

Royal College of Obstetricians and Gynaecologists

Standards for Maternity Care

Report of a Working Party



Royal College of
OBSTETRICIANS *and*
GYNAECOLOGISTS



Royal College of
MIDWIVES



Royal College of
ANAESTHETISTS



Royal College of
PAEDIATRICS *and* CHILD
HEALTH

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THE WORKING PARTY

Terms of reference

Aim

To develop national standards for maternity care.

Remit

1. To review current evidence-based published standards in the area of maternity practice.
2. To derive from these documents agreed standards for maternity care, from pre-pregnancy through to the postnatal period.
3. To complete the work within 1 year.

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ABBREVIATIONS

CEMACH	Confidential Enquiry into Maternal and Child Health
EPAU	early pregnancy assessment unit
GP	general practitioner
HIV	human immunodeficiency virus
MCADD	medium chain acyl CoA dehydrogenase deficiency
MSLC	Maternity Services Liaison Committee
NCT	National Childbirth Trust
NHS	National Health Service
NHS QIS	NHS Quality Improvement Scotland
NICE	National Institute for Health and Clinical Excellence
QOF	Quality Outcomes Framework
RCOG	Royal College of Obstetricians and Gynaecologists
SANDS	Stillbirth and Neonatal Death Society
SCBU	special care baby unit
SCPHN	specialist community public health nurse
SIGN	Scottish Intercollegiate Guidelines Network
TENS	transcutaneous electrical nerve stimulation
UNICEF	United Nations Children's Fund
WHO	World Health Organization

FOREWORD

In recent years, standards of care in maternity services have been investigated and highlighted in several national audits and surveys, as well as some high-profile examples of service failures. The importance of setting standards for maternity services has been recognised by the inclusion of maternity in National Service Frameworks in each of the countries in the UK but there is a plethora of additional recommendations and guidance from other sources such as the Confidential Enquiry into Maternal and Child Health (CEMACH), National Institute for Health and Clinical Excellence (NICE) and professional bodies.

The publication of *Safer Childbirth*, with agreed standards for intrapartum care, was welcomed by managers and clinicians. It became apparent that providers and commissioners and, of course, women and their families, would benefit from a single, comprehensive set of standards to cover every step of the pathway of care for women from pre-pregnancy through to the transition to infancy and parenthood.

The Royal College of Midwives, the Royal College of Obstetricians and Gynaecologists, the Royal College of Paediatrics and Child Health and the Royal College of Anaesthetists have worked together to agree these standards for maternity care, which are applicable to maternity services anywhere and which we believe will facilitate development of equitable, safe and high-quality care for mothers and their babies.



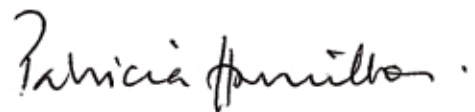
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INTRODUCTION

Excellent maternity care must be comprehensive and flexible to respond to the clinical and social needs of women and their families. For the majority of women, pregnancy and childbirth is a totally normal and uncomplicated experience but the service must be able to respond appropriately to those who may require highly specialised care for existing medical problems, social circumstances and any complications that may develop.

Purpose and scope

The purpose of this document is to provide guidance for the development of equitable, high-quality services across the UK. The standards should be a valuable tool and resource for commissioners and providers to plan and quality assure maternity services. They do not replace policy documents or clinical guidelines published in the four countries but are intended to help.

The standards cover the pathway of care from prepregnancy through to the transition to parenthood. There is deliberate repetition where statements within the standards are applicable to more than one stage in the clinical pathway. Each step of the pathway includes a mix of organisational and clinical standards, which is needed to ensure comprehensive, seamless and high-quality care. The standards for intrapartum care have been taken directly from *Safer Childbirth 2007*¹ to cover the entire maternity care pathway and these standards are therefore presented in a different format as Appendix 1.

As well as covering the clinical pathway of care, the standards encompass the generic dimensions required for support and governance of maternity services. Staffing issues appear in many of the standards but a more complete list has been included as a separate standard to facilitate definition of roles and responsibilities and workforce planning requirements for service delivery and training.

To monitor maternity services locally, the Working Group recommends the use of the RCOG *Maternity Dashboard – Clinical Performance and Governance Score Card*, which has demonstrated improvements to the safety of maternity services.² The Dashboard is available from the RCOG website.² Local development and implementation will provide evidence of an audit trail and trend analysis, monitoring projected capacity and clinical outcomes.

Process

The RCOG established this working party, representing four Royal Colleges and other key stakeholder organisations, to develop this comprehensive standards document. In recognition that there is a plethora of recommendations and guidelines from reputable national bodies, it was agreed that only published standards would be used for this document. Fifty source documents on maternity care were identified (Appendix 2) and, from these, a database of over 800 standards was developed.

As many of the standards were duplicated, the working party combined similar standards to formulate one standard to keep the document concise. In collating the statements, some of the original wording has been edited to ensure consistency and to improve the flow.

The working party agreed the titles and rationale of each standard and selected the statements from existing maternity standards to create a single reference document covering the entire pathway of care.

It became apparent during this exercise that there are gaps in the pathway where published standards do not exist. As this document is constrained by existing standards, it was not possible to include standards in these areas. Stakeholders may wish to collaborate to develop additional standards for a complete pathway of care.

Each standard is supported by audit indicators which may be used to assess, directly or indirectly, compliance with the overall standards. In many instances, the audit indicators measure elements of the pathway. Initial audit will provide a local baseline which defines a benchmark for improvement.

Poor levels of achievement should prompt providers to analyse which elements of the service require review and change in practice or organisation of care. It is not suggested that providers will constantly audit against all the indicators but rather use them in a timely manner to test elements of the pathway. The recent Healthcare Commission survey of maternity services in England has influenced the audit indicators.³ Some of the audit indicators are deliberately repeated because they are pertinent to more than one step of the maternity pathway.

The ‘database items’ referencing system used in this document is unique in that it relates to information from many source documents and to the data within over 800 standards published separately on the RCOG website (www.rcog.org.uk).⁴

The application of standards and audit indicators

It is envisaged that these standards will be used by commissioners, providers and healthcare professionals. The ultimate objective is to provide equitable, safe and satisfying services providing the best possible outcome for mothers and babies:

- Commissioners may use the standards to inform service specifications and the audit indicators to contribute to the performance management of maternity services.
- Providers may use the standards for self-assessment to identify gaps and inform a strategy for the development of excellent services.
- The audit indicators may provide evidence to inform resource management.
- Clinicians may use the standards and audit indicators to inform their own practice and service development and as a benchmark for improvement.

All the audit indicators have been collated and published in a separate document to assist self-assessment and action planning.⁴ The process of audit against these standards will act as one of a series of indicators of safety. Maternity services are advised to identify a selection of audit indicators most appropriate to their service. Thresholds should be set locally to prioritise those areas identified as most in need of improvement. There is no overall timescale for implementation but it is anticipated that the standards will be an integral part of the audit and commissioning process. Where high standards are not achieved, data from audit may provide evidence to support a business case for additional resources.

Maternity services should be working towards achieving the standards identified within this document to ensure a contemporary safe service meeting the needs of women and families.

This document should be used in conjunction with other publications: *Standards for Gynaecology*,⁵ *Safer Childbirth*¹ and the Royal College of Anaesthetists’ document *Raising the Standard: A Compendium of Audit Recipes*.⁶

Looking forward to pregnancy

Rationale

In general, healthy women have healthy babies who grow into healthy children. Improving the general health of the whole population through increasing knowledge and understanding of healthy lifestyles should be an underlying philosophy of all health, education and social services. Early access to maternity care is important.

Standards

	Database items
1.1 All commissioners and providers of maternity services, in collaboration with local authorities, should ensure local multi-agency health promotion for pregnancy so that all women of reproductive age are empowered to be as healthy as possible.	31, 231, 281
1.2 A multi-agency strategy should be in place to provide prepregnancy advice, including nutrition and exercise, benefits of breastfeeding, sexual health and avoidance of substance misuse and smoking, starting with school-aged young people. ^{7,8}	35, 281
1.3 Women should be able to access midwives in their community on a drop-in basis for prepregnancy advice about developing healthy lifestyles, including taking folic acid supplements and seeking maternity care as soon as pregnancy is confirmed.	268
1.4 Contact details for midwives should be easily accessible to all women in the local population. The option for all women to access a midwife as the first point of contact, as an alternative to seeing their general practitioner (GP), should be widely publicised.	36, 37, 40

Audit indicators

Documentary evidence of:

- a multi-agency strategy for local health promotion for pregnancy
- availability of healthy lifestyle literature in sexual health clinics, general practice surgeries, pharmacies and schools
- availability of midwives' contact details in the public domain (for example, telephone helpline, advertisements in pharmacies, GP surgeries and public places)
- percentage of pregnancies which were planned (recorded at booking assessment)
- percentage of women taking folic acid at conception (recorded at booking assessment)
- percentage of women with health and social care needs assessment completed by 12 weeks + 6 days of gestation (recorded retrospectively after dates confirmed)
- percentage of women accessing prepregnancy care in the community
- percentage of women receiving smoking cessation support before this pregnancy.

STANDARD 2

Prepregnancy care for women with existing medical conditions or significant family or obstetric history

Rationale

Women with existing medical conditions need to be aware of the effect of their condition on pregnancy and of pregnancy on their condition. Those with a family or personal history of medical disorder or poor obstetric outcomes need to discuss and understand the relevance and implications in a future pregnancy.

Standards

	Database items
2.1 All maternity commissioners and providers should ensure that the maternity care network, GPs and the primary healthcare providers of family planning and sexual health work closely together to identify women with existing medical or familial conditions who may become pregnant and ensure they have access to specialist advice pre-pregnancy.	33, 34, 46
2.2 Women with existing serious medical conditions should have pre-pregnancy counselling at every opportunity, even if they are not immediately seeking pregnancy. This is especially the case if they seek assisted reproduction. ⁹	685
2.3 Pre-pregnancy counselling and support, both opportunistic and planned, should be provided for women of childbearing age with existing serious medical or mental health conditions which may be aggravated by pregnancy; specifically: epilepsy, diabetes, congenital or known acquired cardiac disease, autoimmune disorders, obesity (body mass index greater than 30) or a history of severe mental illness. Information on such conditions should be collected by GPs under the Quality Outcomes Framework (QOF) and should be shared with providers of maternity care.	668, 685
2.4 Specific pre-pregnancy services should be available to women with a poor obstetric or medical history, a previous poor fetal or obstetric outcome, or where there is a family history of significant illness.	176, 177, 178, 232, 359, 366, 367, 368

Audit indicators

Documentary evidence of:

- access to multidisciplinary prepregnancy services, such as prepregnancy clinics (secondary care)
- percentage of women with existing medical conditions who have received prepregnancy care (and recorded in booking assessment)
- percentage of diabetic and mothers with epilepsy provided with a higher dose of folic acid supplementation (and recorded in booking assessment)
- percentage of midwives trained to provide prepregnancy counselling.

STANDARD 3

Access to maternity care

Rationale

Early access to and engagement with maternity services enables a plan of care to be established before the 12th completed week of pregnancy. The plan is tailored to suit the individual health and social care needs of the woman and her partner throughout pregnancy and the transition to parenthood. Late booking is associated with poorer outcomes.

Standards

	Database items
3.1 Antenatal care should be readily and easily accessible to all women and should be sensitive to the needs of individual women and the local community.	130
3.2 The option for all women to access a midwife as the first point of contact should be widely publicised.	36
3.3 Antenatal care should be provided in a variety of local settings and at times that take account of the demands of the woman's working life and family.	269
3.4 All commissioners and providers of maternity care and local authorities should ensure that campaigns and materials are targeted towards women in groups and communities who under-use maternity services or who are at greater risk of poor outcomes.	32
3.5 Maternity services should be proactive in engaging all women, particularly women from disadvantaged and minority groups and communities, early in their pregnancy and maintaining contact before and after birth.	3
3.6 Specialist services should be provided for pregnant teenagers, such as peer parent education and support groups and support in the community with relevant agencies, such as Connexions ⁽ⁱ⁾ and Sure Start Plus ⁽ⁱⁱ⁾ in England.	93, 270
3.7 There should be provision for translation, interpreting and advocacy services, based on an assessment of the needs of the local population.	21
3.8 Services should be flexible enough to meet the needs of all women, including the vulnerable and hard to reach groups. Asylum seekers and refugees are a particularly vulnerable group.	383
3.9 Local maternity services should ensure that they are inclusive for women with learning and physical disabilities and take into account their communication, equipment and support needs.	19

⁽ⁱ⁾ An English governmental support and advisory service for young people between 13 and 19 years and young people who have learning difficulties or disabilities, or both, up to 25 years.

⁽ⁱⁱ⁾ A government programme which aims to achieve better outcomes for children, parents and communities.

Audit indicators

Documentary evidence of:

- a maternity strategy in place that takes into account changes in the profile of the local population
- choice of place to see midwife for booking (survey of women)
- a professional lead for organisation of services for teenage pregnancies
- availability of uptake of translation, interpreting and advocacy services that are reflective of the requirements of the local pregnant population
- percentage of women seen by a midwife before 10 weeks of gestation, by ethnic origin
- percentage of women not booked by 12 weeks + 6 days of gestation, by ethnic origin, and record of the reason.

STANDARD 4

Early pregnancy services

Rationale

A significant number of women develop pain and bleeding in early pregnancy and require timely assessment and sensitive management in a specialist setting. Poor clinical outcomes are linked to inappropriate management.

Standards

	Database items
4.1 All women who experience complications in early pregnancy should have prompt access to an early pregnancy assessment service.	58, 179
4.2 Formal arrangements should be in place for referral to the early pregnancy assessment service, which allows women with previous early pregnancy problems to self-refer.	181
4.3 Commissioners and providers of maternity care should ensure that early pregnancy assessment units (EPAUs) have access to high-quality ultrasound equipment and suitable expertise, other methods of assessment and therapeutic expertise.	60
4.4 A suitable environment should be provided for worried or distressed mothers and their partners with access to counselling and appropriate information.	60, 294
4.5 Diagnostic guidelines should be circulated to all health professionals likely to be consulted by a woman who may have an ectopic pregnancy.	61
4.6 Women who miscarry should have access to a choice of management options (surgical/medical/conservative).	183
4.7 All pregnant women require a high standard of anaesthetic care, including early recovery from anaesthesia, for which anaesthetic services have full responsibility.	682
4.8 A clear and consistent local policy should be in place for the sensitive disposal of fetal tissues after early pregnancy loss.	62
4.9 Women with pain and bleeding should be managed according to an agreed local guideline, including anti-D prophylaxis and chlamydia screening. ⁵	
4.10 Skilled staff should be available to support parents following maternal or neonatal death, stillbirth or miscarriage.	104

See also standard 20 in this document and standard 2 in the companion document, *Standards for Gynaecology*.⁵

Audit indicators

Documentary evidence of:

- guidelines and an algorithm for the pathway of care for women presenting with problems in early pregnancy
- audit of women's choice and uptake rates of medical, surgical and conservative management of miscarriage and ectopic pregnancy
- a minimum of 5-day clinic opening and appropriate prompt weekend arrangements
- patient satisfaction survey of care in EPAU
- audit of algorithm of patient care (such as rate of failed diagnoses/year following opportunity for diagnosis in EPAU, number of ruptured ectopic pregnancies/year following opportunity for diagnosis in EPAU, number of visits to establish confirmed diagnosis, appropriate use of anti-D prophylaxis, chlamydia screening).

STANDARD 5

Maternity booking and planning of care

Rationale

The booking process is an important opportunity to establish a continuing trusting relationship between the woman and her midwife by the 12th completed week of pregnancy. An individualised plan of care is developed through detailed history taking and sharing of information. Women benefit from the support and advocacy of a known midwife throughout their pregnancy.

Standards

	Database items
5.1 Antenatal care should be provided in a variety of local settings and at times that take account of the demands of the woman's working life and family.	269
5.2 At the first contact, pregnant women should be offered information about: how the baby develops during pregnancy, nutrition and diet, including vitamin D supplements, exercise, including pelvic floor exercises, antenatal screening, including risks and benefits of the screening tests, the pregnancy care pathway, planning place of birth, breastfeeding, including workshops, participant-led antenatal classes, maternity benefits. ⁹	122
5.3 At the first contact, pregnant women should be offered information about locally available services to allow them to choose the most appropriate options for pregnancy care, birth and postnatal care. Women who choose a home delivery as their birth option should be supported in that choice, appropriate to the level of clinical risk.	260, 806
5.4 All midwives, obstetricians and GPs must be competent to assist women in considering their options for antenatal, birth and postnatal care and the clinical risks and benefits involved.	39
5.5 Maternity service providers should ensure that antenatal services are accessible and welcoming so that all women, including those who currently find it difficult to access maternity care, can reach them easily and early in their pregnancy.	669
5.6 Booking should take place over two visits in early pregnancy and women should have had their first full booking visit and hand held maternity record completed by 12 completed weeks of pregnancy.	38, 669
5.7 A risk and needs assessment including previous obstetric, ⁹ medical and social history, must be carried out to ensure that every woman has a flexible plan of care adapted to her own particular requirements for antenatal care and delivery.	196, 259, 260, 678

	Database items
5.8 Women with complex needs should be referred as soon as possible after pregnancy is confirmed and, where necessary, be seen at a combined consultation with appropriate professionals.	426
5.9 Information should be available in different languages, with particular cultural beliefs or sensitivities appropriately reflected.	104
5.10 All pregnant women and their partners who smoke should receive clear information about the risks of smoking and the support available to them to help them stop, such as the NHS Stop Smoking Service. ¹⁰	35

Audit indicators

Documentary evidence by case note review and questionnaire of women of:

- information provided concerning pregnancy care and options available
- percentage of women with two visits and risk and needs assessment by 12 weeks + 6 days of gestation
- percentage of women with documented plan of care by 12 weeks of gestation
- percentage of women after the booking appointment knowing the name of their named midwife and contact numbers
- percentage of women booked for midwifery care
- percentage of women booked for team-based care.

STANDARD 6

Pre-existing medical conditions in pregnancy

Rationale

Mothers with pre-existing medical conditions are at a higher risk of serious complications and morbidity. Identification of need will inform a plan of care to be provided by an appropriate multidisciplinary team to optimise and improve outcomes.

Standards

	Database items
6.1 Staff working with women in the prepregnancy and antenatal periods should be competent in recognising, advising and referring women who would benefit from more specialist services.	46
6.2 Women with complex medical conditions must be offered assessment by a consultant obstetrician. These conditions include epilepsy, neurological disorders, diabetes, asthma, renal disease, congenital or known acquired cardiac disease, autoimmune disorders, haematological disorders, obesity (body mass index 30 or more), severe pre-existing or past mental health disorder and any condition for which they are under continuing specialist medical review. ⁹	149, 668
6.3 A system of clear referral pathways should be established so that pregnant women who require additional care are cared for and treated by the appropriate specialist teams, including anaesthetic assessment when problems are identified.	129, 310
6.4 For women with diabetes, an individualised plan of care covering the pregnancy, birth and postnatal period up to 6 weeks of gestation should be clearly documented in the notes.	379
6.5 Women whose pregnancies are complicated by pre-existing medical conditions must receive appropriate multidisciplinary care whilst also promoting normality.	387
6.6 Each woman should receive the support and advocacy of a known midwife throughout their pregnancy to help with promoting the normal aspects of pregnancy and birth as well as supporting and advocating for her through the variety of services she is being offered.	387
6.7 Migrant women may be at risk from previously undiagnosed existing medical conditions. Clinicians should ensure that a comprehensive medical history has been taken at booking and, where appropriate, a full clinical assessment of their overall health, including a cardiovascular examination, is undertaken as soon as possible thereafter.	671

Audit indicators

Documentary evidence of:

- multidisciplinary joint clinics (such as joint diabetes/antenatal clinic)
- percentage of women with a pre-existing medical condition who are assessed by a consultant obstetrician
- percentage of women with a pre-existing medical condition who are seen by an appropriate multidisciplinary team
- percentage of women with a pre-existing medical condition who have a documented plan of care.

STANDARD 7

Women with social needs

Rationale

Social factors have been shown to contribute to poor outcomes for both mother and baby. Some women and their families require specially developed services to ensure access, early engagement and continuing support and care.

Standards

	Database items
7.1 Maternity services must have in place inter-agency arrangements (through clinical and local social services networks) including protocols for information sharing and a lead professional, to ensure that women from disadvantaged groups have adequate support and benefit from other agencies (such as housing) referring women, with consent to local maternity services.	25, 386
7.2 Services should be flexible, accessible and culturally sensitive and planned individually to motivate all women including the vulnerable and hard to reach to engage with maternity services.	22, 383
7.3 Interpreting services should be provided for women where English is not their first language. Relatives should not act as interpreters. Funding must be made available for interpreting services in the community, especially in emergency or acute situations.	21, 388, 733
7.4 Services should be innovative and flexible in meeting the needs of women with communication and other disabilities.	80
7.5 Joint working arrangements should be in place between maternity services and local agencies with responsibility for dealing with domestic abuse and information about these services should be made available to all pregnant women.	57, 708, 711
7.6 All women who have a significant drug and/or alcohol problem should receive their care from a multi-agency team which will include a specialist midwife and/or obstetrician involving social workers and health visitors.	53, 704, 740
7.7 Healthcare professionals should be alert to risk factors and signs and symptoms of child abuse. If there is raised concern, healthcare professionals should follow local and statutory child protection policies.	354, 355, 741
7.8 There should be specialist services available for pregnant teenagers and arrangements in place for support in the community. Maternity services staff should have the knowledge and skills to engage with teenage mothers and fathers.	20, 93, 270

Audit indicators

Documentary evidence of:

- written inter-agency arrangements, including protocols for care of women from disadvantaged groups
- written evidence of local strategies to engage hard to reach women
- appointment of lead professionals, such as specialist midwives, for substance abuse, disability, teenage pregnancy and identification of their working relationships with key agencies where indicated
- the availability and uptake of translation, interpreting and advocacy services
- individual plans of care for women with identified social needs
- a multi-agency care pathway for women at risk of or suffering domestic abuse.

STANDARD 8

Pre-existing and developing mental health conditions in pregnancy

Rationale

Psychological morbidity in the perinatal period has a significant impact on the woman and her family. Unidentified or inadequately treated mental illness during pregnancy and following birth can have serious consequences.

Standards

	Database items
8.1 All pregnant women should be asked about any previous history of psychiatric disorder and/or family history of serious mental illness early in their pregnancy and provided with information on pregnancy and mental health which helps them to disclose and discuss mental health issues.	50, 51, 277
8.2 All maternity care providers and mental health care providers should have in place joint working arrangements for maternity and mental health services, including arrangements for direct access by midwives, GPs and obstetricians to a perinatal psychiatrist.	52, 247,700
8.3 Multidisciplinary care, provided through well-understood clinical and local social service networks, should be available for all women with pre-existing medical, psychological or social problems that may require specialist advice during pregnancy.	360, 386
8.4 Women with an existing mental disorder who are pregnant or planning a pregnancy and women who develop a mental disorder during pregnancy or the postnatal period, should be given culturally sensitive information at each stage of assessment, diagnosis, course and treatment about the impact of the disorder and its treatment on their health and the health of their fetus or child.	356
8.5 During pregnancy, all women who are at identified risk of serious postnatal mental illness should be assessed by a psychiatric team. The woman should have a written management plan of agreed multi-disciplinary interventions and action to be taken which includes a system of close supervision following birth.	98, 696
8.6 All professionals involved in the care of women immediately following childbirth should be able to distinguish normal emotional and psychological changes from significant mental health problems and to refer women for support according to their needs.	96, 346
8.7 Women who require to be admitted to a psychiatric hospital following delivery should be admitted to a specialist psychiatric mother and baby unit.	703

Audit indicators

Documentary evidence of:

- local joint working arrangements within a perinatal mental health network
- information given to women at risk of or developing mental health problems in pregnancy
- percentage of staff trained in mental health issues
- percentage of maternity case notes recording that women are asked about family and personal history of mental health problems
- percentage of at-risk women who received prepregnancy counselling
- percentage of at-risk women with a written plan of care from booking.

STANDARD 9

Antenatal screening

Rationale

An integral component of antenatal care is the timely diagnosis and appropriate management of maternal problems and detection of fetal conditions to inform choice and the continuing plan of care.

Standards

	Database items
9.1 All women should have access to screening services and antenatal diagnostic testing.	191, 236, 274
9.2 All women should be offered a comprehensive, high-quality antenatal screening and diagnostic service, based on the current recommendations of the National Screening Committee, and designed to detect maternal or fetal problems at an early stage. ¹¹	44, 236, 274
9.3 All maternity care providers should ensure that each pregnant woman has two visits early in pregnancy with a midwife who can advise her on her options for care on the basis of an in-depth knowledge of local services. ⁽ⁱⁱⁱ⁾	38
9.4 All providers should ensure that antenatal tests and screening are offered to women as options (with the purpose and consequence of each test explained), rather than as a routine part of the process of being pregnant.	45
9.5 All maternity care providers should ensure that where women request or decline services or treatment, their decision is respected and documented to avoid repetition.	48, 123
9.6 All women who are identified in the screening programme as at risk of rhesus disease should be managed and treated according to an agreed protocol.	192
9.7 Pregnant women should be offered an early ultrasound scan to determine gestational age (in lieu of last menstrual period [LMP] for all cases) and to detect multiple pregnancies.	137
9.8 Pregnancy loss rate following amniocentesis should not exceed 1% above the background rate. ¹²	

⁽ⁱⁱⁱ⁾ Public Service Agreement target: these visits to be before 12 completed weeks.

Audit indicators

Documentary evidence of:

- appointment of screening coordinator and status
- training of maternity staff in current antenatal screening guidelines
- number of attributes tested on fetal anomaly scan
- percentage of eligible women (that is, booking before 20 weeks of gestation) offered screening for Down syndrome
- percentage of eligible women accepting screening for Down syndrome
- percentage of women reporting being offered information and choice about antenatal tests and screening (survey of women)
- percentage of blood screening results available within 7 days
- percentage of amniocentesis or chorionic villus sample tests for Down syndrome that were negative
- pregnancy loss rate after amniocentesis.

STANDARD 10

Routine antenatal care

Rationale

Routine antenatal care focuses upon maintaining and improving health and wellbeing, ensuring that women are equal partners with healthcare professionals in planning their care. Regular antenatal care gives the opportunity to review and update the plan of care to reflect any changes in maternal or fetal health.

Standards

	Database items
10.1 Each maternity service should have an explicit plan for antenatal care for all women, taking account of risk, and which acknowledges that women can move in either direction between different levels of care and lead professionals.	195
10.2 Health professionals should recognise the important role of partners and [where the woman wishes] make sure they are encouraged and supported to take a full and active role in pregnancy and childbirth.	238
10.3 Maternity services should provide comprehensive programmes of education for childbirth and parenthood to women and their partners and families.	21, 121, 186, 438, 677
10.4 For women with an uncomplicated pregnancy, the number of scheduled antenatal appointments should be planned in accordance with national guidelines. ^(iv)	120, 197
10.5 Each antenatal appointment should be of appropriate duration and structured with focused content. Wherever possible, appointments should incorporate routine tests and investigations to minimise inconvenience to women.	136
10.6 A system of clear referral paths should be established so that pregnant women who require additional care ⁹ are managed and treated by the appropriate specialist teams when problems are identified.	129
10.7 All women should be offered the support of a named midwife throughout pregnancy including those with complex pregnancies and those who receive care from a number of specialists or agencies. All women should be able to contact a midwife day or night at any stage in pregnancy if they have concerns.	40, 387

^(iv) In England, NICE guidance for uncomplicated pregnancies suggests ten visits for nulliparous and seven visits for parous women. NHS QIS suggests no more than nine and eight visits, respectively.

- 10.8 Every woman should develop her individual plan of care in partnership with a healthcare professional. The plan is based on an assessment of her clinical and other needs and may be changed at any point in her pregnancy.
- 10.9 Structured maternity records should be used for antenatal care, and maternity services should have a system whereby women carry their own notes. When a standardised, national maternity record with an agreed minimum data set becomes available, this should be adopted.

Database items

41

132, 133, 134

Audit indicators

Documentary evidence of:

- referral pathways for women with complex pregnancies
- average number of antenatal checks for multiparous and primiparous women
- evidence of involvement of partners in antenatal care
- availability of antenatal education
- percentage of women with explicit plan of care
- percentage of women after booking appointment knowing the name of their named midwife and contact numbers
- percentage of women seeing mostly the same midwife throughout pregnancy (for example, 75% of visits)
- percentage of women with hand-held notes following booking appointment.

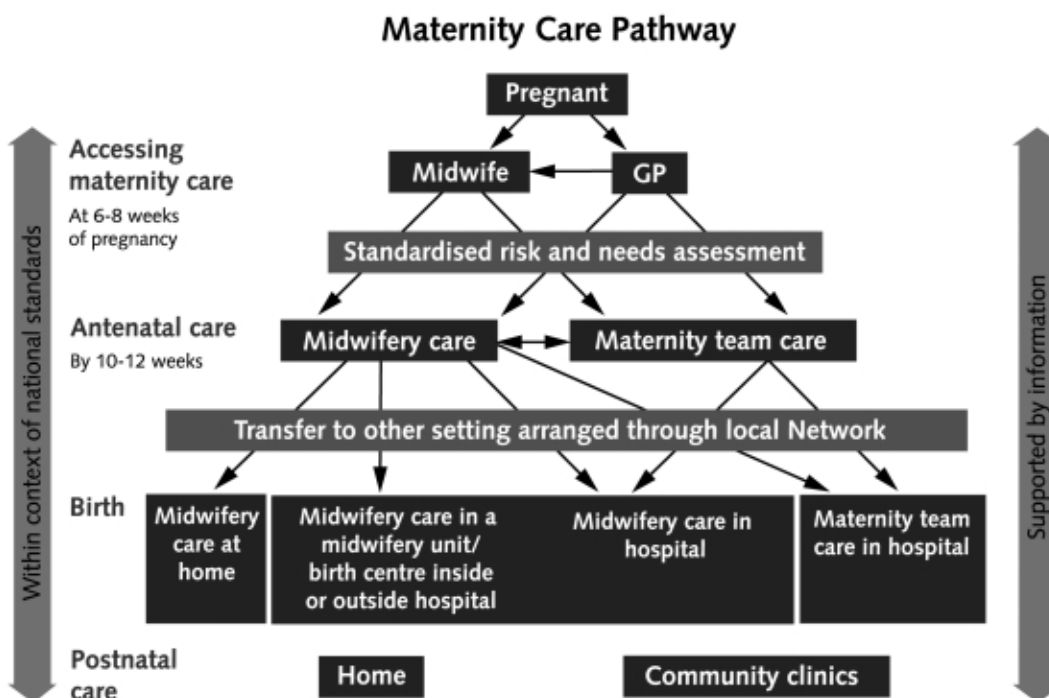


Figure 1 shows an example of a maternity pathway for normal pregnancy, reproduced from *Maternity Matters*.¹³

STANDARD 11

Pregnancy-related conditions

Rationale

The purpose of antenatal care is early detection of problems that require additional support. Maternity services need to be responsive and, when complications arise, provide all necessary facilities and expertise to ensure best possible outcome for mother and baby.

Standards

	Database items
11.1 A system of clear referral paths should be established so that pregnant women who require additional care are managed and treated by the appropriate specialist teams when problems are identified; this may include direct referral by midwives to specialist teams.	129, 700
11.2 Multidisciplinary, high-quality teamwork is essential. Professionals should communicate with other professionals and colleagues and should be supported by identified care pathways for referral.	419
11.3 Maternity services should comply with evidence-based guidelines (e.g. NICE, SIGN) for the provision of high-quality clinical care including the provision of antenatal, intrapartum and postpartum care, induction of labour and caesarean section. ^(v)	47, 105, 106, 796
11.4 Women with complex pregnancies and those receiving care from a number of specialists or agencies should receive the support and advocacy of a known midwife throughout pregnancy.	387
11.5 The development and routine use of an obstetric ‘early warning chart’ which will help in the more timely recognition, treatment and referral of women who have, or are developing, a critical illness should be encouraged. ^(vi)	674, 675
11.6 The consultant obstetrician on-call should be told about all sick pregnant women in hospital, whether they have a medical or an obstetric problem.	690
11.7 Every pregnant woman attending an accident and emergency department for problems other than obvious minor injuries should be seen by a midwife or obstetrician. Where this is not possible, a midwife or obstetrician should be consulted by telephone.	43
11.8 All maternity care providers should ensure that consultant-led services have adequate facilities, expertise, capacity and back-up for timely and comprehensive obstetric emergency care, including transfer to intensive care.	87

^(v) www.nice.org.uk.

^(vi) An example of MEOWS: Modified Early Obstetric Warning System is reproduced on p.247 of *Saving Mothers' Lives*.¹⁴

Audit indicators

Documentary evidence of:

- local protocols for care when complications arise
- audit of appropriate and timely referral and access for women who develop complications
- existence of guidelines for the management of pregnant women in the accident and emergency department and clear escalation policies for the involvement of maternity staff
- local arrangements for transfer to intensive care and guidelines for identification of the lead clinician
- local development of early warning chart for critical illness
- percentage of women referred to obstetricians during pregnancy
- percentage of women referred back to midwifery care following an isolated obstetric consultant care episode
- percentage of pregnant women attending an accident and emergency department assessed in person or by telephone by maternity staff
- percentage of women with complications where consultant was informed and involved in decision-making (case note review).

STANDARD 12

Intrapartum care

Rationale

Promoting normal birth is an important philosophy of maternity care, with intervention only if necessary for the benefit of the mother or child. The principles of normality have been presented in the normal birth consensus statement developed by the Maternity Care Working Party and published by the National Childbirth Trust (NCT), RCOG and Royal College of Midwives.¹⁵ The All Wales Clinical Pathway for Normal Labour has been developed to reduce unnecessary intervention in normal labour and birth.¹⁶ The birth environment influences the birthing experience. The NCT has produced a tool for auditing the environment and resources available for women in labour.¹⁷

Intrapartum care in hospital settings has been covered in detail by the document *Safer Childbirth*¹ and those standards have been reproduced in full in Appendix 1. The rationale for each standard is listed here so that the whole of the maternity care pathway is covered within this document.

Standards

	Database items
12.1 The organisation has a robust and transparent clinical governance framework which is applicable to each birth setting.	796
12.2 Effective multidisciplinary working is essential to the efficient delivery of the service.	797
12.3 Communication is a keystone of good clinical practice.	798
12.4 Safe staffing levels of all professionals and support staff as recommended are maintained, reviewed and audited annually for each birth setting.	799
12.5 There are clear role profiles for clinical leadership promoting good practice and multiprofessional communication.	800
12.6 Core responsibilities of midwives, obstetricians, anaesthetists and neonatal practitioners are defined.	801
12.7 Each birth setting has protocols based on clinical, organisational and system needs.	802
12.8 The organisation must ensure that all the professional staff have the opportunity and support for continuing professional development, including agreed mandatory education and training sessions.	803
12.9 Facilities in birth settings should be at an appropriate standard and take account of the woman's needs and the views of service users by being less clinical, non-threatening and more home-like whenever possible.	804

Audit indicators

All birth settings should audit childbirth outcomes, evaluating annually linked clinical care, any changes or trends.

Documentary evidence of:

- staffing levels (obstetric, midwifery, anaesthetics)
- percentage of staff trained in obstetric emergency skills
- percentage of births by location
- percentage of women receiving one-to-one midwifery care throughout labour and delivery
- percentage of mothers with a medical problem known to the obstetric team who arrived on labour ward having had an anaesthetic consultation during pregnancy
- percentage of women who were attended by the anaesthetist within 30–60 minutes of requesting epidural analgesia
- percentage of occasions the anaesthetist attends within an appropriate period of time [locally determined] and without compromising the care of a patient elsewhere
- percentage of singleton breech where external cephalic version was attempted
- percentage of women with episiotomy or tear sutured within 1 hour
- percentage of primiparous women having a caesarean section
- percentage of vaginal births after caesarean section
- percentage of women with postpartum haemorrhage of 2500 ml or more
- percentage of cases in theatre with a suitably trained anaesthetic assistant present
- percentage of women in whom the fetal heart rate is monitored during initiation of a regional nerve block and until the skin preparation
- percentage of caesarean sections for fetal distress or maternal emergency in which the decision to delivery interval is over 30 minutes.

Audit criteria have been developed by a number of organisations.^{6,18,19}

STANDARD 13

Neonatal care and assessment

Rationale

Most babies are, and remain, healthy. The newborn infant physical examination is a key element of the child health surveillance programme. Early recognition and treatment of some problems can have a significant impact on the health of the child.

Standards

	Database items
13.1 The personal child health record should be given to all women as soon as possible (if it has not been received antenatally) and its use explained.	344
13.2 All consultant-led obstetric units should have a named consultant paediatrician who has responsibility and a special interest in neonatology.	291
13.3 All examinations of the baby should be performed by a suitably qualified healthcare professional who has up-to-date training in neonatal examination techniques.	102, 225, 226, 290, 815
13.4 All newborn infants should have a complete clinical examination within 72 hours of birth. ²⁰ Appropriate recommendations by the National Screening Committee should be followed. ^{21,22}	226
13.5 Both parents should be encouraged to be present at the first examination.	102
13.6 Prompt referral for further medical investigation or treatment should be provided through agreed clinical care pathways.	102, 815
13.7 Professionals should be skilled in sharing concerns and choices with parents if any abnormal condition is diagnosed.	102
13.8 Wherever possible, separation of mothers and babies should be avoided by nursing babies who require additional care with appropriately trained staff on the postnatal wards.	264
13.9 Babies at high risk of hypoglycaemia (e.g. small for dates or born to women with diabetes) should be closely monitored in the postnatal period. Clear guidelines should be in place.	375
13.10 Guidelines should be in place to minimise the number of infants who require rewarming or avoidable admission to special care baby unit (SCBU).	224
13.11 The newborn blood spot screening (heel prick) tests for phenylketonuria, congenital hypothyroidism, cystic fibrosis, MCADD (medium chain acyl CoA dehydrogenase deficiency) should be offered ²⁰ and discussed with all women and their partners following the birth of the baby. ²³	

Audit indicators

Documentary evidence of:

- named consultant paediatrician with responsibility of neonatal care
- implementation of policies to avoid separation of mothers and babies
- guideline for management of babies at high risk of hypoglycaemia
- audit of avoidable admissions to SCBU
- percentage of women receiving personal child record antenatally
- percentage of maternity staff who have had training in neonatal examination techniques
- percentage of baby examinations carried out by midwives
- percentage of babies who have received the newborn infant and physical examination within 72 hours of birth
- percentage of recorded postnatal plan of care including details of care for the baby
- percentage of bloodspot tests taken at 5–8 days
- percentage of blood spot tests taken that were of high enough quality for testing.

STANDARD 14

Postnatal assessment and care of the mother

Rationale

Every mother must receive continuing assessment and support throughout the postnatal period to give her the best possible start with her new baby and for the change in her life and responsibilities.

Standards

	Database items
<p>14.1 A documented, individualised postnatal plan of care should be developed with the woman, ideally in the antenatal period or as soon as possible after birth. This should take into account:</p> <ul style="list-style-type: none"> ● relevant factors from the antenatal, intrapartum and immediate postnatal period ● details of the healthcare professionals involved in her care and that of her baby, including roles and contact details ● plans for the postnatal period including choice of place of care ● This should be reviewed at each postnatal contact. 	335
<p>14.2 All women should be assessed immediately after giving birth by a suitably qualified member of the birth team (doctor or a midwife) and again prior to transfer to community care and/or within 24 hours of giving birth, by a midwife.</p>	214, 215
<p>14.3 Shortly after birth an identified lead professional, normally the named midwife, should be responsible for reassessing individual needs and coordinating the postnatal care of all babies and women.</p>	91, 263
<p>14.4 Any symptoms reported by the mother or identified through clinical observations should be assessed, specifically, for recognition of complications e.g. infection, haemorrhage, thromboembolism and anaesthetic problems.</p>	216, 388
<p>14.5 All professionals involved in the care of women immediately following childbirth should be able to distinguish normal emotional and psychological changes from significant mental health problems, and to refer women for support according to their needs.</p>	96
<p>14.6 Anticipated length of stay in a maternity unit should be discussed, agreed and documented, taking into account the mother's health and wellbeing and that of her baby and the level of support available following discharge.</p>	88, 339

	Database items
14.7 Women and their partners should be given the opportunity to reflect on their experiences of pregnancy and childbirth in the postnatal period with a healthcare professional.	246, 288, 336
14.8 Women should receive information on contraception within 2 weeks of birth.	217

Audit indicators

Documentary evidence of:

- choice in place of postnatal care
- availability of home visits for postnatal care
- average number of postnatal contacts with midwife after going home
- percentage of women with documented and comprehensive postnatal plan of care
- percentage of women who know the name of the lead professional responsible for their care in the postnatal period
- percentage of women admitted or readmitted within 2 weeks of delivery and reasons
- percentage of women receiving information on contraception within 2 weeks of delivery.

STANDARD 15

Supporting infant feeding

Rationale

Mothers need to be effectively supported in the feeding method of their choice and to be fully informed that breastfeeding has many positive long-term healthcare benefits and provides the optimal nutrition for the baby.

Standards

	Database items
15.1 Maternity services should adhere to the principles and work toward the recommendations of UNICEF/WHO Baby Friendly ^(vii) status. ²⁴	219
15.2 Attention should be paid to facilitating an environment that supports skin-to-skin contact where possible. Skin-to-skin should last until after the first breastfeed or until the mother chooses to end it. Babies should remain with their mothers unless there is a medical indication not to.	353, 375
15.3 All healthcare providers (hospitals and community) should have a written breastfeeding policy that is communicated to all staff and parents.	350
15.4 Each provider should identify a lead healthcare professional responsible for implementing the breastfeeding policy.	350
15.5 Maternity services should promote breastfeeding and support the mother to initiate and sustain breastfeeding regardless of the location of care.	103, 218, 289, 349
15.6 A woman who wishes to feed her baby formula milk should be taught how to make feeds using correct, measured quantities of formula, as based on the manufacturer's instructions, and how to cleanse and sterilise feeding bottles and teats and how to store formula milk. ²⁰	
15.7 Where postnatal care is provided in hospital, attention should be paid to facilitating an environment conducive to breastfeeding.	353
15.8 Mothers should have access to [nutritious] food and drink on demand.	353
15.9 Women who are taking medicines should receive specialist advice, based on best available evidence, in relation to breastfeeding.	103
15.10 Women should be provided with readily accessible information (including helpline numbers) and support in their chosen method of feeding, including access to peer support groups and voluntary organisations.	103, 220, 245, 278

^(vii) The Baby Friendly Initiative is a worldwide programme of the World Health Organization and United Nations Children's Fund.

Audit indicators

Documentary evidence of:

- audit against UNICEF/WHO Baby Friendly recommendations
- written breastfeeding policy
- appointment of a designated breastfeeding coordinator
- annual percentage increase in women initiating breastfeeding
- arrangements for 24-hour access to advice for support in infant feeding
- readmission rate of neonates with a diagnosis of dehydration or hypoglycaemia
- percentage of mothers intending to breastfeed at birth, initiating breastfeeding and still breastfeeding at 6–8 weeks postpartum
- percentage of women achieving skin-to-skin contact within the birthing environment
- percentage of women reporting good advice, help and support on infant feeding.

STANDARD 16

Care of babies requiring additional support

Rationale

Some babies may have or can develop problems, for which timely and appropriate treatment is essential. The effective use of networks will ensure the best possible outcome.

Standards

	Database items
16.1 All newborn infants should have a clinical examination by a competent healthcare professional to detect preclinical abnormalities within the first week of life for full-term babies or prior to discharge home from neonatal care.	102, 815
16.2 A documented, individualised postnatal plan of care should be developed with the woman, ideally in the antenatal period or as soon as possible after birth. This should take into account: <ul style="list-style-type: none"> ● relevant factors from the antenatal, intrapartum and immediate postnatal period ● details of the healthcare professionals involved in her care and that of her baby, including roles and contact details ● plans for the postnatal period including choice of place of care. ● This should be reviewed at each postnatal contact. 	335
16.3 Any concerns expressed by the parents as to the wellbeing of the baby, or identified through clinical observations, should be assessed.	338
16.4 Health professionals should ensure that parents are offered newborn screening for their babies and that appropriate follow-up care is commissioned if necessary.	275
16.5 Particular support in breastfeeding should be provided for mothers who have had a multiple birth or have a premature or sick baby (see also Standard 15).	103
16.6 Care of the baby should ensure there is ongoing assessment, including recognition of group B streptococcal infection and jaundice.	227
16.7 Babies born to women with diabetes and others at high risk of hypoglycaemia (e.g. small for dates, preterm) should be closely monitored. They should remain with their mothers during this time unless there is a specific medical indication for admission to a neonatal intensive care unit.	375

	Database items
16.8 Maternity services should have agreed arrangements for the transfer of a recently delivered mother and her newborn baby to a linked secondary or tertiary unit should problems arise.	251
16.9 Parents of babies with identifiable medical or physical problems should receive timely and appropriate care and support in an appropriate environment.	265

Audit indicators

Documentary evidence of:

- policies to avoid separation of mothers and babies
- guidelines for postnatal care, including surveillance for infection and jaundice
- guidelines for diagnosis and management of hypoglycaemia and sepsis in babies
- admission rates to neonatal care for symptomatic hypoglycaemia
- readmission rates for poor feeding and dehydration
- readmission rates for hypernatraemic dehydration
- readmission rates for neonatal jaundice.

See also **Standard 13: Neonatal care and assessment.**

STANDARD 17

Care of babies born prematurely

Rationale

Preterm birth is a distressing event for parents and families and can have lifelong consequences. Timely access to an appropriate level of neonatal care and expertise results in the best possible outcome.

Standards

	Database items
17.1 Formal arrangements must exist for women and their babies to access a network of specialist services; commissioners and providers should collaborate to establish a strategy to ensure appropriate capacity.	148, 405
17.2 Managed maternity and neonatal care networks should include effective arrangements for managing the prompt transfer and treatment of women and their babies experiencing problems or complications.	6
17.3 Because extremely premature births may take place rapidly when no senior members of the team are available, advance liaison should take place whenever possible between the consultant obstetrician, consultant paediatrician and senior midwife to ensure that there is prospective understanding on the management and on who will try to be present at the delivery.	571
17.4 Special care baby unit facilities should be available on site in all level II and level III consultant-led units and there should be a defined rapid access route to neonatal intensive care in all level II and level III consultant-led units.	160
17.5 All maternity services must have systems in place for identifying high-risk women, informing plans of care for women admitted with threatened preterm delivery, and for transporting preterm babies in a warmed transport incubator.	584, 663
17.6 Prompt referral to an obstetrician with appropriate expertise should be made in all cases of threatened preterm labour to assess the need for a tocolytic and to avoid delay in the administration of corticosteroids.	592, 594
17.7 Recommendations for the care of babies born at the threshold of viability, such as those produced by the British Association of Perinatal Medicine, should inform local guidelines. ²⁵	567–583

Audit indicators

Documentary evidence of:

- number of inappropriate *in utero* or neonatal transfers, such as level III to level III transfers
- number of transfers out of an agreed network
- percentage of preterm babies (born at less than 35 weeks of gestation) whose mothers received antenatal steroids
- percentage of babies born at less than 30 weeks of gestation whose temperature on admission was less than 36°C
- percentage of babies born at less than 30 weeks of gestation who required artificial ventilation who were not offered surfactant
- percentage of babies born at 34–37 weeks of gestation who are admitted to the neonatal unit rather than being cared for in an appropriately staffed area of the maternity unit.

STANDARD 18

Promotion of healthy parent–infant relationships

Rationale

Specific professional input focusing on the parent–infant relationship, including the provision of appropriate services, may be required to ensure the development of a positive and healthy relationship. There may be factors that inhibit the development of positive parent–infant relationships that require professional intervention.²⁶

Standards

	Database items
18.1 Maternity services should provide postnatal care to facilitate the transition to motherhood by making sure that ill health is prevented or detected and managed appropriately. Women and their partners should be supported to make a confident and effective transition to parenthood.	242
18.2 Healthcare professionals should use hand held maternity records, the postnatal plan of care and personal child health records, to promote communication with women.	341
18.3 The Department of Health booklet <i>Birth to Five</i> , ²⁷ which is a guide to parenthood and the first 5 years of a child’s life, or equivalent, should be given to all women within 3 days of birth (if it has not been received antenatally).	343
18.4 Midwives and public health nurses should be able to support parents in developing a basic understanding of attachment issues, infant mental health and their role in supporting their child’s mental and emotional development. ²⁶	
18.5 Midwives, public health nurses, social services staff and care staff should be able to ensure that parents’ own mental health needs are recognised and addressed as well as being aware of the potential impact of the parent’s condition on any dependants and young siblings. ²⁶	

Audit indicators

Documentary evidence of:

- information available to women and their families about parent–infant relationships
- number of mothers receiving personal child health record prior to discharge from midwifery care
- quality of formal handover between midwife to health visitor (specialist community public health nurse, SCPHN)
- percentage of notes confirming appropriate transfer of records to community care and then to the health visitor (SCPHN).

STANDARD 19

Transition to parenthood

Rationale

Health professionals support women and their partners in the transition to parenthood by discussing the postnatal health and social needs of the mother and her baby and by developing an individual plan of postnatal care to address those needs.

Standards

	Database items
19.1 The personal child health record should be given to all women as soon as possible (if it has not been received antenatally) and its use explained.	344
19.2 The postnatal plan of care should be documented to identify and promote the health and wellbeing of the mother and her baby and plan for her continuing care and support needs. It should be reviewed at each postnatal contact.	91, 335
19.3 The plan of care should take into account relevant factors from the antenatal, intrapartum and immediate postnatal period and include details of the healthcare professionals involved in the mother's care and that of her baby, including roles and contact details.	335
19.4 Postnatal care should include provision of information to both mothers and fathers on infant care, parenting skills and accessing local community support groups.	92
19.5 A coordinating healthcare professional should be identified for each woman. Based on the changing needs of the woman and baby, this professional is likely to change over time (for example midwife to health visitor, specialist community public health nurse).	90, 334
19.6 At the end of the postnatal period, the coordinating healthcare professional should ensure that the woman's physical, emotional and social wellbeing is reviewed.	348
19.7 There should be local protocols about written communication; in particular, about the transfer of care between clinical sectors and healthcare professionals.	340
19.8 A system should be established to ensure that information on women and their babies in the postnatal period is collated and transferred between secondary and primary care in a reliable, timely and secure manner.	229

Audit indicators

Documentary evidence of:

- local provision of information given in the postnatal period and examples
- protocols concerning written communication; in particular, about the transfer of care between clinical sectors and healthcare professionals
- percentage of women receiving personal child health record antenatally
- percentage of notes with documented postnatal plan of care
- percentage of women knowing the name of lead professional in the postnatal period
- percentage of postnatal records with documentation of transfer out of midwifery care.

STANDARD 20

Supporting families who experience bereavement, pregnancy loss, stillbirth or early neonatal death

Rationale

Bereavement is extremely traumatic. Providers of maternity care need to ensure support and information for women and their families both during the acute time of the event and continuing through the weeks or months afterwards. See also **Standard 4: Early Pregnancy Services**.

Standards

	Database items
20.1 Maternity care providers should ensure there are comprehensive, culturally sensitive, multidisciplinary policies, services and facilities for the management and support of families (and staff) who have experienced a maternal loss, early or mid pregnancy loss, stillbirth or neonatal death.	104
20.2 Skilled staff should be available to support parents following maternal or neonatal death, stillbirth or miscarriage.	104
20.3 Information [that includes details about investigations (including postmortem), birth and death registration and options for disposal of the body] should be available in different languages with particular cultural beliefs or sensitivities appropriately reflected.	104
20.4 Local guidelines must include clear communication pathways between secondary care and the primary care team with both the woman's GP and community midwife informed of any death within one working day.	654
20.5 Parents of stillborn babies or babies with identifiable medical or physical problems should receive timely and appropriate care and support in an appropriate environment. Maternity services should provide appropriate facilities including en suite toilet and shower and the provision of beds for both the woman and her partner.	265
20.6 Information should be given to the woman and her partner about the grieving process, including local support offered and other agencies which also offer support following stillbirth or early neonatal death (e.g. SANDS).	104, 399

	Database items
20.7 Following the death of a baby, placental and postmortem histology should be available within 6 weeks of the examination. The woman and her partner should be given the opportunity to meet with the lead clinician (obstetrician and/or paediatrician) to discuss the results of a postmortem examination and other investigations.	266, 648
20.8 There must be a clear and consistent local policy about the sensitive disposal of fetal tissues after early pregnancy loss.	62
20.9 Postmortem examination of a baby should be performed by a specialist perinatal pathologist where resources allow.	646

Audit indicators

Documentary evidence of:

- policies relating to maternal loss, early or mid pregnancy loss, stillbirth or neonatal death
- availability of a dedicated bereavement coordinator, usually a specialist midwife
- dedicated facilities for grieving families
- policy for sensitive disposal of fetal tissue
- percentage of GPs and community midwives notified within 1 working day of a stillbirth or neonatal death
- percentage of women offered postmortem examination of their baby and percentage of these who accept the offer
- percentage of postmortem reports available to the lead clinician within 6 weeks.

STANDARD 21

Choice and appropriate care

Rationale

Successful maternity services are those that enable women to choose the most appropriate care through each phase of their maternity experience. Offering a range of options and discussing possibilities provides women with informed choices that best meet their needs.

Standards

	Database items
21.1 Midwives, obstetricians and GPs must be competent to assist women in considering their options for antenatal, birth and postnatal care and the clinical risks and benefits involved.	39
21.2 All pregnant women should be offered information on the full range of options available to them throughout pregnancy, birth and early parenthood, including locally available services, place of birth (including home birth), screening tests and types of antenatal and postnatal care.	10, 64, 162, 164, 260
21.3 All women should receive information about a range of pain management techniques which include: transcutaneous electrical nerve stimulation (TENS); oral and intramuscular analgesia; inhalational analgesia; and the use of water for pain relief. Epidural analgesia should be available at all times in consultant-led units (but not midwifery-led units).	69, 203, 205
21.4 Pregnant women should be offered evidence-based information and support to enable them to make informed decisions regarding their care. Information should include details of where they will be seen and who will undertake their care. Addressing women's choices should be recognised as being integral to the decision-making process.	119, 241
21.5 Women should be given enough time between receiving information and making choices to reflect upon the information, consider their options and seek additional information and advice where they wish to.	11, 435
21.6 The promotion of normality of childbirth should be integral to a quality maternity service but it is essential that recognition of the ill mother and infant is paramount.	454
21.7 Where women request or decline services or treatment, their decision should be respected.	48

Audit indicators

Options and alternatives for place and type of care are available in all services but true assessment of choice within the available services depends on the woman's perception and will require surveys of women to evaluate.

Evidence of:

- percentage of women always given information or explanations needed, and involved in decisions during antenatal care
- percentage of women always given information or explanations, and involved in decisions during labour and birth
- percentage of women given a choice at the start of pregnancy of where to have their baby
- percentage of women having a home birth
- percentage of women offered information in advance of screening tests
- percentage of women given choice of where antenatal and postnatal check-ups took place
- percentage of women receiving pain relief of their choice
- percentage of women with breech presentation at term offered external cephalic version.

STANDARD 22

Communication

Rationale

Effective, high-quality communication between healthcare professionals and women and their families will empower them to become active partners in decision making and their overall care. Good interprofessional communication is essential for effective and coordinated care.

Standards

	Database items
22.1 Training on how to communicate information in an effective sensitive manner should be provided to all healthcare professionals.	167, 255
22.2 There should be effective systems of communication between all team members and each discipline, as well as with women and their families.	798
22.3 Healthcare professionals should work in partnership with women and their families, respecting their views and striving to ensure safe and positive outcomes for women and babies at all times.	280, 812
22.4 All pregnant women should be offered information on the full range of options available to them throughout pregnancy, birth and early parenthood, including locally available services, place of birth (including home birth), screening tests and types of antenatal and postnatal care. ³	10, 162, 164, 540
22.5 Women should be given enough time between receiving information and making choices to reflect upon the information, consider their options and seek additional information and advice where they wish to.	11, 434
22.6 Interpreting services should be provided for women where English is not their first language. Relatives should not act as interpreters. Funding must be made available for interpreting services in the community, especially in emergency or acute situations.	21, 388, 733
22.7 Communication and information should be provided in a form that is accessible to pregnant women who have additional needs, such as those with physical, cognitive, or sensory disabilities.	19, 125
22.8 There should be a personal handover of care on the labour ward when midwifery and medical shifts change. Locums should receive a personal handover either by the post holder or senior member of the medical team and vice versa. ²⁸	

Audit indicators

Documentary evidence of:

- follow-up of complaints relating to communication
- policies and working practices that clearly demonstrate that personal handover of care takes place with adequate time for discussion
- percentage of mothers receiving antenatal education on analgesia and anaesthesia
- percentage of mothers for whom written or verbal consent for an anaesthetic intervention in labour has been documented
- percentage of women reporting that they were treated with respect, kindness and understanding by healthcare professionals
- percentage of women reporting that they were fully informed about choices in maternity care
- percentage of women reporting they were fully involved in the decisions made during the course of their pregnancy, birth and as new parents
- percentage of women offered information in a language or format they could understand
- percentage of non-English speaking women who were satisfied with translation and advocacy services
- percentage of women who have discussed their experience of pregnancy and birth with a midwife postnatally.

STANDARD 23

Training and professional competence

Rationale

All maternity care providers are responsible for ensuring the provision of a skilled maternity care workforce of confident and competent practitioners working in multiprofessional teams to maximise the quality of care. Individual members of the team are responsible for developing and maintaining their knowledge and skills through training and continued professional development.

Standards

	Database items
23.1 Staff working with women in the prepregnancy and antenatal period should be competent in recognising, advising and referring women who would benefit from more specialist services.	46
23.2 Midwives, obstetricians and GPs must be competent to assist women in considering their options for antenatal, birth and postnatal care, and the clinical risks and benefits involved.	39
23.3 All professionals providing maternity care should undertake regular, specific, continuing on-site training on the early identification and referral of women with obstetric or other complications. This includes cardiac arrest and haemorrhage procedures for the management of obstetric emergencies.	7, 82, 151
23.4 Specific training is needed so that advocates and translators understand the provision of maternity care and social services so that they can effectively help to guide women around the system.	113
23.5 Clinical staff should have appropriate, multidisciplinary training to ensure that they work in partnership, including inter-agency, with a shared philosophy of care.	112
23.6 Doctors are required to 'Provide a good standard of practice and care, keep professional knowledge and skills up to date, recognise and work within the limits of competence'. ²⁹ Midwives are required to 'maintain professional knowledge and competence'. ³⁰	
23.7 All staff should have up-to-date skills and knowledge to support women who choose to labour without pharmacological intervention, including the use of birthing pools, and in their position of choice.	70
23.8 Midwives and obstetricians should be competent to elicit relevant information sensitively and identify serious conditions occurring simultaneously or a potentially serious past psychiatric history.	51

- 23.9 Maternity service staff should have a working knowledge of the impact of domestic abuse. Staff should be competent in recognising the symptoms and presentations of abuse and be able to make appropriate referrals.

Audit indicators

Evidence of:

- percentage of maternity staff who are trained on how to communicate information in an effective and sensitive manner
- percentage of midwives who have up-to-date skills and knowledge to support women who choose to labour without pharmacological intervention, including supporting women in the use of birthing pools
- percentage of midwives who are able to support women to labour and deliver in the position of their choice
- percentage of maternity professionals who have had training in obstetric complications and emergencies (such as cardiac arrest and haemorrhage)
- percentage of maternity professionals who have had annual update training from anaesthetic staff, particularly those who care for women with epidural anaesthesia
- percentage of maternity professionals who are trained in recognising significance of past serious psychiatric history and domestic abuse
- percentage of maternity professionals who are trained in mental health issues
- percentage of maternity professionals who are trained in current antenatal screening guidelines.

See also **Standard 25: Clinical governance**.

STANDARD 24

Documentation and confidentiality

Rationale

Records relating to the care of women and babies are an essential aspect of practice to aid communication between maternity staff, the woman and others providing care.³¹

Standards

	Database items
24.1 Structured and accurate records should be kept of all antenatal, intrapartum and postnatal care.	132, 172
24.2 Maternity staff should keep, as contemporaneously as is reasonable, continuous and detailed records of observations made, care given and medicine and any form of pain relief administered to a woman or baby.	13
24.3 All women should carry their own case notes and be actively encouraged to contribute to their maternity record.	41, 133, 173, 283, 431
24.4 Booking should take place over two visits in early pregnancy and women should have had their first full booking visit and hand-held maternity record completed by 12 completed weeks of pregnancy.	38, 669
24.5 Whenever possible, [unless the woman has withheld her consent] the GP should give the woman's named midwife confidential access to her full written and electronic records.	727
24.6 GPs should ensure that any significant letters are copied into the woman's hand-held maternity record.	728
24.7 Healthcare services should be provided in environments which promote effective care and optimise health outcomes by being supportive of patient privacy and confidentiality.	546
24.8 The personal child health record should be given to all women as soon as possible after birth (if it has not been received antenatally) and its use explained.	344

Audit indicators

Documentary evidence of:

- audit of record keeping conducted annually
- availability of facilities where confidential matters may be shared with women/families
- percentage of women carrying hand-held maternity records by the 12th completed week of pregnancy
- percentage of personal child health records received antenatally.

Clinical governance

Rationale

A comprehensive clinical governance framework monitors the quality of care provided to women and their families, encourages clinical excellence, enables the continuous improvement of standards and provides clear accountability. Safety is the top priority in clinical care.

Standards

	Database items
25.1 Clinical governance structures should be implemented in all places of birth.	807
25.2 All health professionals must have a clear understanding of the concept of risk assessment and management to improve the quality of care and safety for mothers and babies, while reducing preventable adverse clinical incidents.	252
25.3 Where an incident has occurred, every unit should follow a clear mechanism for managing the situation including investigation, learning, communication and, where necessary, implementing changes to existing systems, training or staffing levels.	108, 145
25.4 Maternity services should comply with evidence-based guidelines (e.g. NICE, SIGN) for the provision of high-quality clinical care, including the provision of antenatal, intrapartum and postpartum care, induction of labour and caesarean section.	47, 105, 106, 796
25.5 There should be evidence that appropriately trained and experienced professionals obtain informed consent for interventions and investigations, and this should be documented. Intrapartum consent is not optimal but may be necessary and valid. ³	165
25.6 There should be a lead clinician for audit and there should be an audit system in place to monitor important aspects of maternity care, and ensure an audit cycle to effect change.	150, 559
25.7 A compliments, comments and complaints procedure should be in place to enable women to express views about their pregnancy and childbirth experience.	146
25.8 The person in overall charge of incident reporting, the clinical risk manager, must ensure that forms are completed whenever an identified trigger event has occurred or whenever an incident has occurred which is outside the normal or expected.	556

25.9 All maternity care providers and commissioners should ensure that all staff participate in the relevant Confidential Enquiries into maternal, perinatal or infant deaths.

Audit indicators

Documentary evidence of:

- a risk management strategy
- staff involvement in risk management; for example, percentage who have completed incident forms and had feedback (staff questionnaire)
- staff knowledge of and availability of up-to-date clinical guidelines
- compliance with guidelines (notes review, obstetric review meeting records)
- trend analysis; for example, use of the Maternity Dashboard
- appropriate professional taking consent (notes review)
- clinical audit with topics, action plans, reaudit and documentation to show improvement in outcome or care
- multiprofessional attendance at obstetric case review and audit meetings
- complaints procedure and timely response
- confirmation of referrals to the Confidential Enquiry into Maternal and Child Health, National Patient Safety Agency and UK Obstetric Surveillance System
- evidence of participation in local safeguarding children board reviews.

Development, implementation and review of local maternity services strategy

Rationale

Effective development of a maternity service which meets the needs of the local population relies on an agreed strategy developed by key stakeholders working within the national service framework. Maternity services need to be appropriate, acceptable and accessible to women and their families. It is important that women are involved in the planning and monitoring of services.

Standards

	Database items
26.1 The provision of maternity services should be based on an up-to-date assessment of the needs of the local population.	15
26.2 Maternity care providers and commissioners should ensure that the capacity of the midwife-led and home birth services are developed to meet the needs of the local population.	67
26.3 Maternity care providers and commissioners should ensure that maternity services develop the capacity for every woman to have a designated midwife to provide care for them when in established labour for 100% of the time.	74
26.4 In every area there should be an effective multidisciplinary maternity services forum such as a maternity services liaison committee (MSLC), where commissioners, providers and users of maternity services bring together their different perspectives in partnership to plan, monitor and improve local maternity services.	437, 442
26.5 Commissioners should facilitate and manage recruitment, training and involvement of representatives of women by ensuring communications, joint training and liaison between representatives locally, regionally and nationally and with patient advice and liaison services and Public Patient Involvement Forum representatives.	443
26.6 The assessment and planning of services should take into account the availability of information technology equipment and networks, local transport services, access to facilities for wheelchairs or baby buggies and for women with physical, sensory or learning disabilities, and access for women from disadvantaged or minority groups.	116
26.7 Maternity providers should arrange for staff to participate in and support the work of the MSLC and they should take account of the MSLC's advice in operating and delivering services.	447, 448

Audit indicators

Documentary evidence of:

- the existence of an up-to-date, local maternity services needs assessment
- a strategy developed in partnership with local users of services
- the existence of an effective multidisciplinary services forum (such as an MSLC)
- number of forum meetings held in past year
- number of maternity services representatives on forum
- expenses paid to forum members
- annual report produced and shared with board within the previous year
- percentage of women offered a home birth
- percentage of births under midwifery care
- percentage of women cared for by one midwife during labour and delivery
- percentage of forum composed of patient and primary care representatives and stakeholders.

Maternity and neonatal networks

Rationale

Good maternity care relies upon inter-agency collaboration, with a full range of services for all pre-existing or developing health or social needs of the mother or baby. This requires links between health and social care and provision within maternity and neonatal care networks that have the capacity to meet demand.

Standards

	Database items
27.1 Commissioners and providers must develop maternity and neonatal care networks. This is achieved through a multidisciplinary and multi-agency approach requiring agreement with all those likely to be involved in providing care, including service managers and all relevant health and social care professionals and service user representatives.	14, 148, 194, 250
27.2 Multidisciplinary care, provided through well-understood clinical and local social services networks, should be available for all women with pre-existing medical, psychological or social problems that may require specialist advice in pregnancy.	386
27.3 Within a locally managed maternity network, there should be clear pathways of care and standardised protocols and guidelines, including rapid and effective communication between specialties, services and health professionals.	722
27.4 Units that do not have adult intensive care facilities, advanced imaging and cardiology on site must have protocols in place for the care of women with significant medical or obstetric illness to ensure that they are delivered in a unit that can provide these resources on site.	158
27.5 Maternity services should agree arrangements for both <i>in utero</i> transfer and the transfer of a recently delivered mother and/or her newborn baby to a linked secondary or tertiary unit.	251

Audit indicators

Documentary evidence of:

- the existence of a maternity and neonatal clinical network
- multidisciplinary input and appropriate referral in complex cases, such as a retrospective case note review
- a record of all transfers and transfer requests
- agreed pathways of care and standardised protocols and guidelines

- records of time from decision to transfer to time transfer takes place and reasons for delay if appropriate
- number of transfers out of an agreed network
- number of inappropriate *in utero* or neonatal transfers, such as level III to level III transfers
- percentage of women transferred in labour or after delivery to a different service within or outside the network.

Child protection and safeguarding babies

Rationale

All maternity care providers have a duty of care to protect children from harm. Staff must be aware of child protection and safeguarding issues and be able to identify where abuse might be occurring and take appropriate action.

Standards

	Database items
28.1 All staff with access to patients should have Criminal Records Bureau checks on appointment and, where the duties of the post involve access to persons under 18 years or vulnerable adults (as defined in the Police Act 1977 section 115), an Enhanced Disclosure is required. Checks should be repeated every 3 years. ^{32,33}	
28.2 All staff must receive level 1 child protection training annually. This may be by means of written update following formal training. Its provision and receipt should be recorded.	342, 347, 354, 355
28.3 All clinical and nonclinical staff with infrequent contact with parents, babies, children and young people (including existing children of expectant parents) should receive level 2 child protection training before contact and subsequently at least every 3 years, with written briefings received a minimum of annually. Attendance at and receipt of training should be recorded by the employer and the professional. ³²	
28.4 All staff working predominantly with parents, babies, children and young people should receive level 3 child protection training with annual refresher/update training. ³²	
28.5 A lead midwife with responsibility for child protection should be appointed who monitors multi-agency arrangements and ensures staff are up-to-date and follow local child protection policies.	293, 355, 517, 693

Audit indicators

Documentary evidence of:

- a lead midwife within the service with responsibility for child protection
- percentage of maternity service staff with current Criminal Records Bureau checks
- percentage of Criminal Records Bureau checks that have been reviewed in the last 3 years
- percentage of maternity service staff who have received level 1 and 3 child protection training in the previous year

- percentage of clinical and non-clinical staff with contact with parents and babies that have received level 2 child protection training prior to contact
- percentage of clinical and non-clinical staff with contact with parents and babies that have received level 2 child protection training every 3 years.

Infection prevention and control

Rationale

Good infection control will reduce hospital acquired infections. Infection in healthcare settings is a major cause of morbidity and occasional mortality. The *Code of Practice for the Prevention and Control of Healthcare Associated Infections* sets out standards required by law that are appropriate for all healthcare environments.³⁴ Page references in this section are from this document.

Standards

- 29.1 All healthcare providers should have in place appropriate arrangements for and in connection with allocating responsibility to staff, contractors and other persons concerned in the provision of healthcare in order to protect patients from the risks of acquiring healthcare-associated infections (page 5).
- 29.2 Healthcare providers must ensure that there are in place policies in relation to preventing and controlling the risks of healthcare-associated infections (page 8). Specifically in maternity services these should include:
 - aseptic technique policy
 - safe handling of sharps policy
 - prevention of occupational exposure to blood-borne viruses policy
 - disinfection policy
 - antimicrobial prescribing policy
 - uniform and workwear policy (page 7).
- 29.3 Maternity service providers must ensure that prevention and control of infection is included in induction programmes for new staff and in training and ongoing education programmes for all staff (page 9).
- 29.4 Maternity service providers should ensure that there is adequate provision of suitable hand washing facilities and antibacterial hand rubs (page 6).
- 29.5 Maternity service providers should ensure that information relating to hand washing and visiting restrictions is provided for women and visitors (page 13).
- 29.6 All birthing pools and other equipment (such as mirrors and thermometers) should be disposed of or thoroughly cleaned and dried after every use, in accordance with local infection control policies. Local information and guidelines regarding prevention of legionella build up in water supply from seldomly used pools should be obtained from local NHS trust estates and should be adhered to. Midwives should use universal precautions and follow local trust infection control guidelines.³⁵
- 29.7 Guidance and policies should be in place to prevent mother-baby transmission of pre-existing conditions such as HIV , hepatitis B and streptococcus B.

Audit indicators

Documentary evidence of:

- specific policies in **Standard 29.2** relating to prevention of healthcare-associated infections
- induction programme for all new staff that includes prevention and control of infection
- policy relating to infection control and the use of birthing pools
- infection rates and trends: maternal and newborn
- length of stay and readmission rates due to infection.

Staffing

Rationale

High-quality maternity services rely on having an appropriate workforce with the leadership, skill mix and competencies to provide excellent care at the point of delivery. All references to standards relating to staffing found throughout the database have been incorporated within this section to provide evidence to:

- assist commissioners in understanding the staffing requirements within maternity services
- assist the managers and professionals within the maternity services to prioritise their workforce planning and allocation of resources
- define the roles and responsibilities of the staff.

Standards

General

	Database items
30.1 All maternity units and labour wards should have a lead named midwife, obstetrician, paediatrician and anaesthetist.	482
30.2 Commissioners and providers should ensure that staffing levels and competencies on labour wards comply with standards of Clinical Negligence Scheme for Trusts or equivalent (Welsh Risk Pool or Clinical Negligence and Other Risk Indemnity Scheme).	68
30.3 Consultant obstetric units require a 24-hour anaesthesia and analgesia service with consultant supervision, adult high-dependency and access to intensive care, haematology blood transfusion and other district general hospital support services and an integrated obstetric and neonatal care service.	491
30.4 Health care organisations should ensure that: <ul style="list-style-type: none"> ● they take into account nationally agreed guidance when planning and delivering treatment and care ● clinical care and treatment are carried out under supervision and leadership ● clinicians continuously update skills and techniques relevant to their clinical work ● clinicians participate in regular clinical audit and reviews of clinical services. 	521

	Database items
30.5 Commissioners and providers should strengthen services for women from disadvantaged and minority groups and communities by having a staffing profile which, as far as possible, reflects the profile of the local population.	17
30.6 Complex intrapartum cases require integrated, multiprofessional specialist management and direct consultant involvement.	492
30.7 Maternity care providers must ensure that all healthcare professionals directly involved in childbirth are competent in basic adult obstetric, neonatal resuscitation and immediate care.	151
30.8 Maternity care providers must ensure that staff who deliver services to mothers and babies, in any location, are trained to carry out neonatal and adult life support.	287
30.9 All women who have a significant problem with drug and/or alcohol use should receive their care from a multi-agency team which will include a specialist midwife and/or obstetrician. [This standard is also applicable to medical conditions such as diabetes, epilepsy and mental health disorders and women with additional needs, such as teenagers, women with disabilities and asylum seekers.]	53, 704
Midwives	
30.10 An experienced midwife (shift coordinator) should be available for each shift on the labour ward.	800
30.11 Maternity care providers and commissioners should ensure that maternity services develop the capacity for every woman to have a designated midwife to provide care for them when in established labour for 100% of the time.	74
30.12 Each woman should receive one-to-one midwifery care during established labour and childbirth by a trained midwife or trainee midwife under supervision.	199, 284
30.13 All commissioners and providers should ensure that for all transfers to hospital, midwives refer directly to the most senior obstetrician on call.	86
30.14 All commissioners and providers should ensure that in all out-of-hospital labours/births, the midwife is responsible for transfer and continues to care for the woman on transfer where possible.	85
30.15 There should be a lead midwife for child protection.	293
Obstetricians	
30.16 All obstetric units must have a lead consultant obstetrician and a labour ward manager.	800
30.17 All women with risk factors for their pregnancy should be offered assessment by a consultant obstetrician.	149

	Database items
30.18 Commissioners and providers should ensure that a consultant is involved in the decision to undertake any caesarean section.	73
30.19 Outside the recommended minimum 40 hours of consultant obstetrician presence, the consultant should conduct a physical ward round as appropriate at least twice a day during Saturdays, Sundays and bank holidays, with a physical round every evening, reviewing midwifery-led cases on referral.	801
30.20 A consultant obstetrician should be available within 30 minutes outside the hours of consultant presence.	802
30.21 The consultant obstetrician must be contacted prior to emergency caesarean section and must be involved when a patient's condition gives rise for concern and attend as required.	802
30.22 Complicated births in obstetric units should be attended by a consultant obstetrician.	802
30.23 Any planned delivery earlier than 27–28 weeks of gestation requires review, as early as possible, by staff with appropriate expertise in the interpretation of fetal wellbeing tests. Women in this group should be seen within 24 hours of admission by a consultant obstetrician and their plan of care reviewed.	591
Anaesthetists	
30.24 There should be a lead consultant obstetric anaesthetist with responsibility for the organisation and management of the specialist anaesthetics service within consultant-led units with sessions which reflect the clinical and administrative workload.	207, 800
30.25 Arrangements should be in place in consultant-led units to ensure that a specialist anaesthetic service is available at all times during childbirth.	208
30.26 A duty anaesthetist of appropriate competency and dedicated only to the labour ward must be immediately available.	799
30.27 The anaesthetic team's response time must be such that a caesarean section may be started within a time appropriate to the clinical condition (this requires all team members to be informed of the case appropriately).	802
30.28 Trainee anaesthetists must be able to obtain prompt advice and help from a designated consultant anaesthetist at all times. They and their consultants must know the limits of their competence and when close supervision and help are needed. Morbidly obese women should not be anaesthetised by trainees without direct supervision.	683
30.29 All women requiring conduction or general anaesthesia should be seen and assessed by an anaesthetist before an elective procedure.	801

Paediatricians

	Database items
30.30 All consultant-led obstetric units should have a named consultant paediatrician who has responsibility and a special interest in neonatology.	291
30.31 There must be 24-hour availability in obstetric units within 30 minutes of a consultant paediatrician (or equivalent staff and associate specialist grade) trained and assessed as competent in neonatal advanced life support.	802
30.32 Units should ensure that there are guidelines concerning the circumstances in which senior or consultant neonatal staff should attend preterm deliveries.	608

Audit indicators

Documentary evidence of:

- named lead consultant obstetrician, lead obstetric anaesthetist and a paediatrician with interest in neonatal care
- multiprofessional teams and named specialist midwives for specific conditions
- policy for midwives accompanying women who transfer to or from unit
- ratio of midwives to mothers
- 40-hour dedicated consultant cover on labour ward
- consultant obstetrician presence on labour ward (hours/week) and evidence of ward rounds
- percentage of maternity care staff with up-to date adult and neonatal resuscitation training
- percentage of baby checks undertaken by specially trained midwives
- percentage of midwives reporting working in a well-structured team environment
- percentage of women with the same named midwife for antenatal and postnatal care
- percentage of women left alone during labour or shortly after the birth
- percentage of emergency caesarean sections with consultant present in theatre
- percentage of parents seen by consultant within 24 hours of baby's admission to neonatal care
- percentage of women seen by anaesthetist prior to elective regional anaesthesia.

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APPENDIX 1

Intrapartum care

Rationale

Standards for maternity care must reflect the importance of a seamless pathway from pre-pregnancy through to the postnatal period. Intrapartum care has been covered in detail by the document *Safer Childbirth*¹ and those standards have been reproduced here so that the whole of the maternity care pathway is covered within this document. This has resulted in some duplication of other standards.

Standards

Standard 1: Organisation and documentation

The organisation has a robust and transparent clinical governance framework which is applicable to each birth setting.

- Comprehensive evidence-based guidelines and protocols for intrapartum care are agreed by the labour ward forum or equivalent, ratified by the maternity risk management group and reviewed at least every 3 years.
- A maternity risk management group meets at least every 6 months.
- There is a written risk management policy, including trigger incidents for risk and adverse incident reporting.
- There is evidence of multiprofessional input in protocol and standard setting and in reviews of critical incidents.
- Meetings involving all relevant professionals are held to review adverse events.
- Past guidelines and protocols are dated and archived in case they are needed for reference at a later date.
- The standard of record keeping and storage of data is clear, rigorous and precise. All units have access to computerised documentation systems, using recognised and acceptable programmes.
- There is an evaluation of midwifery and obstetric care through continuous prospective audit to improve outcomes, which are published as an annual report.

Database items

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Standard 2: Multidisciplinary working

Effective multidisciplinary working is essential to the efficient delivery of the service.

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- Local multidisciplinary maternity care teams, comprising midwives, obstetricians, anaesthetists, paediatricians, support staff and managers, are established.
- A labour ward forum or equivalent meets at least every 3 months.

Standard 3: Communication

Communication is a keystone of good clinical practice.

- There are effective systems of communication between all team members and each discipline, as well as with women and their families.
- Employers ensure that staff have both appropriate competence in English and good communication skills.

Standard 4: Staffing levels

Safe staffing levels of all professionals and support staff as recommended are maintained, reviewed and audited annually for each birth setting.

- Staffing levels are audited annually.
- Midwifery staffing levels are calculated and implemented according to birth setting and case mix categories to provide the midwife-to-woman standard ratio in labour (1.0–1.4 whole-time equivalent midwives to woman) with immediate effect.
- The duration of prospective consultant obstetrician presence on the labour ward are in line with the recommendations in this document.
- Note: units should work towards the targets contained in *The Future Role of the Consultant*² and with immediate effect:
 - units with more than 6000 births a year should provide 60 hours of consultant presence
 - units with between 2500 and 6000 births a year or classed as high risk should provide at least 40 hours a week of consultant presence
 - units with up to 2500 births a year are strongly recommended to have 40 hours of consultant obstetric presence but should conduct a risk assessment exercise to determine their individual requirements.
- Obstetric staffing levels will depend on the training opportunities as defined in the trainee's logbook.
- Medical staff (obstetricians, anaesthetists and paediatricians) of appropriate competence are immediately available on the labour ward.
- A duty anaesthetist of appropriate competency and dedicated only to the labour ward must be immediately available.
- Units providing neonatal care must be appraised against and meet British Association of Perinatal Medicine staffing standards.

Standard 5: Leadership

There are clear role profiles for clinical leadership promoting good practice and multiprofessional communication.

- All obstetric units must have a lead consultant obstetrician and a labour ward manager.
- An experienced midwife (shift coordinator) is available for each shift on the labour ward.
- All midwifery units must have one whole-time equivalent consultant midwife.
- All obstetric units must have one whole-time equivalent consultant midwife to 900 low-risk women.
- For obstetric units, there should be a lead obstetric anaesthetist in charge of anaesthetic services with sessions which reflect the clinical and administrative workload.

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Standard 6: Core responsibilities

- Women in established labour receive one-to-one care from a midwife.
- Outside the recommended minimum 40 hours of consultant obstetrician presence, the consultant will conduct a physical ward round as appropriate at least twice a day during Saturdays, Sundays and bank holidays, with a physical round every evening, reviewing midwifery-led cases on referral.
- All women requiring conduction or general anaesthesia are seen and assessed by an anaesthetist before an elective procedure.
- A professional (midwife, neonatal nurse, advanced neonatal nurse practitioner, paediatrician) trained and regularly assessed as competent in neonatal basic life support must be immediately available for all births, in any setting.

801

Standard 7: Emergencies and transfers

Each birth setting has protocols based on clinical, organisational and system needs.

- There are local agreements with the ambulance service on attendance at emergencies or when transfer is required.
- Complicated births in obstetric units are attended by a consultant obstetrician.
- The consultant obstetrician must be contacted prior to emergency caesarean section and must be involved when a patient's condition gives rise for concern and attend as required.
- The anaesthetic team's response time is such that a caesarean section may be started within a time appropriate to the clinical condition (this requires all team members to be informed of the case appropriately).

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- As a target for best practice (because regional anaesthesia is safer than general anaesthesia for caesarean section) more than 95% women should receive regional anaesthesia for elective caesarean section and more than 85% women should receive regional anaesthesia for emergency.
- There must be 24-hour availability in obstetric units of experienced paediatric colleagues who have advanced skills for immediate advice and urgent attendance, who will attend within 10 minutes.
- There must be 24-hour availability in obstetric units within 30 minutes of a consultant paediatrician (or equivalent staff and associate specialist grade) trained and assessed as competent in neonatal advanced life support.
- A consultant obstetrician should be available within 30 minutes outside the hours of consultant presence.

Standard 8: Training and education

The organisation must ensure that all the professional staff have the opportunity and support for continuing professional development, including agreed mandatory education and training sessions.

803

- There should be adequate clinical support and supervision for newly qualified midwives, junior doctors and students.
- Multiprofessional in-service education/training sessions should be mandatory and attendance documented.
- A personal logbook of attendances should be kept and cross-referenced to midwives' and doctors' rotas, sickness and annual leave.
- There should be provision for support of new staff entering the environment of the birth setting.

Standard 9: Environment and facilities

Facilities in birth settings should be at an appropriate standard and take account of the woman's needs and the views of service users by being less clinical, non-threatening and more home like whenever possible.

804

- Facilities should be reviewed at least biannually and plans made to rectify deficiencies within agreed timescales.
- The audit process should involve user groups and a user satisfaction survey.
- Dedicated and appropriate facilities for bereaved parents should be available.

Auditable standards

Standard 10: Outcomes

All birth settings should audit childbirth outcomes, evaluating annually linked clinical care, any changes or trends:

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- normal births without interventions
- inductions – indications, outcomes and success
- augmentation of labour
- percentage of labours lasting longer than 18 hours
- instrumental births, ventouse, rotational or non-rotational forceps
- third- and fourth-degree tears
- epidural rates, including dural taps
- failed maternal intubation
- total births
- elective caesarean section – incidence and indications
- emergency caesarean sections – incidence and indications
- intrapartum stillbirths
- Apgar scores less than 7 at 5 minutes in babies below 37 weeks of gestation
- need for neonatal resuscitation of babies below 37 weeks of gestation
- admissions to a neonatal unit for babies weighing more than 2.5 kg
- incidence of primary postpartum haemorrhage
- maternal transfer to intensive care unit
- maternal transfers to other units
- transfers of babies to other units
- caesarean hysterectomy and other haemostatic methods
- percentage of complicated births attended by a consultant obstetrician
- breastfeeding rates at birth and discharge
- antenatal steroids prior to preterm birth
- maternal deaths
- neonatal deaths
- neonatal birth injury, such as Erb's palsy
- neonatal encephalopathy (neonatal seizures are easier to define).

Auditable standards (from Healthcare Commission indicator set and RCoA document)³

- Percentage of primiparous women having caesarean.
- Vaginal birth after caesarean rate.
- Percentage of singleton breech pregnancies where external cephalic version was attempted.
- Percentage of women with postpartum haemorrhage of 2500 ml or more.
- Percentage of women with episiotomy or tear sutured within 1 hour.
- Extent that staff are trained in core maternity skills.
- Staffing levels (obstetric, midwifery, anaesthetics).
- 100% of cases in theatre should have a suitably trained anaesthetic assistant present.
- On 100% occasions, the anaesthetist should attend within an appropriate period of time and without compromising the care of a patient elsewhere.

- Percentage of mothers with a medical problem known to the obstetric team who arrived on labour having had previous anaesthetic consultation. Cardiac disease, diabetes, severe asthma respiratory disease, neurological disease and thrombocytopenia should be included.
- Percentage of women satisfied with non-regional analgesia.
- Percentage of women satisfied with regional analgesia
- Percentage of caesarean sections for fetal distress or maternal emergency in which the decision to delivery interval is 30 minutes.
- Percentage of women who are attended by the anaesthetist within 30 or 60 minutes of requesting epidural analgesia.
- Percentage of women in whom the fetal heart rate is monitored during initiation of a regional nerve block and until the skin preparation.
- Percentage of births by location.
- Percentage of women receiving on-to-one midwifery care throughout labour and delivery.

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Source documents

The Working Party developed a database of 50 documents initially. To be inclusive, further documents were identified and are cited as references. To keep the document concise, the standards were prioritised and are not all included in the report. Some documents are referred to in their entirety and so do not have associated database item numbers.

The database item numbers were generated automatically; during the cleansing process, some numbers were removed. Thus, there are gaps in the sequence below.

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