SCHEDULE 2 – THE SERVICES

A. Service Specifications

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

All subheadings for local determination and agreement

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<tr>
<th>Service Specification No.</th>
<th>Annex to the Maternity Services (GM Core Specification)</th>
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<td>Service</td>
<td>Salford Freestanding Midwife-led Unit (FMU)</td>
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<td>Commissioner Lead</td>
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1. Population Needs

1.1 National/local context and evidence base
The purpose of this service specification is to describe the requirements and outcomes of midwife-led maternity services provided in Salford. This specification forms an annex to the Greater Manchester Core Specification for Maternity Services and should be read in conjunction with this document.

The standards, evidence base and best practice outlined in the core specification apply to this service provision. Insert Who quote

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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<th>Preventing people from dying prematurely</th>
<th>Enhancing quality of life for people with long-term conditions</th>
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2.2 Local defined outcomes
The service will contribute to the CCG’s overarching strategic objective to ensure that all children have the best start in life and continue to develop well during their early years.

The provision of the midwife led service model will contribute to the following outcomes:

- Improved maternal physical and mental health
  - Improved nutritional status
  - Reduced smoking
  - Reduced substance misuse
  - Improved psychological wellbeing

- Improved pregnancy outcomes
  - Low rates of surgical delivery
o Low rates of postnatal maternal morbidity and mortality
o Lower rates of perinatal mortality and morbidity
o Fewer LBW infants

• High rates of breastfeeding initiation and duration
  o Initiation rates at least the England average
  o 6-8 week rates at least the England average

• Care provided close to home and in a high quality child and family friendly environment;
  o High rates of homebirth appropriately reflecting individual choice.
  o Antenatal and postnatal care provided in Children’s Centres and at home

• Development of a highly skilled workforce
  o Staff with high levels of technical competence and skills
  o Staff with excellent relational skills

3. Scope

3.1 Aims and objectives of service
Salford CCG commissions all four birth settings outlined in the NICE Guideline for Intra partum (2014b) care (home, freestanding midwifery unit, alongside midwifery unit or obstetric unit). This specification is for the provision of midwife-led services with the freestanding midwifery unit in Salford as the focal point.

Salford CCG aims to commission midwife led services that are compliant with national guidance and best practice as outlined in the Core Specification. The service must provide for the health needs of women in Salford and their right to patient choice. This specification does not intend to reproduce sections of existing guidance documents, but care has been taken to highlight relevant points and local priorities. In addition to ensuring safe maternity care to women and babies the overarching local priority is to reduce health inequalities.

Pregnancy and birth should be seen as a normal physiological part of a woman’s life. Giving birth is also a life-changing event, and the care that a woman receives during labour has the potential to affect her both physically and emotionally in the short and longer term. Good communication, support and compassion from staff, whilst having her wishes respected, can contribute to making birth a positive experience for the woman and those accompanying her (NICE 2014b).

Key principles of service provision

• Contributes to the Strategic Objectives – public health facing addressing health inequalities
• Social model of care – woman centred care, keeping labour and birth normal and using emotional support and encouragement. The FMU/service as community resource and a focus for local identity and pride, contributing to local ‘social capital’
• Continuity of Midwife-led Care – provides continuity of care and maximise care from the same midwife / midwife team.
• Robust Communication Channels – the 2013 Maternity Review found that communication between health and social care teams could be improved.
• Safety- appropriate skills- safe transfers – collaboration amongst providers – agreed policies
• Cost effective / Value for Money - services based on tariff
• Patient experience – culture and ethos
• Innovation

These principles will form the basis of the service model and pathway.

Aims

• Establish a meaningful and supportive relationship with the woman, encouraging engagement with her pregnancy, birth and transition to parenthood.
• Provide an additional, alternative place of birth for women and their families, which increases the range of choice in line with current government policy, research evidence and national guidance.
• Provide a relaxed, comfortable and friendly environment where women considered at low risk of complications can be supported in the spontaneous, physiological processes of birth.
• Enable women and their families to feel in control of their birth experience.
• Promote the bonding process for the family, by including the companion throughout labour, birth and postnatal period.
• Fully utilise the skills of midwives so that women can benefit from high quality, individualised care throughout the continuum of pregnancy, birth and the postnatal period.
• Reduce unnecessary medical intervention rates for low risk women (NICE 2014b; Hollowell et al 2011)
• Catalyst for change. The BC will enable development of midwifery skills in supporting physiological
childbirth, with an aim to disseminate good practice through sharing/infiltrating through all areas.

Objectives – Defined by Commissioners
- Provide antenatal, labour and postnatal care to a cohort of women who fit the criteria for midwife led care.
- Provide continuity of care by named midwife
- Provide care to low risk women according to agreed standards and guidelines.
- Encourage women to be active in labour, use a range of positions for birth and explore non-pharmacological approaches to working with pain, for example immersion in water.
- Involve birth companion(s) in labour, birth and postnatal care.
- Provide training for clinical staff to respond effectively in emergency situations, and appropriate techniques to facilitate normal birth.
- Promote a positive birth experience to increase satisfaction for women and their families.
- Review specific outcomes and monitor transfer rates in labour ensuring that they reflect sound clinical decision making.
- Monitor and continually review performance, effectiveness and user satisfaction, ensuring the aims and objectives are met.

Objectives – Defined by Women
- I will have access to appropriate support and advice as soon as I know I am pregnant
- I will have a named midwife whom I know and trust
- I will choose where to have my baby based on available evidence
- I will feel safe and supported during my birth experience
- I will feel confident to care for my baby
- My views will be taken into account

3.2 Service model description and care pathway

Service model
The culture and ethos of the service will be based on clinical safety, continuity of care, compassion and kindness. The key principles of service provision underpin this and are expanded upon as service requirements below:

Contributes to the Strategic Objectives – public health facing addressing health inequalities
It is widely accepted that those with the poorest health, and therefore the greatest need for health services, are those least likely to receive them. Whilst many health inequalities are created by socio-economic factors, the structure of health services often contributes to inequalities and disempowerment. Many women in the UK who have socially complex lives and experience significantly high morbidity and mortality rates, often struggle to engage with maternity services (CMACE 2011). NICE (2010) suggest that a lack of antenatal care and engagement with services is directly linked to poor maternal and neonatal outcomes; therefore policies are often focused on improving access to care.

The Salford FMU will enable parents to access services closer to home and will be more accessible and responsive to local needs. Care will be community-based, and closely linked with other agencies including children’s centres and the voluntary sector. Through collaboration with these agencies, links can be made to enhance social support, which is recognised to be of equal importance to professional input in influencing outcomes for the woman, her baby and family (Garrod and Byrom 2007).

Midwives can make a major contribution to the national agenda for public health when they have the opportunity to develop a supportive relationship with women and their partners. During pregnancy parents are particularly well-motivated to re-consider their own health and lifestyle and to safeguard their child’s health and well-being. In addition, maternal mental health has become a national priority. Continuity of care, positive birth outcomes, and accessible care close to home will aim to contribute to minimizing potential for mental health problems.

The outcomes in section 2.2 will contribute to the public health agenda.

Social model of care
The service will be based on a philosophy consistent with a ‘social model of care’. The FMU should become a community asset that is seen as a resource for those living in the area and a focus for local identity and pride, contributing to local ‘social capital’ (Walsh 2006). When women have non-medical vulnerabilities, social models of care, which acknowledge childbearing as part of the fabric of people’s lives, are helpful in supporting a transition to motherhood (Garrod & Byrom 2007).

Birth in the FMU will be viewed primarily as a normal physiological process, rather than as a risky clinical event. Midwives will aim to work in ways that minimise the routine use of medical interventions, support non-
Continuity of Midwife-led Care

Current guidelines and standards recommend that women have a named midwife who is responsible for ensuring she has personalised, one-to-one care throughout pregnancy, childbirth and during the postnatal period. Continuity of midwifery care models appear to offer increased benefit and reduced harmful outcomes for mothers and babies (Rayment-Jones et al 2015). Midwifery Led models of care show a reduction in: epidural, episiotomy, instrumental birth; an increase in spontaneous normal birth, women were more likely to know their midwife; women were less likely to experience preterm birth and fetal loss before 24 weeks’ gestation; and there was a trend towards a cost-saving effect for midwife-led continuity care compared to other care models (Sandall et al 2013).

The service model will provide each woman with continuity of care throughout pregnancy, birth and the postnatal period, via a known midwife/midwives who is part of a small team. The staffing model is an important element for the success of the birth centres. There will be a flexible model, with a team(s) of midwives working within the community and the birth centre. This will maximise opportunity for midwives and women to feel confident in the use of the birth centre.

Midwife-led continuity of care will be provided in a multi-disciplinary network of consultation and referral with other members of the maternity team, ambulance, GPs and ancillary services, in addition to other relevant care providers.

Robust Communication Channels

The 2013 Salford Maternity Review found that communication between health and social care teams could be improved. Communication and collaboration with the wider maternity team (obstetrics, neonatologists, anaesthetists), primary care (GPs and HVs), the ambulance service, and all associated departments will be an essential expectation from the service provider. Respectful liaisons, where professionals understand each others values and perspectives, will be a priority.

Safety (Midwifery skills and updates. Obstetric emergencies and neonatal transfers)

Booking and transfer protocols should be developed by a multi-disciplinary team, taking account of the best available evidence and NICE guidance to the NHS. Transfers will be audited continually, and will include feedback from women who were transferred. Information from these activities will be relayed to staff on a regular basis, and learning points used. It is expected that the provider will have written agreed transfer protocols in place if transfers occur out with the organisation.

Ensure safe staffing is regularly reviewed in accordance with Safe Midwifery Staffing for Maternity Settings (NICE 2014a).

Cost effective / Value for Money

Services will be provided on the Maternity Pathway tariff.

The Birthplace economic evaluation (Schroeder et al 2011) compared the costs to the NHS of care planned in each of the four different settings. NICE (2014b) also performed an economic analysis, which supports these findings.

On average, costs per birth were highest for planned obstetric unit births and lowest for planned home births. Average costs were as follows:

- £1631 for a planned birth in an obstetric unit
- £1461 for a planned birth in an alongside midwifery unit (AMU)
- £1435 for a planned birth in a freestanding midwifery unit (FMU)
- £1067 for a planned home birth.

These figures include all NHS costs associated with the birth itself – for example midwifery care during labour and immediately after the birth, the cost of any medical care and procedures needed in hospital, and the cost of any stay in hospital, midwifery unit, or neonatal unit immediately after the birth either by the mother or the baby. The costs for planned home and midwifery unit births take account of interventions and treatment that a woman may receive if she is transferred into hospital during labour or after the birth.
Community-based units have faced financial pressures (RCM 2007) however, an RCM report (O’Sullivan & Tyler 2007) concluded that, ‘community units can contribute significantly to providing antenatal and postnatal care, take postnatal transfers from more distant obstetric units, and provide a centre where parents can attend preparation for birth and breastfeeding support sessions, as well as providing intrapartum care’.

Patient experience
A recent survey in England revealed that women who give birth in birth centres/FMUs consistently report more respectful care and greater choice and control than women who give birth in hospitals (Birthrights 2013). Feeling in control during childbirth is associated with positive feelings about birth experiences, while women who do not feel in control have higher levels of dissatisfaction and may experience long-term psychological trauma (Waldenström 2004). Childbirth experience has the potential to influence the mother-infant dyad and early attachment. For those already vulnerable, this is a very important consideration.

The provider will ensure that patient experience is at the forefront of service delivery and proven methodologies for seeking patient’s views will be utilised to evidence this.

Innovation
Whilst birth centres are not a new concept, their presence and function are seen as innovative. FMUs are seen as part of the local community, which have been supported and embraced.

One example of an innovative service (due to the constraints of the environment) is Chorley Birth Centre.

Chorley Birth Centre
The Birth Centre won an RCM award in 2015 for putting evidence into practice. It has also been used as an example of good practice, one of only 4 case studies used from the UK focused on nursing and midwifery practice (WHO 2013).

Since January 2014 to October 2014, 232 births have occurred there, over a 45% increase from the previous year (159). The waterbirth rate is 60% and women who used water at some point in labour is 80%. These figures show an increase from the previous year. Waterbirth rates are up by 58%, and women using water in labour up by 70%. Now CBC currently provides 6% of the total birth rate, compared to 2% previously.

Evidence shows CBC provides excellent satisfaction for women, their families and greater job satisfaction for midwives. The women and their families who have used it are advocates for CBC. CBC is also currently being used as an example of good practice by NICE to help implement the new Intrapartum guideline (NICE 2014b). This will help increase generalisability at national and international level.

These elements of women and their families experiences are also supported by the evidence from Walsh (2007) in his investigation of a Freestanding Birth Centre, who also evidenced the job satisfaction of the midwives also seen at Chorley Birth Centre. Kirkham et al (2006) also revealed how midwives were more likely to stay where they had greater job satisfaction and offering different types of environments and models provided this. The evidence (NICE 2014b, Hollowell et al 2011) shows that women with uncomplicated pregnancies have good outcomes in Birth Centres and is a cheaper option (NICE 2014b, Shroeder et al 2012) than birth in an OU. Outcomes show that the investment from the Department of Health and Trust, through listening to the evidence and to women’s voices has increased the opportunity women and their families are offered to have a great normal birth experience...

Care Pathway
The provider will deliver midwifery led services for low risk women throughout the childbirth continuum. The model of care will maximise potential for all women to have a positive pregnancy, and birth experience by providing continuity of care with a focus on normal, physiological birth. The care pathway for the woman will always reflect the philosophy of the service, and having made contact with her community midwife, either directly or via the GP, the woman will move into the maternity care pathway as illustrated in Appendix 1.

Women will be offered information at booking, and at intervals throughout their pregnancy, on their choices of place of birth, taking into account their wellbeing and options available. Information must include the benefits and risks of each option (NICE 2014b). National (http://www.which.co.uk/birth-choice) and local resources should be used. Decision for place of birth should be flexible, up until the beginning of labour.

The charts below show the outcomes of planned place of birth for women with uncomplicated pregnancies, the first chart is based on multiparous women and the second on nulliparous women. The yellow highlighted areas show the best outcomes for women (NICE 2014b):
NICE (2014b) therefore, recommend:

- Explain to both multiparous and nulliparous women that they may choose any birth setting (home, FMU, AMU or OU), and support them in their choice of setting wherever they choose to give birth:
- Advise low-risk multiparous women that planning to give birth at home or in a midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit.
- Advise low-risk nulliparous women that planning to give birth in a midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit. Explain that if they plan birth at home there is a small increase in the risk of an adverse outcome for the baby.

Ante natal and post natal care will be delivered in accordance with the Greater Manchester Service Specification.

A named midwife will be allocated to each woman as early in the care pathway as possible, with women having continuing access to advice, support and face to face contact with the named midwife.

The service will provide continual access to telephone advice and support, and face to face contact as often as
required to provide high quality care, meeting the identified needs and wishes of women.

The service will share care with other appropriate professionals, including obstetric care where indicated.

The service will work in a highly collaborative way to ensure women's needs are met; including where safeguarding concerns are identified either for the woman, her infant or other children and vulnerable adults within the family. The provider must ensure record keeping systems and practice meet Nursing and Midwifery Council standards.

The provider must ensure a person centred approach, maximising continuity for the whole period of care, and acting as Lead Professional for the delivery of maternity care at all times. The provider will work closely with key partner agencies, ensuring a 'seamless' sharing of care by acting as 'care navigator' for the woman.

The provider must ensure safe staffing is regularly reviewed in accordance with Safe Midwifery Staffing for Maternity Settings (NICE 2014a).

**Referral criteria and sources**
The service will be available to all pregnant women within Salford. Women can self-refer and referrals will also be accepted from GPs and other health professionals including health visitors and family nurses. Once a referral is accepted, the woman’s GP must be informed.

**Referral processes**
Referrals can be made in person, by email, letter, phone or fax. Details of referral process must be made available to all women and will include social marketing and the use of leaflets and posters displayed in community areas.

GPs and other health professionals will receive regular updated information on referral processes by email, letter and through direct contact.

**Transfer of care process**
In the event that a woman’s obstetric care is transferred to another maternity provider, either by choice or obstetric need, the provider will ensure that a copy of all maternity records held by the service are forwarded to the receiving maternity provider within 48 hours. This is to ensure accurate, timely information is available at all times to the maternity provider on occasions when the woman's hand held records are inaccessible. Once a transfer of care has occurred, the woman’s GP and all appropriate professionals involved in providing care to the woman and her family must be informed of the new care provider.

In the event of an emergency transfer in the Intra-partum or the immediate post-partum period an appropriate verbal and written handover of care must be provided at the time of transfer.

**Discharge processes**
Discharge processes will be in accordance with the Greater Manchester Core Service Specification.

**Response time and prioritisation**
Contact will be made with the woman within 48 hours of receipt of an initial referral. The initial assessment of need and risk will ideally take place before 8 completed weeks of gestation.; this will guide the development of a mutually agreed plan for care between the woman and midwife;

A comprehensive assessment of health and social care needs will take place within 7 days of initial referral, and aim to be before 12 weeks and 6 days weeks of pregnancy.

Telephone advice and support must be available 24 hours a day, seven days a week, 365 days a year;

Response times for the ‘on call’ service must be less than one hour; this means than midwives providing on call must be within less than one hour travelling time. Regular audit of response times must be carried out by the provider in order to evidence to the commissioner the responsiveness of the service both in terms of provision of telephone advice and support, and face to face contact.

**Self-care, patient and carer information**
All women will be provided with access to their pregnancy care records which enables information sharing with all appropriate professionals involved in providing care to the woman and her family; duplicate notes will be retained by the named midwife;

Verbal information giving will be supported with written information which is in a form appropriate to a woman’s identified needs; this may be in an electronic format.

Women will be provided with written information regarding standards of service, and the complaints process at the first contact. This may also be in an electronic format and on website
**Relevant networks and screening programmes**
The provider will have full participation in local and national maternity networks. Screening programmes will be carried out in accordance with the Greater Manchester Core Service Specification.

3.3 **Population covered**
All women registered with a Salford GP.

3.4 **Any acceptance and exclusion criteria and thresholds**
Guidance for high/low risk care using guidance parameters in NICE (2014b) will be developed by a multidisciplinary team.

3.5 **Interdependence with other services/providers**
The service must work in a highly collaborative way and ensure adherence to and integration with locally agreed pathways, policies and protocols.

The service will work with partners to deliver seamless integrated care pathways that deliver safe and effective care. Key partners include:

- Other providers of community and hospital based maternity services, including obstetricians who will share care for women with identified medical needs
- GPs
- Health Visitors including the Family Nurse Partnership team
- Children's Services, specifically Children's Centres and Children's Social Care services
- Children and Adult Community and hospital based safeguarding teams
- Perinatal mental health services

4. **Applicable Service Standards**

4.1 **Applicable national standards (eg NICE)**

4.2 **Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)**

4.3 **Applicable local standards**

5. **Applicable quality requirements and CQUIN goals**

5.1 **Applicable Quality Requirements (See Schedule 4A-D)**

5.2 **Applicable CQUIN goals (See Schedule 4E)**

6. **Location of Provider Premises**

The Provider’s Premises are located at:

7. **Individual Service User Placement**
References:


NICE (2014b) Intrapartum Care (Update): care of healthy women and their babies during childbirth. London: NICE.

Royal College of Midwives (2007) Implications of PBR for maternity services.


WHO 2013 Good practices in nursing and midwifery- from expert to expert: A manual for creating country case studies. WHO Regional Office for Europe. WHO, Geneva