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Date: 15th November 2018

Our Ref: ID1261

NHS Wirral Clinical Commissioning Group
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Dear Ms Bennett,

Re: Freedom of Information Request

Thank you for your request for information made under the Freedom of Information Act 2000 which was received into this office on 26th October 2018.

You Asked for:

The details of the schedule for the Maternity Service you have commissioned with your Local Acute Trust – Wirral University Teaching Hospital

Our Response:

Extract from Maternity Services Specification.

Population Needs

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.

Scope

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.

3.2 Population covered

All women registered with a Wirral GP that have been booked with Wirral University Trust Hospital midwifery service are eligible to choose this service.

3.4 Any acceptance and exclusion criteria and thresholds

- Women who do not fulfill the criteria for Low Risk Care (see appendix 1) either on booking, during pregnancy or whilst receiving intrapartum care and will require transfer to obstetric care.
- Women choosing interventions requiring medical intervention, e.g. epidural anesthesia.

3.5 Interdependence with other services/providers

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 obstetric care is transferred to another maternity provider, either by choice or obstetric need (e.g. a tertiary centre as a result of detection of antenatal fetal anomaly). The provider is to ensure that copies 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.

We hope this information is useful, however if you require any further information please do not hesitate to contact a member of the Corporate Affairs Team (contact details at the top of this letter)

Yours sincerely

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