
- Improved user experience and public confidence
- Increased prevalence and duration of breastfeeding

- Sustained reduction in the proportion of women smoking during pregnancy and in the postnatal period (measured at time of booking with carbon monoxide (CO) reading, 36 weeks with carbon monoxide reading and at time of delivery with smoking status recorded
- Workforce fit for purpose

3.2 Service description/care pathway

The service shall be delivered in partnership with the woman, her partner and health and social care professionals, based on a comprehensive risk assessment following an agreed pathway of care. Normalisation of pregnancy and the birthing experience shall be underpinned by improved access to services and increased choice during the antenatal, intrapartum and postnatal period of care. There shall be an increased emphasis on community based care and a focus on midwifery led services (where clinically appropriate). Antenatal Day Assessment shall be provided in the community where possible. Competencies shall be established and fully implemented for midwives to perform routine newborn examinations and appropriate immunisations.

Women need to know what maternity services exist and where to find them. They need to be within easy reach and not involve complex journeys or inconvenient opening times. To be accessible, the service should also be attractive, culturally sensitive, and regarded as beneficial from the woman's perspective.

Providers shall use appropriate marketing to women from different backgrounds for early booking with midwives as first point of contact. All provider-produced information must be developed in collaboration with users. Providers shall support development of pathways of care for direct access booking through Children's Centres and other suitable community venues. Women presenting to such venues for booking beyond 12 weeks of pregnancy should be able to access booking directly.

The service provider shall provide flexible access to inclusive services to meet the need of the local population, including targeted services for:

- Vulnerable and disadvantaged pregnant women and the father/partner (where appropriate)
- Services for pregnant women with learning and physical disabilities (taking into account their communication, equipment and support needs)
- Teenage parents
- Interpreting and advocacy services based on assessment of the needs of the local population.

3.2.1 Service model

The services shall be provided in accordance with all national and local policy in particular National Service Framework for Children, Young People and Maternity Standard 11, NICE guidelines and Maternity Matters, Maternity pathway payment. This specification should be amended in accordance with any future national policy.

This service model is based on RCOG Standards for Maternity Care and current best practice.

The underpinning principles of the maternity service provision include:

- An emphasis on pregnancy and birth as essentially a normal physiological process **with a focus on increasing normality and reducing interventions in care**.
- Working with other commissioned service providers in the community to develop seamless care pathways to tackle determinants of infant mortality e.g. smoking, obesity, drug and alcohol misuse, poor diet, poor oral health, breastfeeding support, domestic abuse and poverty.
- Universal use of an antenatal risk assessment tool to identify those women and their partners where appropriate for whom additional care is necessary. The outcome of the antenatal assessment shall determine the level of risk and inform a personalised care plan devised in partnership with the pregnant woman and her partner where appropriate
- All midwives shall attend interagency training (i.e. 2 day safeguarding training with 3 yearly one day updates) as well as single agency training and professional development related to their specific role
- Establishing a community-based multi-professional partnership approach to care that ensures seamless services
- Promoting continuity of care especially for disadvantaged women and those with special needs. Providers shall be expected to demonstrate appropriate care pathways for vulnerable and high risk groups (including teenage pregnancy, mental health, domestic violence and others). Providers shall be expected to demonstrate stratification of service provision dependent upon need.
- Promote family-based care and locally available access to other services such as Parenting Education, Family Planning, Benefits Agencies, and Baby Clinics etc.
- There shall be a choice for women and their partners at each stage of the care pathway
- Provide a seamless service to women who may require medical/obstetric support during their pregnancy with a midwife as the key coordinator.

- Meet the requirements within Breast Feeding Initiative standards including recording information given in pregnancy, skin-to-skin contact, time of first feed, supplementation, staff education, and safe feeding practices for formula fed babies.
- Service providers shall seek to determine the smoking status of women throughout pregnancy with CO readings taken as per care pathway. Provide smoking cessation advice and support, including appropriate use of nicotine replacement therapy (NRT) to women and where possible partners/significant household members during the antenatal/early postnatal period.
- Service providers shall ensure arrangements are in place to ensure supervision of midwives and supervisors as directed by the Local Supervisory Authority and the Nursing and Midwifery Council.
- Service providers ensure appropriate levels of midwifery and medical staffing that complete mandatory multi-professional in-service training in line with the requirements of the clinical negligence scheme for trusts and which shall include training in obstetric emergency skills.
- Acute maternity services shall be available 24 hours a day 7 days a week 365 days a year. Community midwifery services shall be available every day from 9am-5pm. Providers shall ensure appropriate out of hours cover necessary to facilitate safe home births in line with European Working Time Directive (EWTD).

3.2.1.1 Antenatal Care

Pregnant women shall be directly booked by 12 completed weeks gestation to a community midwife, who shall risk assess the women and their partner where appropriate in accordance with the risk assessment tool (to be developed) and lead the provision of community midwifery service in accordance with section 3.2 care pathway.

The service shall work in partnership with service users to enable these women to make informed choices about their maternity care, breastfeeding, smoking and healthy lifestyles.

The service shall be flexible and responsive; assessing need and developing care plans in accordance with national policy and guidance and local care pathways agreed through the appropriate neonatal and maternity care networks.

At least 90% of women shall have a named midwife, with three affiliated midwives to provide continuity of care. This means a total of no more than four identifiable carers (this shall exclude any medical contact) with the aim of moving to 100% of women.

3.2.1.2 Risk Assessment

Providers shall assess social and medical risks for all pregnant women and their partners where applicable at booking using the agreed risk assessment tool (see diagram 1 for proposal), and provide increasing levels of care for women with increasing levels of risk. Three categories of risk for pregnant women are identified:

- Level 1: Low risk medical and low risk social (Universal Care)
- Level 2: Low risk medical and high risk social (Targeted Care) or High risk medical and low risk social (Targeted Care)
- Level 3: High risk medical and high risk social (Specialist Care)

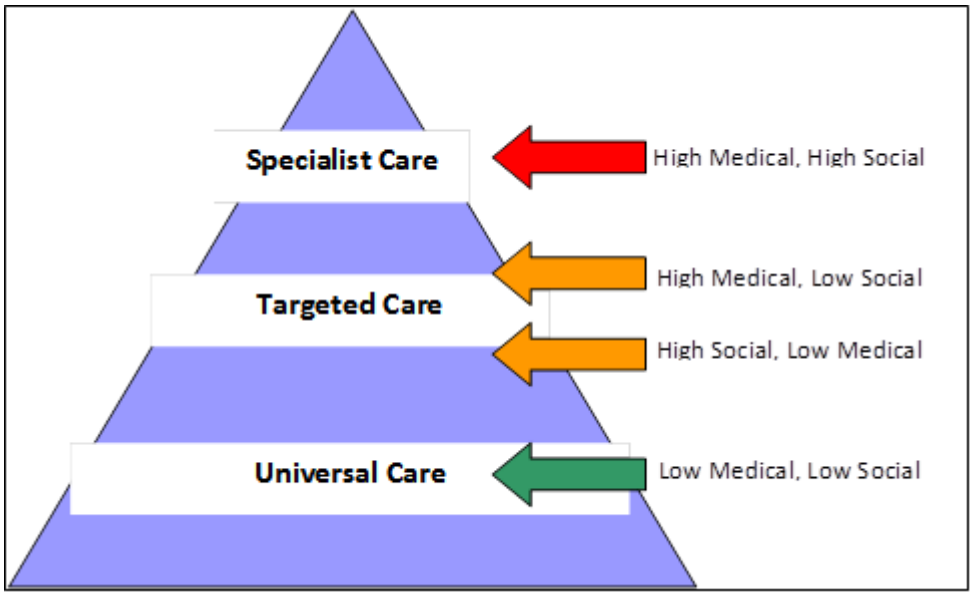


Diagram 1 *provides a diagrammatic representation of risk and care provided at each level*.

Level 1: The schedule and content of antenatal care for women who can be defined as 'normal' is set out in the NICE guidance. Its evidence-based review has produced an algorithm, which recommends that primiparous women receive 10 scheduled antenatal contacts and 7 for multiparous women. This shall provide the basis for the care pathway for all 'normal' pregnancies as set out in section 3.2.care pathway

Level 2: NICE guidance also recognises that a group of women with medical risk factors need additional care as set out in section 3.2 care pathway. These women shall receive additional care according to agreed pathways for their medical risk factors or condition. For example, care for pregnant women and their babies with diabetes mellitus shall be provided in accordance with NICE guidance and standards.

Women at level 2 have social risk factors as identified by CEMACH indicating a need for increased antenatal care provision using jointly agreed pathways of care.

To agree expected antenatal contacts and postnatal contacts and percentage of percentage of people applies to.

Level 3: Women at level 3 have multiple social and medical risk factors. These women and their partners where applicable shall receive the highest levels of specialist, multidisciplinary, multi-agency care.

Table 1: Matrix for determining appropriate pathways for antenatal care

Low Risk Medical & Low Risk Social ○ Universal provision ○ Ongoing risk assessment ○ Midwifery led care ○ NICE antenatal & guidance postnatal ○ Delivery in: Midwife Led Unit or Home birth or obstetric unit with direct access to NICU or obstetric unit with alongside LNU	Low Risk Medical & High Risk Social ○ Enhanced midwifery led care ○ Ongoing Risk Assessment ○ Strong links to Children's Centres and coordinated community support services ○ Delivery in: Midwife Led Unit or Home birth or obstetric unit with direct access to NICU or obstetric unit with alongside LNU
High Risk Medical & Low Risk Social at point of labour ○ Booked under obstetric led care with midwifery care ○ Ongoing risk assessment ○ Delivery in: obstetric unit with the ability of midwifery led delivery depending on risk assessment at point of delivery with direct access to NICU or obstetric unit with alongside LNU	High Risk Medical & High Risk Social ○ Obstetric led with enhanced midwifery input and coordinated specialist support/services ○ Ongoing risk assessment ○ Delivery in: obstetric unit with direct access to NICU or obstetric unit with alongside LNU

Consistent with NICE Guidance PH26 & PH48, providers through use of carbon monoxide monitoring shall also assess smoking status at time of booking, at 36 weeks and record smoking status at time of delivery and where appropriate throughout the antenatal period in line with the integrated care pathway set out in Diagram 2, section 3.2.1.4.

The provider shall be required to work in collaboration with the local health economy to either provide specialist services or be able to refer patients to specialist services for:

- Drug and Alcohol abusers
- Homeless and travellers
- Teenagers
- Women with mental health problems
- Women with diabetes

- Obese women
- Women who have Female Genital Mutilation
- Migrant women and partners including asylum seekers
- Pregnant women who smoke, partners and household members as appropriate

The provider shall meet National Services Framework (NSF) Standard 11 and the RCOG Standards for Maternity Care and identify the following risk factors (as denoted by the Confidential Enquiry into Maternal and Child Health (CEMACH)).

- Smoking
- Single mothers on benefit
- women living in areas of deprivation
- Women who do not speak English/require Translation Services
- Women with communication difficulties and other disabilities
- Asylum Seekers/Newly Arrived Refugees/Afro-Caribbean/Eco Migrants
- Homeless
- Late Booking & Poor Attendees (> 4 Did Not Attend (DNAs))
- Domestic Abuse
- Known to Social Services
- Safeguarding children or vulnerable adult issues – including female genital mutilation
- Previous Children in Care
- Drug and/or Alcohol misuse (woman or partner)
- Nutritional risks - including poor diet or being under or over ideal weight –
- Maternal and/or paternal mental health
- Teenagers (woman and partner)

3.2.1.3 Antenatal screening

All women shall be offered a high quality antenatal screening and diagnostic service based on current recommendations of the National Screening Committee and shall undertake quarterly audits as outlined in quality indicator.

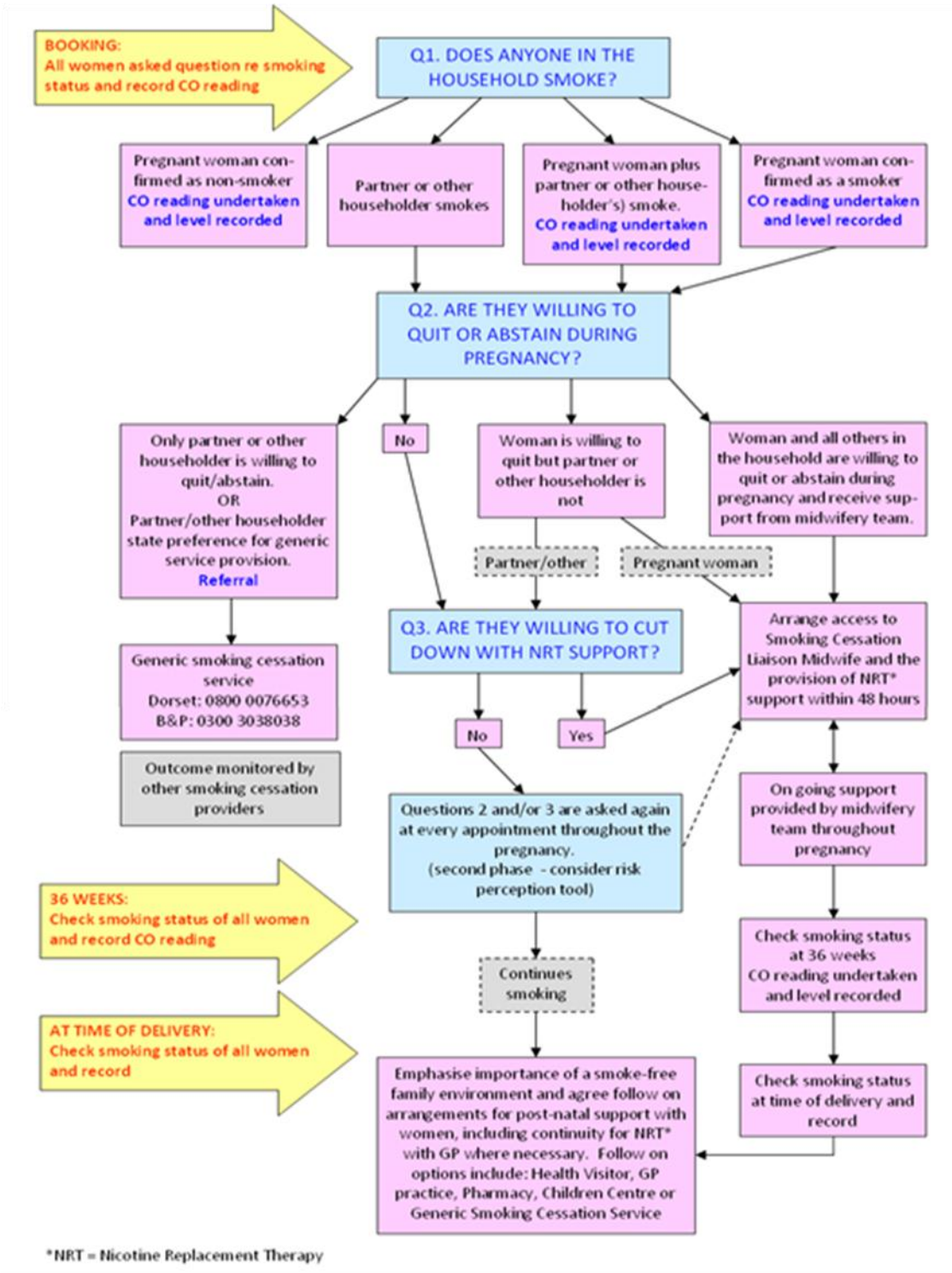
3.2.1.4 Health Improvement

All women shall be informed at the booking appointment about the importance of vitamin D and in particular those women at increased risk of deficiency. Providers shall actively support eligible parents to obtain Healthy Start Vitamins and encourage ongoing usage either through direct provision or proactive signposting to distribution points. Providers should be familiar with local distribution points and local policy, and work with CCG to develop shared policies for promotion and distribution of Healthy Start Vitamins where these are not yet in place.

Providers shall comply with NICE Guidance *"Improving the nutrition of pregnant and breastfeeding mothers and children in low income households".*

- Providers shall inform all pregnant women about the benefits and management of breast feeding and ensure all written materials are free from the promotion of breast milk substitutes, bottles, teats and dummies.
- All women shall receive a body mass index (BMI) assessment at booking. Those with BMI's below 18 or above 35 kg/m2 shall be routinely offered a dietician or equivalent approved weight management programme for additional support. For those identified as at risk, the woman's weight shall be monitored throughout pregnancy aiming for ideal weight management.
- All women shall be offered appropriate parenting education in partnership with alternative providers. "Back to Sleep" advice in accordance with the Foundation for the Study of Infant Deaths (FSID) guidance (incorporating smoke free home advice) should be offered to all women at the end of pregnancy. Supportive Education shall be provided which should be evidence based and conform to the relevant Children and Young People's Trust Parenting Strategy.
- All women shall be assessed at the booking appointment for smoking status including the smoking status of partners and other householders. Where women or other householders are identified as smoking, they shall receive clear advice about the risks of smoking during pregnancy and the risks of second hand smoke as part of a brief intervention by the midwifery team. Providers shall then implement the smoking cessation pathway as set out in Diagram 2 below. Assess smoking status again at 36 weeks (CO monitored) and time of delivery.

Diagram 2: ANTENATAL SMOKING CESSATION



*NRT = Nicotine Replacement Therapy

All community midwives shall undertake training to enable full implementation of the smoking cessation pathway. They shall be supported by a full-time Smoking Cessation Liaison Midwife who shall adopt a professional lead role for smoking cessation. The Liaison Midwife role shall include:

- Provision of expert advice and establish new clients on nicotine replacement therapy (NRT) within 48 hours of booking
- Support clients that have relapsed or require expert advice during pregnancy
- Support the midwifery team to ensure successful implementation of the pathway, including the provision of on-going CPD for smoking in pregnancy, maintenance/ calibration of CO monitors and provision of appropriate resources.

3.2.1.5 Intrapartum Care

Service providers shall be responsible for ensuring all intrapartum care complies with national choice guarantees and demonstrates evidence of:

- Progress in developing appropriate care pathways to minimise intrapartum interventions using NICE guidelines on caesarean section.
- Choice of the type of care and place of birth, including choice of pain relief methods appropriate to the type and place of care chosen. Choice shall be offered in accordance with safety and CNST requirements.
- Individual support for women throughout their birthing/confinement experience.
- All mothers are given their baby to hold with skin-to-skin contact in an unhurried environment for an unlimited period as soon as possible after delivery.
- All mothers are offered help to initiate a first breastfeed when their baby shows signs of readiness to feed.
- Robust and transparent clinical governance framework within provider units which is applicable to each birth setting.
- Each birth setting has protocols based on clinical, organisational and system needs.
- Facilities in birth settings should be at an appropriate standard and take account of the woman's needs and the views of the service users.
- The service provider shall ensure every woman has a designated midwife when in established labour for 100% of the time.

3.2.1.6 Supporting Infant Feeding

Providers shall ensure all women are fully informed that breastfeeding has positive long term health benefits for mother and baby and provides optimal nutrition for the baby. Providers shall ensure all women are offered breast feeding advice and support in accordance with the recommendations of UNICEF/WHO “Baby Friendly Initiative”.

Providers shall assess the need for frenulotomy within 24 hours.

Multi-agency, integrated training between primary and secondary care and the statutory and voluntary sector shall be delivered in partnership with primary care breastfeeding coordinators.

3.2.1.7 Postnatal Care

In accordance with the National Service Framework (NSF), midwifery led postnatal services should be available for up to 28 days after birth. Service Providers shall ensure that women and their partners have a choice of how and where to access postnatal care. This shall be provided either at home, in a community setting e.g. GP surgeries, health centres, community venues, children's centres, or community hospitals.

Service Providers shall ensure accurate and complete birth notification – 90% within 6 hours in accordance with Quality Standards in the NHS Newborn Hearing Screening Programme.

3.2.1.8 Service User Experience

Ensure that feedback from service user and other performance management is used to improve service delivery.

3.2.2 Care Pathways

The provider shall be required to follow the existing care pathway based on the risk assessment completed.

3.2.2.1 Community Midwifery

Providers shall ensure community midwifery services are delivered in compliance with relevant local and national guidance for pre-conceptual, antenatal, postnatal, neonatal and newborn services. Refer to risk assessment in section 3.2.1.2.

Providers shall ensure community midwifery services deliver in accordance with the following table:

Timeframe	Anticipated Activity (to include mother and father, where possible)
Between 8-12 weeks	▪ Allocation of a named midwife ▪ Pregnancy risk assessment incorporating health, social and environmental factors, child protection/safeguarding. ▪ Discussion of screening tests to be offered/and performed as appropriate. ▪ Referral to midwifery led care, maternity team based care in accordance with choice and clinical risk ▪ Referral for dating scan and scan performed. ▪ Information on Healthy Start Scheme and provision of Vitamins where appropriate/available ▪ Provision of Pregnancy Book and the Community Care Information Booklet ▪ Signposting to NHS Choices Website and other relevant websites and resources ▪ Glucose Tolerance test offered /as appropriate ▪ Healthy Eating in Pregnancy discussed based on nutrition checklist ▪ BMI measured and, if <18 or >35, referral support shall be provided by a midwife with additional expertise in weight management and pregnancy. ▪ Monitor carbon monoxide (CO) level and ask smoking in pregnancy questions /provide brief intervention as set out in smoking cessation pathway and record in patient notes ▪ Give advice on weight management as per NICE guidance ▪ Signpost to services in children's Centres where appropriate
Between 16-18 weeks	▪ Social and clinical risk assessment and action plan agreed, identifying factors which may affect outcomes. ▪ Health promotion and action plan developed, agreed and regularly reviewed (Nulliparous women = 10 visits, Parous = 7 visits). ▪ Referral for anomaly scan and screening for Down's syndrome offered.

	▪ Women and their partners where appropriate identified as requiring additional support / increased social risk should be signposted / referred as appropriate.
25 – 26 weeks	▪ Health promotion and review of action plan ▪ Glucose Tolerance Test performed as appropriate
28 weeks	▪ Signposting to parent education classes ▪ Screening tests for anaemia and red cell antibodies ▪ Offer Rhesus negative women Anti D/single dose at 30 weeks
31 weeks	▪ Infant feeding discussed – advise mother of breastfeeding support available in hospital and within the community
34,36,38,40,41 weeks	▪ Health promotion and action plan reviewed ▪ Social assessment – signpost / refer as appropriate ▪ Safeguarding and domestic violence questions asked and documented as appropriate ▪ Review of birth choices and birth plan discussed ▪ Home visit before 36 weeks for vulnerable/at risk women ▪ Liaison between agencies / services / professionals including health visitors, as required ▪ Smoking cessation advice maintained in-line with care pathway and smoking status recorded with carbon monoxide monitoring of all women at 36 weeks with smoking status recorded at time of delivery ▪ Preparation for post birth transfer home
Intrapartum – home birth	▪ Assessment ▪ Care plans for birth discussed ▪ One to one care for woman in established labour ▪ Health visitor informed of birth via the birth notification / child health record
Postnatal care and 6 hours post delivery	▪ Notification of birth to child health/ audiologist/ screening service ▪ Breastfeeding advice/support/signposting ▪ Smoking relapse prevention advice discussed and refer to Smoking Cessation Liaison Midwife as needed
Postnatal care (within 36 hours)	▪ Midwife to undertake assessment at woman's home ▪ Plan for home visiting negotiated with mother based on need ▪ Minimum postnatal visiting schedule to include: Visit 1: day after transfer home, if appropriate midwives to check/arrange an appointment for the baby's 72 hour

	neonatal check. Visit 2: for newborn bloodspot test on Day 5 Visit 3: for discharge from midwifery care, dependent on the mother's circumstances – some mother's may require/request additional support. ▪ Maternity Support Workers may provide additional support up until 28 days as required/appropriate
72 hours	▪ Newborn screening by Midwife/Paediatrician
5 – 8 days	▪ Newborn bloodspot test and reassessment by midwife
10-14 days	▪ Assessment and handover to Health Visiting Service ▪ Notification of handover to General Practice
2-4 weeks	▪ Reassess physical / emotional needs – refer to specialist services as necessary ▪ Consider, discuss, refer as appropriate prior to discharge ▪ Continence ▪ Sexual health & contraception ▪ Emotional health ▪ Nutrition ▪ Health and safety ▪ Social needs ▪ Health promotion ▪ Smoking status ▪ Postnatal depression ▪ Mental health ▪ Infant feeding

3.2.3 Transfer and discharge from care obligations

Providers shall not discharge a woman where discharge would not be in accordance with Good Clinical Practice or Good Healthcare Practice, and shall use best efforts to avoid circumstances and discharges likely to lead to emergency re-admissions.

The Community Midwifery Service shall discharge women and infants at 10-28 days in accordance with guidelines and the woman's preference, where clinically appropriate. Health visitors shall become involved in postnatal care of women and infants earlier, dependent on risk, need and vulnerability of the woman.

Upon discharge from the service, Providers shall:

- Communicate information regarding episode of care to Health Visitors using the Child Health Record and the Birth Notification.

- Formerly document and communicate information regarding ante-natal and post-natal care, labour and birth episode (either birth in hospital or at home) to the GP within 72 hours
- Ensure all women's postnatal / antenatal / and intrapartum notes for integrated services records are stored securely as per local arrangements and in compliance with legal requirements.

3.2.4 Self-care and patient information

Independently and in partnership with the commissioners the provider shall ensure the provision of locally available information about the services it provides.

The provider shall use appropriate social marketing to women from different backgrounds for early booking with midwives as first point of contact. All provider-produced information must be developed in collaboration with users. The Provider must develop pathways of care for direct access booking through Children's Centres and other suitable community venues.

The provider shall ensure women and their partners where relevant have access to timely and appropriate information. Information shall be provided in a range of community languages and formats and targeted to the needs of the local population. Interpreter services shall be available to all women who are not fluent in English, or who may require signing.

Information provided shall cover all elements of what to expect from services during maternity care including antenatal, postnatal and neonatal screening services, how to look after yourself during pregnancy, labour and the postnatal period, infant nutrition including the benefits of breast feeding and practical advice on how to breastfeed, Healthy Start Scheme and information about placing baby in the 'Back to Sleep' position-Information shall also include how to access additional support e.g. Local Charities, Voluntary Groups, POWs and family support, as appropriate.

3.3 Any acceptance and exclusion criteria and thresholds

3.3.1 Acceptance criteria

Women at any stage of pregnancy referred from GP, health professionals, self-referrals and pregnancy fast track service.

Maternity service should accept all referrals having regard to the service model in section 3, with the emphasis upon ensuring referral arrangements do not delay access for service users.

3.3.2 Exclusion criteria

None

3.3.3 Response time & detail and prioritisation

Pregnant women known to the service should be contacted within 48 hours of referral with a time and date of first contact. Women shall have seen a midwife for a health and social care risk assessment within 12 completed weeks of gestation if not a late booker.

3.5 Interdependence with other services/providers

Whole System Relationships

The provider shall work in partnership with neighbouring maternity units, commissioners, general practitioners and users of the service to facilitate the commissioning of high quality service through:

- Multi-organisational working
- Improving delivery of clinical care and outcomes
- Providing leadership to the organisations within the network on implementation of national and local policy initiatives
- Pan Dorset Perinatal pathway
- Health Visiting and midwifery pathway

Patients and the public shall be involved in partnership with commissioners and providers in the planning, monitoring and improvement of maternity services. The provider shall be expected to work with the Maternity Service Liaison Committee.

The provider shall be expected to participate in the maternity operational group.

Interdependencies

Maternity services shall be required to work in partnership with other agencies and ensure appropriate referrals in accordance with the established care pathways. In particular the service provider shall ensure

- They identifiy women, and their partners where appropriate, in need of additional support antenatally and inform health visiting service
- Women are referred to health visiting services within 28 days of birth
- They work in partnership with the women's GP including accepting referrals, keeping them informed of the care provided and on-going clinical management.
- Women and/or their partners who smoke are automatically referred to smoking cessation services, unless they opt out
- Women are referred to community, acute and mental health services as deemed clinically appropriate
- They work in partnership with social services and other social support organisations as appropriate

- They work in accordance with the local and national safeguarding policies and procedures
- They work in partnership with children centres including providing ante-natal care in these settings
- They work with other maternity providers to ensure seamless care
- They work in collaboration with neo-natal providers where required to provide a seamless service

Relevant networks and screening programme

The provider shall be expected to have representation on the following networks/groups:

- Dorset Maternity Services Liaison Committee
- Dorset Maternity Operational Group
- Dorset Maternity Commissioning Delivery Group
- Pan Dorset Antenatal Clinical Governance Board

The provider shall be expected to work with NHS England to deliver the National Screening Programme. This includes:

- Newborn and Infant physical examination programme
- Foetal anomaly screening programme
- Downs syndrome screening programme
- Infection diseases in pregnancy screening programme
- Newborn blood spot screening programme
- Sickle Cell and Thalassaemia Screening Programme
- Newborn hearing screening programme (health visitor lead providers)

The provider shall be expected to work with Public Health Dorset in monitoring agreed outcomes for the smoking cessation pathway and to collaborate on other health promotion initiatives. It should be noted that Public Health Dorset has collaborated with NHS Dorset CCG to co-commission the smoking cessation pathway.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The provider shall comply with all relevant NICE guidance.

4.2 Applicable standards

Providers are expected to comply with all relevant RCOG and RCM guidance. A summary of key guidance can be found below and a full list of this guidance can be found following the hyperlinks below:

RCOG
RCM

- **RCOG (2008)** ***Standards for Maternity*** **Carehttp://www.rcog.org.uk/files/rcog-corp/uploaded-files/WPRMaternityStandards2008.pdf**
- **RCOG (2007)** ***Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labourhttp://www.rcog.org.uk/files/rcog-corp/uploaded-files/WPRSaferChildbirthReport2007.pdf***
- ***RCM Ten tops tips for normal birth***
- ***RCM Innovation and improvement in maternity services***
- ***RCM Making normal birth a reality***
- ***RCM top tips for involving fathers in maternity care***

4.3 Applicable local standards

The provider will:
Work with commissioners to develop a network wide (RBH, PHT, DCH) maternity dashboard to monitor network wide standards for safety and quality

The provider shall implement county wide care pathway for perinatal mental health, with a system of clear referral pathways.

Work with commissioners to develop the service change model as per the Maternity Commissioning Strategy and work with commissioners to develop appropriate care pathways.

Providers shall work with commissioner to meet all requirements of each stage of the Baby Friendly Initiative accreditation process and to achieve full Baby Friendly Initiative accreditation by 2013/14.

Work with Public Health Dorset to ensure successful integration of the Smoking Cessation Pathway and provide access to relevant data for monitoring purposes.

Providers ensure appropriate midwifery and medical staffing levels to deliver the model of care.

Work with the MSLC and other methods to engage families in the design and review of services.

The project plan to operationalise this specification shall include an evaluation strategy. Monitoring of the agreed KPIs shall provide intelligence as to whether the service improvements have happened and whether services users notice a difference.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

The provider's performance shall be monitored against quality standards in the maternity dashboard.

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

Service shall be provided from a variety of settings and locations appropriate to the type of care provided. These shall include: Community Health Centres, Children's Centres, Acute setting, GP surgeries and service users home.

RD3/0149 Removed requirement to provide services at Poole Town Surgery. From 4th August 2014 these services shall be provided at PGH's Maternity Unit in St Mary's Road.

7. Individual Service User Placement

N/A