SCHEDULE 2 – THE SERVICES

A. Service Specifications

1.6.2014

Service Specification No.	
Service	Maternity Services specification
Commissioner Lead	Wirral CCG
Provider Lead	WUTH
Period	May 2014- 2016
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Earlier Maternity Matters (DoH 2007) emphasised the importance of offering choice, access and continuity of care in a safe service. Following this publication a review of maternity services in Wirral took place in 2007 and again during 2011/12 which has informed the commissioning of providers to offer a range of models of care that are able to meet the needs of the local population which has high levels of inequality in both income and health outcomes.

The Standard, National Framework for Children, Young People and Maternity Services (2004) in Standard 11 states that Women need to have easy access to supportive, high quality maternity services, designed around individual needs and those of their babies. The standard recognises that for the majority of women, pregnancy and child birth are normal life events, it aims to promote women`s experience of having choice and control in giving birth to their baby. The standard seeks to improve access to maternity services, which will increase the survival rates and life chances of children from disadvantaged backgrounds. It also aims to ensure that all mothers and babies receive high quality clinical services.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	• **Decreasing infant mortality**
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**	• **Improving women's and their families` experience of maternity services**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	• **Admission of full term babies to neonatal care** • **Incidence of harm to children due to "failure to monitor".**

2.2 Local defined outcomes

The provision of a Maternity service will contribute to the achievement locally of the following aspects of the NHS Mandate:

- Helping people to live longer
- Providing safe care
- Making sure people experience better care

Specific requirements of the mandate for maternity services include:

- Ensuring every woman has a named midwife who will make sure she has personalised, one to one care throughout pregnancy, childbirth and during the postnatal period, including additional support for those who have a maternal health concern.
- Reducing the incidence and impact of postnatal depression through earlier diagnosis, and better intervention and support.

High quality clinical leadership will promote the development of a highly skilled workforce, i.e.

  - Staff with high levels of technical competence and skills
  - Staff with excellent relational skills

Key health outcomes expected from this service:

- Improved maternal physical and mental health;
  - Improved nutritional awareness
  - Reduced smoking in line with national targets
  - Reduced alcohol/substance misuse
  - Improved psychological wellbeing
  - Better outcomes for teenage mothers and their babies
- Improved pregnancy outcomes;
  - Lower rates of instrumental/surgical delivery
  - Lower rates of postnatal maternal morbidity and mortality
  - Lower rates of perinatal mortality and morbidity
  - Fewer LBW infants
- High rates of breastfeeding initiation and duration as defined by Department of Health 2005 collecting baseline data of skin to skin contact and first feed.
  - Initiation rates at least the North West average
  - 6-8 week rates at least the North West average
- Intrapartum care provided in a high quality environment conducive to
  - High rates of normal delivery
  - Quality maternal experience of care this is to be measured via patient experience surveys.
- Antenatal and postnatal care provided close to home in high quality family friendly environments

3. Scope

3.1 Aims and objectives of service

The Department of Health`s objectives for maternity care (as reported in ***Maternity Services in England*** (2013))

- To improve performance against quality and safety indicators
- For mothers to report a good experience
- To encourage normality of births by reducing unnecessary interventions
- To promote public health with a focus on reducing inequalities
- To improve diagnosis and services for women with pregnancy related mental health problems

The Maternity Service will embrace a social model of maternity care where pregnancy and birth are viewed as normal physiological processes and midwives are the lead professional for intrapartum care for Low Risk women and obstetricians are the lead for High Risk women.

3.2 Service description/care pathway

The Maternity Services will provide the full range of antenatal, intrapartum and post natal care for women and their families including scheduled and unscheduled care, outpatient, inpatient, community and home based services. Maternity care will be provided in accordance with the requirements of national policy guidelines, evidence and best practice and will also reflect local needs and priorities. There will be a shared philosophy that supports protects and maintains normality, with the midwife being the lead professional for health women with uncomplicated pregnancies and the obstetrician as a lead carer for medically high risk women.

Continuity of care within the pathway shall not be disrupted because specialist input is required. Maternity services will support the transition from pregnancy to family life with a quality service that is women and family centred, that undertakes continuous audit and that seeks and acts on feedback from women and families.

Antenatal Care

Women identified as high risk at the initial assessment of health and social care needs or at a later point in the antenatal pathway will be offered this service. Women who are identified as “low risk” who request maternity care will have the full options of choice offered to them. The Maternity Service will provide maternity care which maximises the continuity of care, the normalisation of the birthing process and promotion of breastfeeding as a choice for all women.

A lead professional will be allocated to each woman as early in the care pathway as possible. Women to have continuing access to advice, support and telephone/text and face to face. Antenatal care is to be provided, offering women the greatest choice of locations appropriate to the medical needs of the woman and wherever possible, closer to home in high quality family-friendly environments.

The service will provide continual access to telephone advice and support from the maternity team 24 hours a day, 365 days a year. This should be supported by appropriate follow-up arrangements.

The maternity team will provide effective promotion of health and behavioural change based on NICE public health guidance on behavioural change at the population, individual and community level, delivered by skilled practitioners utilising promotional/motivational interviewing and other non-directive tools.

The available tools and ethos of Shared Decision Making will inform the development of a personalised care plan which will contain a risk assessment which will be reviewed with the woman at each routine contact. Women will be fully involved by the lead professional in assessing the risks to themselves and their babies by declining routine care. Women who fail to access routine care will be followed up by a community midwife and offered choice as to how they access their maternity care.

The service will offer access to all commissioned routine scanning; screening and monitoring services in accessible venues at all times to meet the women’s expressed needs, including evening and weekend access. All investigations that are offered to women e.g. amniocentesis and Down’s Syndrome Screening need to use the ethos, tools (including the option of grids) of Shared Decision Making.

Intrapartum Care

Women and their families should always be treated with kindness, respect and dignity. Good communication is essential, supported by evidence-based information, to allow women to reach decisions about their care. The views, beliefs and values of a woman, her partner and her family in relation to her care and that of her baby should be sought and respected at all times (NICE 2007).

The environment for care established during labour, birthing an immediate postnatal period within the Delivery Suite will support as normal a birthing process as is possible, seeking to create a calm, unhurried atmosphere, promoting a sense of welcome and wellbeing for women and their birthing partners. This will

include appropriate adaptations of the physical environment.

A woman in established labour should receive supportive one-to-one midwifery care. Where the woman has a birthing plan, the midwife should read it and discuss with the woman how it can be followed. A woman in established labour should not be left on her own except for short periods of time or at the woman's request. Clinical intervention should not be offered or advised where labour is progressing normally.

Pain relief should be discussed early on with the woman on her admission to the labour ward and the benefits and preferences should be discussed with her. Analgesia should be provided promptly and as per NICE (2007) guidance. Where clinically appropriate the woman may use non-invasive methods of pain relief including complementary therapies. Where normal birth will take place and is clinically appropriate, active labour will be encouraged using birthing positions that promote normal physiological processes. Where there is any delay or complications in labour affecting the woman or her unborn baby, it is essential that there is a good and prompt communication supported by evidence-based information, to allow the women and their birthing partners to reach informed decisions about their care.

Postnatal Care

Following delivery, women should be encouraged to have skin to skin contact with their babies as soon as possible after birth. Initiation of breast feeding should be encouraged as soon as possible after the birth, ideally within one hour.

An examination or treatment of the baby should be undertaken with the consent and in the presence of the parents or if this is not possible, with their knowledge.

Where perineal examination and care is required, the health professionals should explain to the woman what they plan to do and why. Where there is a need for suturing, adequate pain relief must be given and the procedure carried out promptly and with the utmost privacy and with the minimum number of health professionals necessary in the room. The patient's dignity is at all times to be maintained.

Women should be transferred to postnatal care (with the provider of their choice) following the birth. On discharge from the Maternity service, care is to be provided at home and in high quality child and family-friendly environments focusing on the support of breastfeeding. Where a woman has chosen an alternative provider for her antenatal and postnatal care, she should experience a 'seamless' transfer of care into (and out of) the Maternity Service. Protocols to guide collaborative working which place the physical and emotional wellbeing of the woman and her infant at the centre of their purpose should be agreed by all providers. The woman's stated preferences for care during labour should be met as far as they are compatible with the delivery of safe care. The woman's choice of an alternative provider should be supported and in no way undermined by the Maternity Service

3.3 Population cover

Geographic coverage/boundaries

All women requesting this service are eligible to use it.

Inclusion criteria

All women and all women registered with a Wirral GP are eligible to choose this service.

3.4 Any acceptance and exclusion criteria and thresholds

Acceptance criteria:

- This service should be directly accessible to women who need or request a Maternity Service.
- Self-referral as early in pregnancy as possible should be facilitated and promoted by the provider.
- Referrals may also come via the woman's GP or other health and social care professionals
- Once a referral is accepted, the woman`s GP must be informed..

Exclusion criteria:

- A woman who is at low risk at the initial assessment of their health and social care and who does not require or has requested a Maternity care service during their pregnancy.

3.5 Interdependence with other services/providers

Effective maternity services are interdependent on primary care, specialist services and the range of early years services provided in community settings. Stakeholders and interdependencies will vary on an individual basis and the interface with other children's services cannot be overstated. Access to and support from universal services should always be sought and relationships developed as specified and as circumstances dictate.

Should the Provider wish to subcontract the provision of all or part of a service (to an NHS or non-NHS provider) the commissioner will be consulted and will have the final decision on any agreements. Subcontracted services will remain the responsibility of the Provider but must meet all standards and criteria as set out in this contract. The commissioner will have access to the full range of monitoring material where appropriate for the subcontractor.

Transfer of care process

In the event that a woman's maternity care is transferred to another maternity provider, either by choice or clinical need (e.g. a tertiary centre as a result of detection of antenatal foetal anomaly). The provider is to 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.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The following evidence/publications guide and inform the specification of this service:

- Andrews, S et al. (2006) 'A Review of Midwifery Matters'. *Caseload Midwifery.* p.108.
- Audit Commission. (2010). Giving Children a Healthy Start. London: Audit Commission.
- Care Quality Commission. (2010) Maternity services survey 2010. London: http://www.cqc.org.uk/public/reports-surveys-and-reviews/surveys/maternity-services-survey-2010
- Department of Health. (2007a) *Review of the Health Inequalities Infant Mortality PSA.Target* (2007).
- Department of Health. (2007b) Maternity Matters: Choice, access and continuity of care in a safe service. London: DH publicationswww.dh.gov.uk.
- Department of Health. (2010, March 16). Maternity and early years: making a good start to family life. London, UK.
- Department of Health. (2011, April 7). Parents' views on the maternity journey and early parenthood. London, UK.
- Hatem, M et al (2008) 'Midwife-led versus other models of care for childbearing women.' *Cochrane Database of Systematic Reviews,* 4.

- Health Care Commission (2007). Towards better births: a review of maternity services in England. London
- Hodnett E. Pain and women's satisfaction with the experience of childbirth: a systematic review. American Journal of Obstetrics and Gynaecology 186, 5 (2002) S160-72
- Hodnett E. Cochrane review (2002). *Home-like versus conventional institutional settings for birth.* The Cochrane Library; Issue 3.
- Marmot, M. (2010). Fair Society, Healthy Lives. London: University College London.
- http://www.midwifery2020.org/documents/MW2020_EXEC_SUMMARY_MS_WEB.pdf
- Mott MacDonald (2010) NHS Wirral Maternity Matters Findings Report : Qualitative Findings Report
- NHS Commissioning Board (2012). *Commissioning Maternity Services: a resource pack to support Clinical Commissioning Groups* Produced by Dr Suzanne Tyler Strategic Maternity Lead, NHS South of England..
- National Childbirth Trust. (2009) *Location, location, location - Making choice of place of birth a reality*. London: NCT http://www.nct.org.uk/sites/default/files/related_documents/PlaceofBirthFINALFORWEBv2.pdf
- National Institute of Health and Clinical Excellence (2008) *Antenatal care: routine care for the healthy pregnant woman.* CG 62.
- National Institute of Health and Clinical Excellence (2005). *Promotion of breast feeding initiation and duration.* www.dh.gov.uk/assetRoot/04/07/16/96/0401696
- National Institute of Health and Clinical Excellence (2012). *Antenatal care*. QS 22.
- National Institute of Health and Clinical Excellence (2012). *Ectopic pregnancy and miscarriage*. CG 154
- National Institute of Health and Clinical Excellence (2008). *Maternal and child nutrition.* PH11
- National Institute of Health and Clinical Excellence (2008). *Diabetes in pregnancy.* CG 62
- National Institute of Health and Clinical Excellence (2010). *Quitting smoking in pregnancy and following child birth*. PH 26
- National Institute of Health and Clinical Excellence (2008). *Pregnancy (rhesus negative women) - routine anti-D (review)*. TA 156
- National Institute of Health and Clinical Excellence. (2008). *Induction of labour*. CG 70
- National Institute of Health and Clinical Excellence. (2011). *Caesarean section.* CG 132
- National Institute of Health and Clinical Excellence. (2007). *Intrapartum care*. CG 45
- National Institute of Health and Clinical Excellence (2006). *Post natal care.* CG 37
- National Institute of Health and Clinical Excellence (2010). *Weight management before, during and after pregnancy.* PH 27
- National Institute of Health and Clinical Excellence (2010). *Hypertension in pregnancy.* CG 107
- National Institute of Health and Clinical Excellence (2010*). Pregnancy and complex social factors.* 2010
- National Institute of Health and Clinical Excellence (2011). *Multiple pregnancy.* CG 129

- National Institute of Health and Clinical Excellence (2012*). Antibiotics for early onset neonatal infection.* CG 149
- National Institute of Health and Clinical Excellence (2010*).Neonatal jaundice.* CG 98
- National Institute of Health and Clinical Excellence (2012). *Hepatitis B & C –ways to promote testing*. PH 43
- NHS Confederation Research Digest. (2012) Birthplace in England – new evidencehttp://www.nhsconfed.org/Publications/Documents/birthplace-england_130612.pdf
- Right Care: Shared Decision Making: *Deciding on diagnostic testing for Down's Syndrome, Pregnancy after C section.* www.rightcare.nhs.uk
- Sandall, J et al (2009). *Midwife-led versus other models of care for childbearing women (Review)* published in *The Cochrane Library 2009*, Issue 4 http://www.thecochranelibrary.com.
- Thomson et al (2012) *A public health perspective of women's experiences of antenatal care: An exploration of insights from a community consultation.* Midwifery. ISSN 02666138
- Walsh, D & Downe, S (2004). 'Outcomes of free standing, midwife led birth centres: a structured review.' *Birth* 31; (3): pp. 222-229
- Wiegers, T. (2003) Health Policy, Volume 66, Issue 1, pp. 51-59. www.independentmidwives.org.uk
- World Health Organisation. (2006) *The World Health Report: Working together for Health*. Geneva: WHO.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- Cresswell, JL & Stephens, RM. (2007) *Joint Statement No. 2, Home Birth*. London: Royal College of Obstetricians and Gynaecologists/Royal College of Midwives.
- Midwifery 2020 Programme. (2010a) *Delivering Expectations work stream*. London: http://www.midwifery2020.org/documents/2020/Core_Role.pdf
- Nursing and Midwifery Council (2004). Nursing and Midwifery Council: *Midwives rules and standards.*

4.3 Applicable local standards

The service must work in a highly collaborative way with all other children's services and ensure adherence to and integration with locally agreed pathways, policies and protocols, including

- Use of Common Assessment Framework and Team Around the Child structures for multi-agency working
- MARAC policy and procedure
- The Wirral Perinatal Mental Health pathway
- Wirral's Health Visiting service;
- Wirral's Family Nurse Partnership programme
- Wirral's School Nurse service
- Children's Centres outreach and family support services
- Wirral's Chlamydia screening programme
- Wirral's Teenage Pregnancy Action Plan

Safeguarding

- On occasions the team will assess and make an appropriate referral to social services if there are any concerns regarding safeguarding children, vulnerable adults, and other family members.
- Team members will contribute to the delivery of multi-agency safeguarding plans as appropriate

- Staffing structures must be in place to ensure induction of new staff and on-going case and clinical supervision of all staff. This must include safeguarding supervision from an appropriately qualified professional.

Safeguarding training

- The provider must ensure the delivery of a comprehensive annual continuing professional development programme for all staff, ensuring within six months of joining:
    - Staff attend multi-agency safeguarding training at the appropriate level, for children and adults.
    - Undertake refresher training at the appropriate level in accordance with statutory guidance.

Applicable Local Standards

- Wirral Safeguarding Children's Board Policies and Procedures
- Wirral Safeguarding Adult Partnership Board Policies and Procedures
- Wirral Children's Partnership Council's Guide to Integrated Working (which includes comprehensive guidance on information sharing)
- Wirral MARAC policy and procedure
- Wirral CCG (2014) Safeguarding Children and Vulnerable Adults Policy; Incorporating Safeguarding & Mental Capacity Act standards for commissioned services.

Applicable National Standards

- Working Together to Safeguard Children (DE/DH 2010/2013)
- Children Act 1989 & 2004
- National Service Framework for Children, Young People and Maternity Services (DH 2004)
- No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse (DH 2000)
- NICE CG89: When to suspect child maltreatment (2009/2013)
- Safeguarding children and young people: roles and competencies for health care staff. Intercollegiate Document (2014).

5. Applicable quality requirements and CQUIN goals

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

The Working Together to Safeguard Children Guidance must be adhered to, with all staff trained appropriately in line with local arrangements outlined by the Local Safeguarding Children's Board.

Staffing structures must be in place to ensure induction of new staff and on-going case and clinical supervision of all staff. This must include safeguarding supervision from an appropriately qualified professional at least three monthly, and monthly if the caseload of individual clinician merits it.

The provider must ensure the delivery of a comprehensive annual continuing professional development programme for all staff, ensuring within six months of joining:

- Training in multi-agency safeguarding
- Record keeping and information governance
- Brief interventions for Smoking Cessation
- Breast feeding initiation

The provider must ensure a minimum of 80% uptake of planned training each year.

The provider must co-operate with research/review activities of the commissioner where there is no additional cost to the provider. Where there are cost implications this should be agreed in advance with the commissioner. The provider should ascertain the view of the commissioner before participating in external research programmes. Regular updates on current research and activity studies should be given

via the commissioning monitoring meetings.

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

The Provider's Premises are located at:
Wirral University Teaching Hospital NHS Foundation Trust

7. Individual Service User Placement

Not applicable

8. Information / Reporting Requirements

All reports to be produced for Wirral wide reporting and by GP consortia.


Copy of Maternity Dashboard May 15.x

Monthly dashboards to be sent to the lead commissioner.

Indicator	*Monitoring / Reporting Threshold*	*Frequency of Reporting to Commissioners*	*Consequence of Breach*
Demand – Total number of referrals to enhanced service	Monthly figure identified.	Monthly reporting	An action plan (if required) to be agreed with the CCG
Service referrals – self referrals	Monthly figure identified.	Monthly reporting	An action plan (if required) to be agreed with the CCG
Service referrals – GP referrals	Monthly figure identified.	Monthly reporting	An action plan (if required) to be agreed with the CCG
Service referrals – Other referrals	Monthly figure identified.	Monthly reporting	An action plan (if required) to be agreed with the CCG
Activity - Total number pre-conceptual contacts	Monthly figure identified.	Monthly reporting	An action plan (if required) to be agreed with the CCG
Activity - Total number ante-natal contacts	Monthly figure identified.	Monthly reporting	An action plan (if required) to be agreed with the CCG
Activity - Total number post-natal contacts.	Monthly figure identified.	Monthly reporting	An action plan (if required) to be agreed with the CCG
Activity – Total number acute care based contacts	Monthly figure identified.	Monthly reporting	An action plan (if required) to be agreed with the CCG
The Provider must ensure compliance with the Health Act 2008: Code of Practice for the Prevention and Control of Healthcare Associated Infection in all provider services identified in this SLA. The following must take place in the next 12	Demonstrate adherence to policies and procedures for the environments practised in on an ongoing basis	Audit report provided by the provider annually in January.	An action plan (if required) to be agreed with the CCG from the assessment

months.			
A client user survey which must cover all service aims and objectives.	Questionnaire and evaluation process to be agreed in advance with the commissioners, offered to all service users.	Every three months, with report detailing experience and recommended improvements due each year by January.	An action plan (if required) to be agreed with the CCG
Patient satisfaction survey on patient expectations of intrapartum care and delivery experience at 20 weeks antenatally and repeated at 6 weeks post natally	Survey offered to all service users.	Quarterly	Questionnaire to be agreed with the commissioner and an action plan (if required) to be agreed with the CCG
To ensure universal coverage of screening programmes.	Quarterly monitoring of uptake/ coverage	Report detailing adherence with recommended improvements due each year by January.	An action plan (if required) to be agreed with the CCG
Monthly data of number of patients on the service list who were admitted to secondary care through an unplanned episode.	Monthly figure identified.	Monthly reporting	An action plan (if required) to be agreed with the CCG
The service to identify characteristics that are barriers to access for vulnerable groups and implement mutually agreed recommendations.	Monthly meeting feedback	6 Monthly reporting	An action plan (if required) to be agreed with the CCG
Determine baseline for DNAs and cancellations.	Monthly figure identified.	Monthly reporting	An action plan (if required) to be agreed with the CCG
An annual clinical audit plan will be agreed with the provider and commissioner by the end of Q1 Audit programme to include reviews of Antenatal, Intrapartum and Postnatal care.	Annual report	Report detailing experience with recommended improvements due each year by January.	An action plan (if required) to be agreed with the CCG
Data on all patients Body Mass index	Monthly	Monthly reporting	An action plan (if required) to be agreed with the CCG
Number of Low Risk Care Bookings	Monthly figure identified.	Monthly reporting	An action plan (if required) to be agreed with the CCG
Number of admissions to MLU in labour	Monthly figure identified.	Monthly reporting	An action plan (if required) to be agreed with the CCG
Number of Normal Vaginal Delivers achieved in MLU	Monthly figure identified.	Monthly reporting	An action plan (if required) to be agreed with the CCG
Number of women transferred out of MLU to delivery suite.	Monthly figure identified.	Monthly reporting	An action plan (if required) to be agreed with the CCG
Number of women who initiate breast feeding	Monthly figure identified.	Monthly reporting	An action plan (if required) to be agreed with the CCG
Number of babies breast feeding post natally at 10 days	Monthly figure identified.	Monthly reporting	An action plan (if required) to be

			agreed with the CCG
Number of shoulder dystocia	Monthly figure identified.	Monthly reporting	An action plan (if required) to be agreed with the CCG
Number of post partum haemorrhage	Monthly figure identified.	Monthly reporting	An action plan (if required) to be agreed with the CCG
Number of 3rd and 4th degree tears	Monthly figure identified.	Monthly reporting	An action plan (if required) to be agreed with the CCG
Number of admissions to NNU	Monthly figure identified.	Monthly reporting	An action plan (if required) to be agreed with the CCG
Birth Pool Rate	Monthly figure identified.	Monthly reporting	An action plan (if required) to be agreed with the CCG
Births using alternative positions i.e. not lying down on bed	Monthly figure identified.	Monthly reporting	An action plan (if required) to be agreed with the CCG
Number of births using alternative therapies	Monthly figure identified.	Monthly reporting	An action plan (if required) to be agreed with the CCG
Early transfer home from MLU	Monthly figure identified.	Monthly reporting	An action plan (if required) to be agreed with the CCG

9. Quality Requirements

Performance Indicator	*Threshold*	*Method of Measurement*	*Consequence of Breach*
Bookings undertaken by 12 weeks and 6 days.	85%	Monthly reporting	An action plan (if required) to be agreed with the CCG
Breastfeeding initiation	>45%	Monthly reporting	An action plan (if required) to be agreed with the CCG
Breastfeeding at 4 weeks	>35%	Monthly reporting	An action plan (if required) to be agreed with the CCG
Smoking cessation from booking to delivery	>35%	Monthly reporting	An action plan (if required) to be agreed with the CCG
DNA clinic rate	<5%	Monthly reporting	An action plan (if required) to be agreed with the CCG
Home birth rate – Year 1 Year 2 onwards	>3% >4%	Monthly reporting	An action plan (if required) to be agreed with the CCG
Appointment cancellation rate	<5%	Monthly reporting	An action plan (if required) to be agreed with the CCG
Where routine antenatal and postnatal care is delivered, women to have same midwife or link midwife for full care episode	>60%	Monthly reporting	An action plan (if required) to be agreed with the CCG
Discharge summary of care will be provided with 24hrs to the woman's GP	100%	Monthly	An action plan (if required)

and Health Visitor.		reporting	to be agreed with the CCG
Local safeguarding service to be informed of any new referrals where safeguarding risk is identified within 24hrs of first contact.	100%	Monthly reporting	An action plan (if required) to be agreed with the CCG
All midwives who have attended level 3 safeguarding children training within six months of joining team and updated as a minimum three yearly.	100%	Monthly reporting	An action plan (if required) to be agreed with the CCG
All midwives to attend breast feeding annual updating and training.	100%	Monthly reporting	An action plan (if required) to be agreed with the CCG
All midwives to have attended training in the identification and management of domestic abuse and all new midwives to attend within six months of joining the team.	100%	Monthly reporting	An action plan (if required) to be agreed with the CCG
Quarterly patient satisfaction survey on patient expectations of intrapartum care and delivery experience at 20 weeks antenatally and repeated at 6 weeks post natally.	97%	Monthly reporting	An action plan (if required) to be agreed with the CCG
Low Risk Care Bookings	>64%	Monthly reporting	An action plan (if required) to be agreed with the CCG
Admissions to MLU in labour	>70%	Monthly reporting	An action plan (if required) to be agreed with the CCG
Achieved births in MLU	>70%	Monthly reporting	An action plan (if required) to be agreed with the CCG
Transfer rate out of MLU to Delivery Suite	<15%	Monthly reporting	An action plan (if required) to be agreed with the CCG
Use of Birth Pool for labour and/or delivery	>35%	Monthly reporting	An action plan (if required) to be agreed with the CCG
Births using alternative positions i.e. not lying down on the bed	>35%	Monthly reporting	An action plan (if required) to be agreed with the CCG
Women not requiring admission to a post natal ward	>60%	Monthly reporting	An action plan (if required) to be agreed with the CCG
Shoulder dystoncia	<1%	Monthly reporting	An action plan (if required) to be agreed with the CCG
Post partum haemorrhages	<1%	Monthly reporting	An action plan (if required) to be agreed with the CCG
3rd and 4th degree tears	3%	Monthly reporting	An action plan (if required) to be agreed with the CCG
	>1%		