Royal College of Obstetricians & Gynaecologists

PROVIDING QUALITY CARE FOR WOMEN

A FRAMEWORK FOR MATERNITY SERVICE STANDARDS

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THE ROYAL COLLEGE OF MIDWIVES

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A framework for maternity service standards

Introduction

SERVICE SPECIFICATIONS AND STANDARDS FOR THE PROVISION OF MATERNITY CARE

IN 2015, the RCOG established the Safer Women's Health Care working party to identify the workforce and service standards needed to deliver safe, high-quality maternity and gynaecological care. This report is the output of the multi-disciplinary maternity standards work stream. It sets out a framework for commissioners and service providers of high-level maternity service standards that aim to improve outcomes and reduce variation in maternity care. There is also an accompanying framework for gynaecology services.

The maternity service standards framework is based on the principle that quality improvement demands continuous effort. The standards define quality of care within maternity, building on the WHO vision which defines quality of care as 'the extent to which health care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care needs to be safe, effective, timely, efficient, equitable, and people-centred.'[1–3]

We envisage that multi-disciplinary teams will use the framework and standards to ensure their contributions meet the needs of women, their babies and their families, whether or not they have medical or obstetric complications. The framework and standards should also support maternity staff to work in well-structured teams, with supportive line management and infrastructure to deliver safe, personal, kind, professional and high-quality maternity care.

The framework is a progression of the national standards for maternity care developed by an inter-disciplinary expert working party and published by the RCOG in 2008.[5] The 2008 document covers a mixture of clinical and organisational standards and continues to be a highly relevant reference resource for service providers, commissioners, healthcare professionals and for women, and for quality improvement in UK maternity care. This new framework for maternity service standards builds on this to offer providers and commissioners a contemporary structure for the delivery of quality improvement and safe maternity care.

This report sets out a framework for commissioners and service providers of high-level maternity service standards that aim to improve outcomes and reduce variation in maternity care

Introduction

High quality maternity care is provided through services that nurture and develop trusting and responsive relationships with women and their families

FORMAT AND CONTENT OF THIS REPORT

The first section of the report presents overarching service standards which cover elements of quality such as communication, service governance, staffing, education, accountability, family centred care, and the care and birth environment.

Subsequent sections present key service standards along the maternity pathway from preconception through pregnancy, labour and birth, and the postnatal period.

Each section has at least one key statement about care and then lists associated standards; measurement criteria are given that could be used to show compliance. The criteria are examples and are not all-inclusive.

References are listed at the end of the report which provide contextual evidence and information and were used to develop the standards. Where there was limited evidence-based guidance, the standard has been developed through consensus and is referenced as 'group consensus.'

The statements and standards were developed by a review of available evidence, discussion amongst work stream group members and through pragmatic informal discussion with colleagues and all relevant stake holders including service users.

The standards have been developed recognising that:

- **High quality maternity care is provided through services that nurture and develop trusting and responsive relationships with the women and their families they serve.**
- **Delivering such quality means that the service providers work in collaboration with all key stakeholders and engage proactively with service users, ensuring that their views are sought when any significant changes to systems are proposed.**
- **Service providers respond to feedback in a timely manner and foster a culture of learning and supportive work practices which is open and transparent in the response to and investigation of any critical incidents.**

These standards are most effectively delivered within an interconnected system of service providers, working, for example within collaborative supra-local network structures which provide strategic and/or operational functions.[4] Such networks are essential to ensure that women have timely access when they need it to a multi-professional team that works in partnership with local and regional specialists and agencies which ensures seamless links between primary, secondary, specialist and community services. Effective networks should also ensure that no woman is exposed to unnecessary intervention or remains at an inappropriately escalated level of care.[1, 3]

A framework for maternity service standards

Overarching standards for services throughout the maternity pathway

1.1 Care must be accessible, responsive and provided in partnership with women and their families, respecting their diverse health and wellbeing needs, preferences and choices; and in collaboration with other organisations whose services impact on family wellbeing.

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
1.1.1 Commissioners and providers of maternity healthcare should ensure that there are a variety of routes and mechanisms for women to access care in a timely manner whether during pregnancy, birth or the postnatal period.	*Network policy and audit*	*Previous RCOG Maternity Standards*[5] *NHS London*[6]
1.1.2 Systems should be in place to ensure there is outreach to frequently excluded groups, encouraging them to engage with services.	*Network policy and audit*	*HSCIC*[7]
1.1.3 Services should be planned on the basis of high quality information about local population needs.	*Local joint assessment and planning* *Network policy*	*National Maternity Review*[8]
1.1.4 There should be effective partnership working across communities, including local authorities and the voluntary sector, providing pathways of care with access to social care agencies.	*Local policy and audit*	*National Maternity Review*[8]
1.1.5 There should be a structure that addresses the requirements of the relevant Children and Young People's legislation which includes safeguarding policies and collaboration with the relevant local networks.	*Local policy and audit*	*RCPCH*[9]

Overarching standards

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
1.1.6 There should be evidence that the local Maternity Services Liaison Committee (MSLC) or other such structures embed user involvement to develop and improve services.	*Local policy and audit*	*Public Health England*[10]
1.1.7 Feedback from women and their families' experiences must be used to drive continuous improvement of care.	*Local policy and audit*	*National Maternity Review*[8]
1.1.8 The service provider should ensure that generic pre-pregnancy advice should be included in all consultations, medical and surgical, with women of reproductive age, regardless of indication, in primary and secondary care, including lifestyle and healthy eating, weight optimisation, smoking reduction/ cessation, appropriate dietary supplementation, review of medication, and social support.	*Local policy and audit*	*The King's Fund*[12] *RCM standards for mental health*[13]
1.1.9 The provider should ensure that there must be appropriate provision for investigation and optimisation of physical and mental health prior to pregnancy as well as a full range of support services to provide antenatal, intrapartum and postnatal care for that woman once she conceives.	*Network policy and audit* *Network wide level agreement*	*The King's Fund*[12] *RCM standards for mental health*[13]
1.1.10 Maternity services must demonstrate encouragement and support for a woman's partner to be involved during maternity care to prepare for parenthood.	*Local policy*	*RCM*[14] *Department of Health*[15]

1.2 Staff must have the ability to communicate effectively with all members of the maternity team, other professionals, women receiving care and their family members. They should ensure that all information relevant to the care pathway is accessible, aids decision making and assists communication so that women are actively encouraged to express their preferences, listened to and supported to make personal choices, share decisions and take responsibility for their own health care.

1.2.1 There should be processes and systems in place that support good communication in all elements of care.	*Local policy and audit*	*The King's Fund*[16]

Overarching standards

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
1.2.2 There should be formal communication and referral pathways for obstetricians and midwives with GPs, Health Visitors, laboratory services, emergency services, acute and primary care services and other health and social care networks.	*Local policy and audit*	*NHS London*[17]
1.2.3 There should be protocols on the content and format of written communication, in particular about transfer of care between professionals (may include text messages and emails).	*Local policy and audit*	*Dept. of Health (Ireland)*[18]
1.2.4 All providers and commissioners of maternity services should ensure that data collection, reviews, reports, and healthcare improvement activities focus on outcomes that matter to patients and families and that these are regularly reviewed and co-created with pregnant women and families.	*Review of dashboards* *Review of consultation processes* *Feedback*	*Each Baby Counts*[19]
1.3 Care is provided in a chosen, comfortable, clean, safe setting that promotes the wellbeing of women, families and staff, respecting women's needs, preferences and privacy; and the physical environment supports normality and compassionate care.		
1.3.1 There must be clear, evidence based guidelines and policies supporting women's access to different care settings.	*Local policy and audit*	*Group consensus*
1.3.2 Maternity services should ensure that all women have access to midwifery care in all care settings.	*Local policy and audit*	*National Maternity Review*[8]
1.3.3 All care settings must protect and promote women's privacy and dignity, respecting their human rights.	*Local policy and audit*	*WHO*[20]
1.3.4 Consideration should be given to the efficiency, effectiveness and sustainability when planning care environments.	*Local policy and audit* *Regional policy*	*RCOG Good Practice 15*[21]

Overarching standards

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
1.3.5 Staff should have a safe working environment and culture that provides space which enables and supports them to take adequate rest, comfort, and meal breaks.	*Local policy and audit* *Staff survey*	*NHS Employers*[22] *RCM Caring for You*[23]
1.4 Health professionals and staff in maternity services have a personal accountability for continuing professional development and life-long learning. The system they work in should provide a positive learning culture with opportunities to fulfil these responsibilities.		
1.4.1 Employers must provide time and opportunities for all registered health care staff to maintain professional development in line with professional revalidation.	*Local policy and audit*	*NMC*[24] *GMC*[25]
1.4.2 There should be annual appraisal of performance and development review for every member of the maternity team that identifies learning and development needs.	*Local policy and audit* *Staff survey*	*NHS Employers*[26]
1.4.3 There must be a framework for effective accessible clinical supervision, mentoring and preceptorship.	*Local policy and audit*	*Group consensus* *DoH*[27]
1.4.4 Employers should ensure that all members of the maternity team have access to learning opportunities for team building, and to learn new, and maintain, skills.	*Local policy and audit*	*The King's Fund*[16]
1.4.5 Women with medical disorders should be cared for by multidisciplinary teams with both adequate knowledge and experience of their condition in pregnancy.	*Local policy and audit*	*Previous RCOG Maternity Standards*[5]

Overarching standards

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
1.4.6 Employers should ensure that all members of the maternity team have time to attend team meetings, reflective sessions and perinatal mortality meetings.	*Local policy and audit*	*Group consensus*
1.5 Safe staffing levels of medical, midwifery and support staff are maintained and audited. Continuity of carer throughout the woman's maternity care pathway is pursued as a high priority.		
1.5.1 There should be an appropriate skill mix that supports safe delivery of maternity care that meets the needs of women in all environments.	*Local policy and audit*	*RCOG Safer Childbirth*[28] *RCOG Good Practice 15*[21] *The King's Fund*[29] *NICE Midwifery Staffing*[30]
1.5.2 Care should be organised so that a woman has continuity of care and carer from an appropriately skilled maternity team.	*Local policy and audit*	*RCM Continuity of midwife-led care*[31] *RCOG/RCM joint statement on continuity of carer*[32]
1.5.3 The organisational leadership structure should include individuals with the clinical and professional expertise to promote the philosophy of care, provide expert advice, and support the staff in the working environment in a way which maximises their contribution to high quality care.	*Local policy and audit*	*Previous RCOG Maternity Standards*[5]
1.5.4 New staff in all care environments must have access to induction and preceptorship.	*Local policy and audit*	*NHS Employers*[33]
1.5.5 Good morale and culture should be demonstrated through evidence from staff surveys, rates of sickness, absence and staff retention.	*Local policy and audit*	*Picker Institute Europe*[34]

Overarching standards

1.6 The planning and organising of maternity care takes place through multi-disciplinary collaboration under obstetric and midwifery and neonatal leadership which supports a high quality clinical governance framework that delivers personalised maternity services.

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
1.6.1 There must be multi-professional input into the development of evidence based guidelines, policies and procedures that are relevant to clinical practice and subject to regular review.	*Local policy and audit*	*National Clinical Guideline Centre*[35]
1.6.2 There should be a multidisciplinary steering/management group responsible for oversight of clinical care, which meets at least quarterly with published minutes and is directly accountable to the service provider's clinical governance body.	*Local policy and audit*	*SIGN*[36]
1.6.3 There should be structures that facilitate open, transparent, respectful, non-hierarchical professional communication.	*Local policy and audit*	*Dept. of Health (Ireland)*[18]
1.6.4 There must be a written risk management policy, including trigger incidents, adverse incident reporting and multi-professional review, with feedback to providers and users to progress quality improvement.	*Local policy and audit*	*RCOG Clinical Governance Advice 2*[37]
1.6.5 There must be a process to ensure that all critical incidents, including all maternal and perinatal deaths, are thoroughly reviewed by a multi-disciplinary group, including service user representation and independent peers, and with feedback to providers and families to ensure that there is reflective learning and quality improvement measures are put in place.	*Local policy and audit*	*RCOG Clinical Governance Advice 2*[37] *The Health Foundation*[38] *Each Baby Counts*[19]
1.6.6 There must be a process of rapid dissemination of learning from such reviews to facilitate multidisciplinary learning.	*Local policy and audit*	*RCOG Clinical Governance Advice 2*[37]

Overarching standards

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
1.6.7 There must be effective collaborative partnership working with the local and national maternal, neonatal and child health services.	*Network and local policy and audits*	*Health Improvement Scotland*[39]
1.6.8 Systems must be in place to ensure electronic collection, reporting and transfer of information regarding activity, performance and outcomes of care which support midwives and other clinical staff to have access to the relevant data to assess and improve outcomes.	*Local policy and audit*	*HSCIC*[40] *Health Improvement Scotland*[41]
1.6.9 Maternity networks should develop care pathways to provide care and advice for pregnant women with medical disorders that promote and maintain expertise in caring for such women. These pathways should acknowledge the need for the centralisation of some aspects of maternity care for these women (as per fetal medicine services).	*Network policy and audit*	*MBRRACE 2015*[42] *MBRRACE*[43]
1.6.10 Commissioners and service providers should commission services to ensure the development and maintenance of expertise in caring for pregnant women with medical disorders. These commissioned care pathways should acknowledge the need for the centralisation of some aspects of maternity care for these women (as per fetal medicine services).	*Local policy and audit*	*MBRRACE*[42] *MBRRACE*[43]
1.6.11 There should be a system in place to alert the local neonatal/paediatric team about any issues in pregnancy that may have implications for the fetus/baby and that would facilitate communication between parents and paediatricians antenatally as well as development of a postnatal management plan for the baby. This should facilitate proactive communication and shared decision making between parents and the clinical team.	*Evidence of an alert system in place* *Regular review/audit of system* *Learning from audits and misses*	*Care Quality Commission*[44]

A framework for maternity service standards

2 Pre-pregnancy services

2.1 The pre-pregnancy health of all women.

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
2.1.1 Providers of maternity care should take every opportunity, both antepartum and postpartum, to promote key public health messages regarding diet, exercise, smoking and pregnancy planning.	*Network policy and audit, local relevant guidelines/ policy and audit*	*Annual Report of the Chief Medical Officer, 2014*[45]
2.1.2 Maternity services should engage in multi-agency co-productive partnerships which have as their goal the improved health of women of reproductive age.	*Network policies*	*Annual Report of the Chief Medical Officer, 2014*[45]

2.2 Pre-pregnancy counselling for women with complex medical needs.

2.2.1 Maternity networks must set out clear pathways for pre-pregnancy counselling, ensuring that the right advice is given by an appropriate healthcare provider who has experience in managing their disorder in pregnancy.	*Network policy* *Service level agreement*	*MBRRACE 2014*[46]
2.2.2 Condition-specific advice should be given in primary care by a primary care physician or healthcare professional trained and competent in this counselling, and referral to specific secondary or tertiary care providers should occur if this expertise is not available in primary care, or if the woman requests it.	*Network level audit*	*Group consensus* *MBRRACE 2014*[46]

2 Pre-pregnancy services

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
2.2.3 Condition-specific pre-pregnancy advice should be given by the multidisciplinary healthcare team that will provide care during a subsequent pregnancy, where possible, or at the very least by an obstetrician who works within a multidisciplinary team.	*Case review*	*MBRRACE 2014*[46]
2.2.4 All women with a condition that the secondary care team do not have experience of managing in pregnancy, or where the obstetric services do not meet specified criteria to provide care in the antepartum and intrapartum period, should be referred to a tertiary service, ideally within a network. It is expected that within networks, localities will develop policies and guidelines with respect to what type of care can be provided in which units, and by whom.	*Network policy and service level agreement*	*Group consensus* *MBRRACE 2014*[46]
2.2.5 There should be established links/ referral pathways for reproductive medicine departments to discuss assisted reproduction in the context of medical illness if required.	*Network policy and service level agreement*	*Group consensus* *MBRRACE 2014*[46]
2.2.6 Providers of pre-pregnancy advice must summarise the information given and future plans in a format that the woman can understand and keep. Any recommendations or plans made with the woman must also be communicated to providers of primary care and specialised medical secondary care.	*Local audit*	*Group consensus* *MBRRACE 2014*[46]

A framework for maternity service standards

3 Antenatal care

3.1 Maternity networks should ensure that antenatal care is accessible to women at the right time in their pregnancies and is offered by the appropriate provider so that they can be informed of risks and be supported to make decisions which would keep them as safe as possible.

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
3.1.1 There must be a variety of routes and mechanisms for all women to access antenatal care in a setting of her choice, ideally before 10 weeks gestation.	*Local policy and audit*	*Group consensus*
3.1.2 All women should have a named midwife throughout their pregnancy.	*Local audit*	*NICE Quality Standard 22*[47]
3.1.3 Women with complex social, medical, obstetric or fetal conditions should have a named lead professional who works with the woman's named midwife.	*Local policy and audit*	*Previous RCOG 2008 Standards*[5]
3.1.4 The service provider should organise and resource antenatal clinics and consultations so that staff have the appropriate competencies and resources to support women who access them to make informed decisions about often complex medical and social needs.	*Patient satisfaction surveys*	*Group consensus*
3.1.5 All women should have a clear plan for antenatal, intrapartum and postpartum care and this must be communicated to her relevant care providers.	*Local audit*	*Group consensus*

3 Antenatal care

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
3.1.6 A system of clear referral pathways should be established so that women who require additional care because of pre-existing medical conditions or because of complications during their pregnancy are cared for and treated by the appropriate multidisciplinary or specialist teams, including anaesthetic assessment when problems are identified.	*Local policy and review* *Pathway documentation*	*MBRRACE 2014*[46]
3.1.7 Maternity networks should develop care pathways to provide care and advice for pregnant women with medical disorders that promote and maintain expertise in caring for such women. These pathways should acknowledge the need for the centralisation of some aspects of maternity care for these women (as per fetal medicine services).	*Pathway documentation* *Network guidelines*	*MBRRACE 2014*[46]
3.1.8 Service providers should only offer care to women with medical disorders when they have both the expertise and continued regular exposure to the medical disorder to ensure a safe high quality service.	*Job plans* *Consultant appraisals*	*MBRRACE 2014*[46]
3.1.9 Commissioners and service providers should commission services to ensure the development and maintenance of expertise in caring for pregnant women with medical disorders. These commissioned care pathways should acknowledge the need for the centralisation of some aspects of maternity care for these women (as per fetal medicine services).	*Network and local services review*	*MBRRACE 2014*[46]
3.1.10 Women should be offered screening for factors which may impact on the outcome of the pregnancy and where risks are identified, they should be referred to specialist services.	*Local audit*	*NICE Quality Standard 22*[47] *Annual Report of the Chief Medical Officer, 2014*[45] *UK National Screening Committee programmes*[48]

3 Antenatal care

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
3.1.11 Services should provide personalised advice from an appropriately trained person on healthy eating and physical activity for pregnant women with a body mass index of 30 kg/m^2 or more at the booking appointment.	*Local audit*	*NICE Quality Standard 22*[47]
3.1.12 Women who smoke should be referred to an evidence-based stop smoking service at the booking appointment.	*Local audit*	*NICE Quality Standard 22*[47]
3.1.13 Commissioners and service providers responsible for the organisation of local antenatal services should provide for flexibility in the length and frequency of antenatal appointments, to allow more time for women to discuss any complex social issues, such as domestic abuse, they may be experiencing.	*Clinic appointment schedules*	*NICE Clinical Guideline 110*[49]

A framework for maternity service standards

4 Vulnerable women

4.1 Service standards for the maternity care of women with/at risk of mental health problems.

4.1.1 There must be a regional perinatal mental health strategy and all providers of care for perinatal mental health problems must participate.

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
4.1.1.1 Perinatal mental health clinical networks should be established to develop local services and clear pathways of care to prevent care being fragmented and uncoordinated.	*Network Policies* *Network Level Agreements*	*Joint Commissioning Panel for Mental Health*[50]
4.1.1.2 There must be a perinatal mental health integrated care pathway in place which covers all levels of service provision and severities of disorder.	*Network policies* *Network pathways*	*Joint Commissioning Panel for Mental Health*[50] *Annual Report of the Chief Medical Officer, 2014*[45]
4.1.1.3 Maternity services should work closely with specialised perinatal mental health services to develop local care pathways so that all primary and secondary health care professionals know how to access these services and can ensure a seamless clinical service along the patient journey during and following pregnancy.	*Network policies* *Network pathways*	*RCOG Good Practice 14*[51] *Annual Report of the Chief Medical Officer, 2014*[45]
4.1.1.4 Networks should always include specialist addictions services.	*Review of local service provision* *Service level agreement*	*MBRRACE 2015*[42]
4.1.1.5 Ensure that women with the whole range of mental health problems in pregnancy and postnatally have access to NICE-compliant psychological therapies.	*Review of local provision*	*Annual Report of the Chief Medical Officer, 2014*[45]

4 Vulnerable women

4.1.2 At a local level, providers of maternity care should have a strategy for identifying women at risk of mental health problems during and after pregnancy which assists them in accessing tailored care specific to their needs and those of the baby.

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
4.1.2.1 All NHS maternity care providers have in place policies and protocols for identifying and supporting women who are at high risk of developing a serious mental illness during pregnancy or after birth.	*Local guidelines* *Local referral criteria* *Local referral pathways*	*Department of Health*[52]
4.1.2.2 A pre-pregnancy advice service should be available for women identified as having, or who are at high-risk of developing, serious mental disorders, provided ideally by specialised perinatal mental health services where available, or by general psychiatric services.	*Description of local service*	*RCOG Good Practice 14*[51]
4.1.2.3 Commissioners and service providers should ensure that published and accepted clinical standards are being followed, e.g. Management of Women with Mental Health Issues during Pregnancy and the Postnatal Period.	*Local audit*	*RCOG Good Practice 14*[51] *SIGN 127*[53]
4.1.2.4 Women should have continuity of care. Where more than one mental health team is involved, there should be a clearly identified individual who co-ordinates care.	*Local audit*	*RCOG Good Practice 14*[51]
4.1.2.5 Local perinatal mental health services should be led by a named specialist or general consultant psychiatrist.	*Job description*	*RCOG Good Practice 14*[51]
4.1.2.6 A named obstetrician should be identified to lead service and training development along with the named perinatal psychiatrist and midwifery lead.	*Job description*	*RCOG Good Practice 14*[51]
4.1.2.7 Contact details for the specialised perinatal mental health service or, in its absence, a consultant psychiatrist with special interest in psychiatric disorders of pregnancy should be clearly signposted in each maternity unit.	*Review of local practice*	*RCOG Good Practice 14*[51]

4 Vulnerable women

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
4.1.2.8 Contact details for the specialised perinatal mental health service or, in its absence, a consultant psychiatrist with special interest in psychiatric disorders of pregnancy should be clearly signposted in each maternity unit.	*Review of local practice*	*RCOG Good Practice 14*[51]
4.1.2.9 Providers of maternity care must establish regular basic training and updating in the identification of current, and past history of, mental health problems in pregnancy and the postpartum period and when to refer to mental health and primary care services. Training should be provided locally in collaboration with specialised perinatal mental health services.	*Training material and logs*	*RCOG Good Practice 14*[51] *Annual Report of the Chief Medical Officer, 2014*[45]
4.1.2.10 Locally agreed arrangements should be in place between maternity, specialised perinatal mental health services (or, in their absence, general psychiatric services) and primary care on the management of pregnant women on antidepressant medication. These may include written guidance to indicate risks associated with specific drugs during and after the pregnancy, availability of telephone advice or, where indicated, assessment by specialised perinatal mental health services.	*Written evidence* *Local referral guidelines* *Evidence of telephone advice offered*	*RCOG Good Practice 14*[51]
4.1.3 **There is a clear duty on all health professionals to share relevant information which may affect the care a woman receives during pregnancy, or which may alter her outcomes.**		
4.1.3.1 **Lines of communication must ensure that:** • GPs inform maternity services of any past psychiatric history. • Maternity services inform the GP of a woman's pregnancy and enquire of the GP about past psychiatric history. • Mental health services are informed that women known to them are pregnant. • Mental health services must inform maternity services of any risk a pregnant woman faces. • Each woman who has been identified as at risk of a recurrence of a severe mental illness has a written plan of agreed multi-disciplinary interventions and action to be taken.	*Local assessment tools* *Risk assessment logs* *Local annual report of psychiatric maternal deaths* *Root cause analyses*	*RCOG Good Practice 14*[51] *Department of Health*[52] *SIGN 127*[53]

4 Vulnerable women

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
4.1.3.2 All communication between maternity and mental health services should include primary (community midwives, GPs and health visitors) and social care, including when women decline referral to specialised mental health services.	*Local assessment tools* *Risk assessment logs* *Yearly report of psychiatric maternal deaths*	*RCOG Good Practice 14*[51] *Group consensus*
4.1.3.3 Health and social care professionals must escalate through safeguarding policies if a woman is thought to be at risk to herself or to the unborn baby.	*Local policies* *Local audit*	*Group consensus*
4.1.3.4 The provision of care for women with mental health problems should be through integrated multi-stakeholder teams, including child safeguarding teams, ideally reflecting the needs of the population.	*Review of local practice* *Case audit*	*RCOG Good Practice 14*[51]
4.1.3.5 Liaison, crisis and home treatment teams require additional support and education in understanding the distinctive features and risks of perinatal mental illness, and in the application of safeguarding policies where required, if they are to provide emergency and out of-hours care for pregnant and postnatal women.	*Training materials and logs*	*MBRRACE 2015*[42]
4.1.4 **Each managed perinatal mental health network should have designated specialist inpatient services.**		
4.1.4.1 Women who require admission to a psychiatric hospital following delivery should be admitted to a specialist psychiatric mother and baby unit and this unit should fulfil the standards set out in The Royal College of Psychiatrists 'Service Standards for Mother and Baby Units, Fourth Edition 2014'.	*Audit* *Review of local practice*	*RCOG Good Practice 14*[51] *Previous RCOG Maternity Standards*[5] *RCPsych 2014*[54] *Annual Report of the Chief Medical Officer, 2014*[45]

4 Vulnerable women

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
4.1.4.2 Mother and baby units should be accredited by the Royal College of Psychiatrists' quality network for perinatal services, and have formal established links with a number of specialised community perinatal mental health teams in their region.	*Local audit*	*Joint Commissioning Panel for Mental Health*[50]
4.1.4.3 Specialised perinatal community mental health teams should be members of the Royal College of Psychiatrists' quality network for perinatal services and should case manage serious mental illness. They should have a formal link with a mother and baby unit.	*Network documentation*	*Joint Commissioning Panel for Mental Health*[50]
4.1.5 A perinatal mental health service which solely offers advice or signposting, whilst the care of the woman is undertaken by a general adult team, does not safeguard the woman's condition.		
4.1.5.1 Community perinatal mental health services should be adequately resourced so that they can provide both senior specialist clinical opinion and undertake the care of women with serious perinatal illness until its resolution.	*Local guidelines* *Risk assessment logs*	*MBRRACE 2015*[42]
4.1.6 Investigations into deaths from psychiatric causes at any stage during pregnancy and the first postnatal year should be multi-agency and involve all the services that cared for the woman.		
4.1.6.1 Mental health services should produce a multidisciplinary report on maternal deaths from psychiatric causes and publicise it widely among mental health staff in order to highlight the messages directly relevant to improving care for pregnant and postpartum women with mental health problems.	*Local yearly report of psychiatric maternal deaths* *Root cause analyses*	*MBRRACE 2015*[42]
4.2 Service standards for the maternity care of women who misuse substances or alcohol.		
4.2.1 Women who misuse alcohol and/or substances should receive multidisciplinary care from a number of agencies who must communicate freely and conscientiously.		

4 Vulnerable women

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
4.2.1.1 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, social workers, health visitors and a perinatal mental health team.	*Local guidelines* *Review of local practice*	*Previous RCOG Maternity Standards*[5]
4.2.1.2 A coordinated care plan with contributions from all agencies involved should be available in a single document through which the woman's progress can be tracked and plans noted for the care of the baby.	*Local documentation*	*NICE Clinical Guideline 110*[49]

4.2.2 Access to appropriate health and social care should be facilitated for women who misuse alcohol and/or substances during pregnancy.

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
4.2.2.1 Commissioners and service providers responsible for the organisation of local antenatal services, should work with local agencies, including social care and third-sector agencies that provide substance misuse services, to coordinate antenatal care by, for example, co-locating services.	*Network policies*	*NICE Clinical Guideline 110*[49]
4.2.2.2 Services must fast-track pregnant women into drug treatment to promote early engagement and achieve progress at the earliest possible stage.	*Local guidelines and case review*	*Department of Health*[55]
4.2.2.3 Pregnant and postpartum women who are substance misusers often have complex social and mental health issues and these women should have easy access to assertive outreach care from specialist addiction and mental health services.	*Network policies*	*MBRRACE 2015*[42]
4.2.2.4 The woman should be offered a named midwife or doctor who has specialised knowledge of, and experience in, and is accountable for, the care of women who misuse substances, and be provided with a direct-line telephone number for the named midwife or doctor.	*Local audit*	*NICE Clinical Guideline 110*[49]

4 Vulnerable women

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
4.2.2.5 The provider should ensure that women who misuse alcohol and drugs have access to specialist breastfeeding advice.	*Local guideline* *Review of local practice*	*Previous RCOG Maternity Standards*[5]

4.3 Service standards for the care of pregnant women subject to, or at risk of, domestic abuse.

4.3.1 A multi-agency partnership should support women who are at risk of, or who experience, domestic abuse.

4.3.1.1 Local authorities, health services (including maternity services) and their strategic partners (including the voluntary and community sectors) should ensure senior officers participate in a local strategic partnership to prevent domestic violence and abuse, along with representatives of frontline practitioners and service users or their representatives.	*Local policy review*	*NICE Clinical Guideline 110*[49] *NICE PH50*[56]
4.3.1.2 There must be a local guideline which is developed jointly with social care providers, the police and third-sector agencies, written by a healthcare professional with expertise in the care of women experiencing domestic abuse, with clear referral pathways.	*Local guideline*	*NICE Clinical Guideline 110*[49]
4.3.1.3 All health professionals caring for women should be aware of the pathway of care once domestic abuse is disclosed, and escalate to senior staff if necessary.	*Local guideline* *Training log*	*NICE Clinical Guideline 110*[49]
4.3.1.4 A named midwife should take responsibility and provide the majority of antenatal care for pregnant women who experience domestic abuse.	*Job description*	*NICE Clinical Guideline 110*[49]

4.3.2 Information and access to support services must be readily available to women at risk.

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
4.3.2.1 There should be clearly displayed information in waiting areas and other suitable places about the support on offer for those affected by domestic violence, modern slavery and abuse. These details should be provided in booking information and hand-held maternity notes.	*Local documentation* *Local review*	*NICE Clinical Guideline 110*[49] *NICE PH50*[56] *Annual Report of the Chief Medical Officer, 2014*[45]
4.3.2.2 An up to date list of sources of support for women, including addresses and telephone numbers, such as social services, the police, support groups and women's refuges must be easily accessible to pregnant women and their carers.	*Local documentation*	*NICE Clinical Guideline 110*[49]

4.3.3 Disclosure of domestic abuse must be encouraged and facilitated.

4.3.3.1 Ensure frontline staff in all services are trained to recognise the indicators of domestic and other abuse and can ask relevant questions to help people disclose their past or current experiences of such violence or abuse.	*Training logs and documentation*	*MBRRACE 2015*[42]
4.3.3.2 Ensure trained staff in antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health, children's and vulnerable adults' services routinely ask service users whether they have experienced domestic violence and abuse.	*Audit*	*NICE Guideline PH50*[56]
4.3.3.3 Facilities and strategies must be in place to ensure that the enquiry should be made in private on a one-to-one basis in an environment where the person feels safe, and in a kind, sensitive manner.	*Local guidelines*	*MBRRACE 2015*[42]

4 Vulnerable women

4.3.4 All agencies involved in the care of pregnant women must learn from serious untoward events resulting from domestic abuse.

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
4.3.4.1 The care of any woman murdered during or up to one year after pregnancy should be subject to multi-agency Domestic Homicide Review or equivalent.	*Serious case reviews*	*Home Office*[57]

4.4 Service standards for vulnerable populations.

4.4.1 Care of pregnant teenagers.

4.4.1.1 Commissioners and service providers should ensure a mostly community based specialist antenatal service for young women aged under 20, using a flexible model of care tailored to the needs of the local population.	*Network policy*	*NICE Clinical Guideline 110*[49]
4.4.1.2 There should be identified specialist midwives and a lead clinician who can guide and oversee the provision of this service.	*Job descriptions*	*Previous RCOG Maternity Standards*[5]
4.4.1.3 Young women aged under 20 should have access to a named midwife, who should take responsibility for and provide the majority of her antenatal care. A direct-line telephone number for the named midwife should be provided.	*Audit*	*NICE Clinical Guideline 110*[49]
4.4.1.4 Healthcare professionals should be given training to ensure they are knowledgeable about safeguarding responsibilities for both the young woman and her unborn baby, and the most recent government guidance on consent for examination or treatment.	*Training documentation and logs*	*NICE Clinical Guideline 110*[49]

4 Vulnerable women

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
4.4.1.5 Young women aged under 20 should have access to information that is suitable for their age – including information about care services, antenatal peer group education or drop-in sessions, housing benefit and other benefits – in a variety of formats.	*Local documentation*	*NICE Clinical Guideline 110*[49]
4.4.2 Women with disabilities.		
4.4.2.1 Local maternity services must ensure that they are inclusive for women with learning disabilities, taking into account their communication, equipment and support needs.	*Local guidelines*	*Department of Health*[52]
4.4.2.2 Local maternity services must ensure that they are inclusive for women with physical disabilities, taking into account their communication, equipment and support needs.	*Local guidelines*	*Department of Health*[52]
4.4.2.3 Services should strive to be innovative and flexible in meeting the needs of women with communication and other disabilities.	*Local guidelines* *Case review*	*Previous RCOG Maternity Standards*[5]
4.4.3 Women under detention or in prison.		
4.4.3.1 Maternity services with asylum seeker accommodation, or a women's prison, in their locality must have in place arrangements to link health care services for expectant women and mothers with newborns in these institutions to local maternity services.	*Local guideline*	*Department of Health*[52]
4.5 Service standards for those at risk of, and survivors of, female genital mutilation (FGM).		
4.5.1 Survivors of FGM should have ready access to high quality multi-agency care.		

4 Vulnerable women

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
4.5.1.1 There should be multiple and clear routes of referral into FGM services, including self referral.	*Local service review*	*Department of Health*[58]
4.5.1.2 In low prevalence areas networks may need to establish 'Hub and Spoke' models of service provision to ensure that women can be cared for by professionals with the appropriate expertise.	*Network policy*	*Department of Health*[58]
4.5.1.3 Access to antenatal de-infibulation should be available to all pregnant women with type 3 FGM.	*Local service review*	*Department of Health*[58]
4.5.1.4 FGM services should have comprehensive links with other specialist services such as psychology and urogynaecology.	*Local service review*	*Department of Health*[58]
4.5.2 **FGM services will provide patients with high quality health care, and the opportunity to consider the need for safeguarding any women and girls in the family unit, and to initiate a suitable multi-agency response, including the police and social services.**		
4.5.2.1 All acute trusts/health boards should have a designated consultant and midwife responsible for the care of women with FGM.	*Job plans*	*RCOG Green-top Guideline 53*[59]
4.5.2.2 All services should be designed following consultation with patient groups and local community groups. Where possible, ongoing involvement should be built into the service assurance model to ensure it remains fit for purpose.	*Minutes of service meetings*	*Department of Health*[58]
4.5.2.3 FGM services must be designed to meet both the physical and mental health needs of a woman with FGM.	*Local service review*	*Department of Health*[58]

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
4.5.2.4 FGM services must perform a safeguarding assessment of the woman or girl, and the children of the patient, and consideration should be given to other children within the family unit.	*Local service review* *Local audit*	*Department of Health*[58]
4.5.2.5 Written information should be available to all women attending the clinic. This should contain information about the clinic and staff as well as basic information about the health risks and legal status of FGM.	*Written documentation*	*Department of Health*[58]
4.5.2.6 Contact details for the Trust/ Health Board safeguarding lead must be available in the clinic.	*Local service review*	*Department of Health*[58]
4.5.2.7 Peer support is of benefit and contact details should be offered of any local community groups as well as national groups such as FORWARD and Daughters of Eve.	*Written documentation*	*Department of Health*[58]
4.5.3 Education of health care workers about FGM is mandatory, and learning should be facilitated by review and audit of local services.		
4.5.3.1 FGM services must complete the mandatory Department of Health FGM Enhanced Dataset return.	*Data review*	*Department of Health*[58]
4.5.3.2 FGM services should record and audit FGM referrals and de-infibulation procedures.	*Local audit*	*Department of Health*[58]
4.5.3.3 All gynaecologists, obstetricians and midwives should receive mandatory training on FGM and its management, including the technique of de-infibulation. They should complete the programme of FGM e-modules developed by Health Education England.	*Local training lists* *Consultant appraisals*	*RCOG Green-top Guideline 53*[59]

5 Medical complexity

5.1 Access to specialised care.

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
5.1.1 All women should have a comprehensive risk assessment at booking.	*Local guideline*	*NICE Quality Standard 22*[47]
5.1.2 All women with a pre-pregnancy medical diagnosis should be reviewed by an experienced physician (obstetric or specialty) before 20 weeks gestation if they: a) Are attending a physician pre-pregnancy. b) Have received pre-pregnancy counselling from a physician prior to pregnancy. c) Have been recently discharged from a general medicine service. d) Have an unplanned pregnancy. e) Have noticed any change in their medical problem since becoming pregnant.	*Local guideline and audit*	*MBRRACE 2014*[46]
5.1.3 Maternity services must identify women who need to be seen more urgently than this and have guidelines and capacity to facilitate rapid review.	*Local guideline and audit*	*NICE Quality Standard 109*[60]
5.1.4 Maternity networks should develop care pathways to provide optimal care and advice for pregnant women with medical disorders as close to home as possible. These pathways should acknowledge the need for the centralisation of some aspects of maternity care for these women.	*Network pathways*	*MBRRACE 2014*[46] *Group consensus*

5 Medical complexity

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
5.1.5 Fully trained specialists should be involved in the decision making surrounding the care of pregnant women with medical problems who require inpatient care. Decisions may include the location of care and the means and timing of inter- or intra-hospital transfer.	*Case review*	*MBRRACE 2014*[46]
5.1.6 Clear and efficient pathways must be in place for women wishing to safely discontinue their pregnancies if the decision is made on maternal health grounds.	*Local and network guidelines*	*Group consensus*
5.2 Multidisciplinary working.		
5.2.1 Providers of maternity services should only commission services which ensure the development and maintenance of expertise in caring for pregnant women with medical disorders.	*Job plans* *CPD documentation and logs*	*MBRRACE 2014*[46]
5.2.2 Care for women with suspected or confirmed medical disorders will be provided by a multidisciplinary team, co-ordinated by a consultant obstetrician with a special interest in maternal medicine (MM), or a subspecialist in maternal fetal medicine (MFM).	*Job plans* *Case review and audit*	*Group consensus*
5.2.3 A specialist Maternal Medicine centre is one staffed by at least two subspecialist consultants who provide care for women with medical disorders in collaboration (and co-located) with other specialist services. The service will have specialist midwifery support. Women will be seen jointly by a subspecialist in MFM and a consultant from the relevant medical subspecialty, who has an interest and expertise in pregnancy. They will be seen in a maternal medicine clinic (a joint obstetrics/medical clinic run by an obstetrician and a physician).	*Job plans* *Network services review*	*Group consensus*

5 Medical complexity

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
5.2.4 It is acknowledged that smaller maternal medicine units (staffed by obstetricians with a special interest in maternal medicine) may provide elements of specialised care. Where an organisation provides specialised maternal medicine services these must be compliant with standards which have been discussed and agreed at a network level, and there must be a named consultant with expertise in maternal medicine.	*Job plans* *Network guidelines*	*Group consensus*
5.2.5 An obstetrician with a special interest in maternal medicine will have completed the maternal medicine Advanced Training Skills Module (ATSM) and will be expected to show ongoing professional development in this field with regular attendance at network multidisciplinary and educational meetings. They will be expected to have at least one session each week dedicated to this special interest, even when they have a resident consultant contract.	*Consultant CVs* *Job plans* *Consultant appraisal documentation*	*Group consensus*
5.2.6 Service providers should only offer care to women with medical disorders when they have both the expertise and continued regular exposure to the medical disorder to ensure a safe high quality service.	*Network policy and guideline*	*MBRRACE 2014*[46]
5.2.7 Maternity services for women with medical disorders should be truly multiprofessional and multidisciplinary, with clinic structures designed to minimise the number of separate appointments needed and to maximise communication and learning between specialties and professional groups.	*Descriptions of local teams, clinic structures and job plans*	*MBRRACE 2014*[46]
5.2.8 The care of women with medical disorders during pregnancy should follow national guidance and be the subject of regular audit.	*Local guidelines* *Local audit*	*Group consensus*
5.2.9 Each woman should receive the support and advocacy of a known midwife throughout their pregnancy to help promote the normal aspects of pregnancy and birth as well as supporting and advocating for her through the variety of services she is being offered.	*Case review*	*Previous RCOG Maternity Standards*[5]

5 Medical complexity

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
5.2.10 Participation of maternal medicine services in national audit systems is expected, in order to facilitate collection of detection rates and to aid learning from rare disorders and their interaction with pregnancy.	*Evidence of UKOSS returns*	*Group consensus*
5.3 Postnatal care for women with medical problems.		
5.3.1 Women who develop medical complications during pregnancy, or who have ongoing medical disorders, should be reviewed by a senior obstetrician prior to discharge, with a clear plan for the postnatal period. This review should include input from all relevant colleagues.	*Case audit*	*MBRRACE 2015*[42]
5.3.2 Targeted follow up must take place for women with complex medical needs, to ensure that the expected recovery has occurred and that the need for any on-going care is being met. A single individual should take a leadership role in this respect.	*Case audit*	*NICE Clinical Guideline 37*[61]
5.3.3 The senior obstetrician should provide a comprehensive summary of the maternity care episode, including follow-up arrangements, to the GP who should be responsible for co-ordinating care after discharge from the maternity service.	*Case audit*	*MBRRACE 2015*[42]
5.4 Learning from maternal deaths.		
5.4.1 Investigations into maternal deaths where a woman had a pre-existing medical problem at any stage during pregnancy, or the first postnatal year, should be multi-agency and involve all the services that cared for the woman.	*Serious incident reviews*	*MBRRACE 2015*[42]

6 Inpatient care

6.1 Women who are inpatients should experience coordinated care underpinned by clear and accurate information exchange between relevant health and social care professionals.

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
6.1.1 The provider should ensure that an SBAR (Situation, Background, Assessment, Recommendation) tool is used to improve communication between staff.	*Local audit*	*RCOG Good Practice 12*[62]
6.1.2 A tool should be used to improve and standardise handover between teams (e.g. the SHARING tool –Staff, High risk, Awaiting theatre, Recovery ward, Inductions, Neonatal unit, Gynaecology).	*Local audit*	*RCOG Good Practice 12*[62]
6.1.3 The consultant obstetrician on-call should be told about all sick pregnant women who have been admitted to hospital, whether they have a medical or an obstetric problem.	*Local audit*	*Previous RCOG Maternity Standards*[62]
6.1.4 All inpatients should be reviewed on a daily basis by a clinical team with the appropriate competencies and experience.	*Local audit*	*Group consensus*
6.1.5 All emergency admissions must be seen and have a thorough clinical assessment by a consultant with the appropriate competencies as soon as possible, according to the woman's clinical condition, and at the latest within 14 hours from the time of arrival at hospital.	*Local audit*	*NHS England*[63]

6 Inpatient care

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
6.1.6 A system of clear regional and local 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.	*Local referral guidelines* *Local audit*	*Previous RCOG Maternity Standards*[5]
6.1.7 Women whose pregnancies are complicated by pre-existing medical conditions must receive appropriate multidisciplinary care whilst also promoting normality.	*Documentary evidence of multidisciplinary joint clinics*	*Previous RCOG Maternity Standards*[5]
6.1.8 Providers should ensure that staff have adequate training and assessment of their critical care competencies.	*Review of training records*	*OAA standards*
6.1.9 Providers of obstetric services must ensure that there is at least one midwife/health professional available on each shift to deliver maternal enhanced care to women in need.	*Local audit*	*OAA standards*
6.1.10 Providers should ensure that specific Obstetric Early Obstetric Warning Scores (ObsEWS) should be used for all to support early recognition and treatment of the acutely ill woman.	*Local audit*	*OAA standards*
6.1.11 There must be guidelines for referral to intensive care and high-dependency units.	*Local referral guidelines*	*RCOG Safer Childbirth*[28] *OAA standards*
6.1.12 High-dependency care should be available on or near the labour ward, with appropriately trained staff. If unavailable, there should be general high-dependency facilities within the same hospital.	*Local guidelines* *Local governance documents*	*RCOG Safer Childbirth*[28] *OAA standards*

6 Inpatient care

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
6.1.13 All women on high dependency areas should be seen and reviewed by a consultant twice daily.	*Local guidelines* *Local audit*	*NHS England*[63] *OAA standards*
6.1.14 All obstetric, anaesthetic and midwifery staff should have training in cardiopulmonary resuscitation.	*Local training records*	*RCOG Safer Childbirth*[63] *OAA standards*
6.1.15 Access to Level 3 critical care must be available for all obstetric patients and preferably available on site. Portable monitoring with the facility for invasive monitoring must be available to facilitate safe transfer of obstetric patients to the ICU.	*Service review*	*RCoA*[64] *OAA standards*

7 Elective birth

7.1 Service standards for planned birth prior to spontaneous onset of labour: induction of labour.

7.1.1 Decisions made regarding induction of labour should be made in partnership with the woman.

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
7.1.1.1 The discussion and offer regarding induction of labour should be with a healthcare provider who is capable of an individualised approach and takes into account relative maternal and newborn risks, practice environment, patient preferences, and the alternatives to induction.	*Local audit* *Documentation*	*NICE Clinical Guideline 190*[65]
7.1.1.2 Maternity services should provide written information to women who are offered induction of labour, regarding the process involved.	*Written information*	*NICE Clinical Guideline 70*[66]

7.1.2 Women being offered induction of labour should be able access urgent obstetric and neonatal care.

7.1.2.1 Providers offering induction of labour should follow evidence based guidelines which set out indications and methods, and provide clinical guidelines for women being induced in particular circumstances, for example previous caesarean birth.	*Local review*	*NICE Clinical Guideline 70*[66]
7.1.2.2 Services providing induction of labour must offer a full range of pain relief options for labour.	*Local review*	*NICE Clinical Guideline 70*[66]

7 Elective birth

7.1.3 The service should be continuously reviewed including implementation of a maternity dashboard.

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
7.1.3.1 Services should have quality assurance programs and induction policies, including safety tools such as checklists, to ensure that inductions are performed only for acceptable indications.	*Local guidelines and paperwork*	*Society of Obstetricians and Gynaecologists of Canada*[67]
7.1.3.2 Services should continuously collect and review data regarding rates and gestations for induction of labour and should consider including this information on their maternity dashboard.	*Continuous audit*	*Group consensus*
7.1.3.3 Services must perform an ongoing audit of the proportion of women who have their induction of labour delayed beyond the original date planned and include this information on their maternity dashboard.	*Rolling audit* *Maternity dashboard*	*Group consensus*
7.1.3.4 Providers must learn from poor outcomes and near misses occurring during induction of labour.	*Risk register* *Serious untoward/high level investigations*	*Group consensus*

7.2 Service standards for planned birth prior to spontaneous onset of labour: elective caesarean section (CS).

7.2.1 Pre-operative decision making and assessment.

7 Elective birth

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
7.2.1.1 The provider must ensure that every woman has the option to discuss options for birth and the pros and cons of different modes of delivery prior to the birth, and with a healthcare provider who is appropriately trained to provide up-to-date and evidence-based non-directive information and counselling. Written information should be available to support this. Addressing women's views and concerns should be recognised as being integral to the decision making process.	*Local audit of notes*	*NICE Quality Standard 32*[68]
7.2.1.2 Decisions for elective caesarean section should be made, or at the very least agreed, by a consultant, fully trained specialist, or advanced obstetrics trainee with the appropriate competencies.	*Local audit of notes*	*Group consensus*
7.2.1.3 A point of contact in the hospital must be identified, and their number provided to women who have a planned caesarean section, so that women can access further information, or have ongoing anxieties about the procedure addressed in advance of the day of the surgery.	*Written information given to women*	*Group consensus*
7.2.1.4 Women with significant co-morbidities should have the opportunity to meet an anaesthetist with the appropriate competencies pre-operatively for additional assessment.	*Local audit*	*AAGBI &OAA*[69]
7.2.1.5 The service must provide the option of external cephalic version for women with a persistent breech presentation.	*Local guidelines and ECV services*	*NICE Quality Standard 32*[68]
7.2.1.6 A clear pathway and guideline must be in place for women requesting caesarean section in the absence of a well-defined medical indication.	*Local guidelines*	*NICE Quality Standard 32*[68]

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
7.2.1.7 Pregnant women having a planned caesarean who are at particular risk of major obstetric haemorrhage, should have this carried out on a maternity unit with on-site blood transfusion services.	*Review of local provision*	*NICE Quality Standard 32*[68]
7.2.1.8 All hospitals should have a locally agreed protocol for managing morbidly adherent placenta that sets out how these elements of care should be provided. Small hospitals should have clear pathways of referral for women with suspected morbid adherence for them to have further investigation and management in larger tertiary units.	*Local guidelines and audit*	*NICE Quality Standard 32*[68]
7.2.2 The environment		
7.2.2.1 Women should normally be admitted on the day of the surgery and should be made at ease by a welcoming environment, space for accompanying relative(s) to wait with her and privacy when being seen pre-operatively by the anaesthetist or obstetrician and being prepared for theatre.	*Review of local services*	*Group consensus*
7.2.2.2 There should be an identified member of the midwifery staff who will prepare the woman for theatre, and explain the process.	*Review of local services*	*Group consensus*
7.2.2.3 There must be an opportunity for both the anaesthetic and obstetric teams to meet the woman in advance of the completion of the WHO surgical safety checklist so that notes can be reviewed, introductions made and consent confirmed.	*Review of local services*	*Group consensus*
7.2.2.4 The theatre and its equipment should conform to the guidelines set out by the OAA.	*Review of local services*	*AAGBI & OAA*[69]

7 Elective birth

7.2.3 Staffing issues.

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
7.2.3.1 The service must provide an appropriately trained obstetrician to perform the surgery, as defined by the RCOG curriculum.	*Local audit*	*Group consensus*
7.2.3.2 An ST3 trainee, or below, should only perform an elective caesarean section when there is immediate access to the help and support from an advanced trainee who has the appropriate competencies, or a consultant.	*Staffing rotas and critical incident review* *Trainee feedback*	*Group consensus*
7.2.3.3 The provider must provide sufficient nursing and midwifery staff to perform the elective caesarean section safely, and sufficient assistants must be available.	*Staffing rotas*	*AAFP*[70]
7.2.3.4 Scheduled obstetric anaesthetic activities (e.g. elective caesarean section clinics) require additional consultant sessions over and above the 12 for emergency cover.	*Anaesthetic rotas*	*AAGBI & OAA*[69]
7.2.3.5 There must be separate provision of staffing and resources to enable elective work to run independently of emergency work, in particular to prevent delays to both emergency and elective procedures and provision of analgesia in labour.	*Local review and audit of theatre delays and cancellations*	*AAGBI & OAA*[69] *RCoA*[64]
7.2.3.6 An appropriately trained practitioner skilled in the resuscitation of the newborn should be present at CS performed under general anaesthesia or where there is evidence of fetal compromise.	*Local audit*	*NICE Quality Standard 32*[68]

7 Elective birth

7.2.4 Post-operative care.

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
7.2.4.1 A local guideline should be in place, and adhered to, with respect to routine observations required following elective caesarean section.	*Local guideline and audit*	*NICE Clinical Guideline 132*[71]
7.2.4.2 High dependency care should be accessible for women unexpectedly requiring more intensive care following caesarean birth, with transfer protocols in place if this necessitates movement to an alternative site or hospital.	*Service review* *Critical incident review* *Transfer protocols*	*NICE Quality Standard 32*[68]
7.2.4.3 Enhanced recovery pathways should be established and audited on a regular basis.	*Local guideline*	*Group consensus*
7.2.4.4 While women are in hospital after having a CS, give them the opportunity to discuss with healthcare professionals the reasons for the CS and provide both verbal and printed information about birth options for any future pregnancies. If the woman prefers, provide this at a later date.	*Local audit*	*NICE Quality Standard 32*[68]

7.2.5 Reviewing the service.

7.2.5.1 Providers should continuously collect data on elective caesarean section rates, indications, the proportion performed before 39+0 weeks gestation, and the number delayed from the original planned date. Aspects of this information should be reviewed on a regular basis, for example through a maternity dashboard, and trends noted and acted upon where necessary.	*Maternity dashboard*	*Group consensus*

8 Intrapartum care

8.1 Choice of birth setting.

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
8.1.1 Commissioners and service providers should ensure that all four birth settings are available to all low-risk women (in the local area or in a neighbouring area).	*Network review*	*NICE Quality Standard 105*[72]
8.1.2 Providers should ensure that women are given unbiased information about the benefits and risks associated with each option of birth setting, including statistics and transfer rates, for all local birth settings, to support them to make an informed decision.	*Review of local practice/ literature*	*NICE Quality Standard 105*[72]
8.1.3 Women should have access to information in formats appropriate to their needs about all types of analgesia and anaesthesia available, including information about related complications.	*Review of local practice/ literature*	*RCoA*[64]
8.1.4 Providers should ensure there is easy access to at least one fully equipped and staffed obstetric theatre within the labour ward at all times for women in labour.	*Local review*	*AAFP*[70] *RCoA*[64]
8.1.5 Facilities in all birth settings should be of an appropriate standard and take account of the woman's needs and the views of the service users.	*User satisfaction survey*	*RCOG Safer Childbirth*[28]

8 Intrapartum care

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
8.1.6 Neonatal Operational Delivery Networks, or equivalent, must define what levels of neonatal care can be provided within each provider of maternity care, and ensure transfer and repatriation protocols are in place.	*Neonatal network (ODN or equivalent) policy*	*RCOG Safer Childbirth*[28] *BAPM*[73] *BAPM*[74]
8.1.7 When women are making choices, they should be aware of neonatal and paediatric expertise/ support available in the various birth settings.	*Review of local practice/ literature*	*BAPM*[73] *BAPM*[74]
8.1.8 All providers of maternity services should ensure that both environmental temperatures as well as practices are optimsed in all birthing facilities (e.g. operating theatres) to ensure normal temperatures of newborns.	*Audit of environmental temperature logs* *Audit/Review of cases of newborn hypothermia*	*Group consensus*
8.2 Transfer of care.		
8.2.1 Commissioners and service providers should ensure that there are robust protocols in place for transfer of care between settings, including when crossing provider boundaries, or if the nearest obstetric or neonatal unit is closed to admissions, or the local midwifery unit is full.	*Network policy and audit*	*NICE Quality Standard 105*[72]
8.2.2 There should be local service level agreements with the ambulance service for attendance at emergencies, or when transfer is required.	*Local guidelines*	*RCOG Safer Childbirth*[28]
8.2.3 There should be clear local guidance for transfer to high dependency units (HDUs) or to intensive care units (ICUs) and easy access to these units for all women in labour	*Local guidelines*	*RCOG Safer Childbirth*[28]

8 Intrapartum care

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
8.2.4 Women should be informed in advance about the possibility of needing to transfer care during her pathway.	*Local guidelines*	*Group consensus*
8.2.5 Local standards should be in place regarding the transfer of women.	*Local guidelines*	*Previous RCOG Maternity Standards*[5]
8.3 **Clinical leadership and accountability.**		
8.3.1 Every maternity unit should have a labour ward management lead midwife who is responsible for resource management and ensuring a quality service.	*Job description and local review*	*RCOG Safer Childbirth*[28]
8.3.2 Each labour ward must have a rota of experienced senior midwives as labour ward shift co-ordinators, supernumerary to the staffing numbers required for one-to-one care.	*Local rotas*	*RCOG Safer Childbirth*[28]
8.3.3 There should be one supervisor of midwives to every 15 midwives.	*Staffing lists*	*RCOG Safer Childbirth*[28]
8.3.4 Every NHS organisation should identify a consultant obstetrician to fulfil the role of lead consultant obstetrician on the labour ward who will have responsibility for organisation, standard setting and audit, with formal recognition in their job plan.	*Job plans*	*RCOG Safer Childbirth*[28]
8.3.5 Each obstetric unit should have a nominated consultant in charge of obstetric anaesthesia services with programmed activities (PAs) allocated for this, in addition to direct clinical care PAs.	*Job plans*	*RCoA*[64]

8 Intrapartum care

8.4 Clinical governance.

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
8.4.1 Governance structures should include, as a minimum, a governance operational lead, a senior executive team member, midwifery (including a supervisor of midwives), obstetric, anaesthetic and neonatal expertise, and adequately supported user representation.	*Local governance structures and core members*	*NICE Clinical Guideline 190*[65]
8.4.2 A labour ward forum, or equivalent, should meet at least every three months and be chaired by the leads for midwifery and obstetrics and have neonatal/ paediatric services input.	*Audit of minutes*	*RCOG Safer Childbirth*[28]
8.4.3 Comprehensive evidence-based guidelines, protocols and standards for intrapartum care should be agreed by the labour ward forum or equivalent, ratified by the maternity risk management group and reviewed at least every three years.	*Local guidelines procedure and review of age and content*	*RCOG Safer Childbirth*[28]
8.4.4 The standard of record keeping and storage of data should be clear, rigorous and precise.	*Local audit*	*RCOG Safer Childbirth*[28]
8.4.5 All members of the maternity team should have access to computerised documentation systems at a level appropriate to their role which uses recognised and acceptable programmes.	*Local review*	*Local review*
8.4.6 Past guidelines and protocols should be dated and archived in case they are needed for reference at a later date.	*Guidelines procedure*	*RCOG Safer Childbirth*[28]

8 Intrapartum care

8.5 Learning and improving by audit and review.

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
8.5.1 A maternity risk management group should meet at least every month.	*Minutes of meetings*	*Group consensus*
8.5.2 There should be a written risk management policy, including trigger incidents for risk and adverse incident reporting.	*Local policy review*	*RCOG Safer Childbirth*[28]
8.5.3 There should be evidence of multiprofessional input into reviews of critical incidents.	*Audit of critical incident reviews*	*RCOG Safer Childbirth*[28]
8.5.4 There should be an evaluation of midwifery and obstetric care through continuous prospective audit to improve outcomes, which is published as an annual report.	*Continuous audit* *Maternity dashboard*	*RCOG Safer Childbirth*[28]
8.5.5 The audit process should involve user groups and a user satisfaction survey.	*User satisfaction survey*	*HQIP Clinical Audit Guide 2015*[75]
8.5.6 All birth settings should audit childbirth outcomes, evaluating annually linked clinical care, any changes or trends.	*Participation in local and national audits*	*RCOG 2008*[5]

8 Intrapartum care

8.6 Staffing.

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
8.6.1 Midwifery staffing levels should be 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 WTE midwives to woman).	*Local statistics*	*RCOG Safer Childbirth*[28]
8.6.2 Women in established labour should receive one-to-one care from a midwife.	*Local review*	*NICE Quality Standard 105*[72]
8.6.3 A consultant obstetrician should be available to attend a woman within 30 minutes outside the required hours of consultant presence.	*Local audit* *Critical incident review*	*RCOG Safer Childbirth*[28]
8.6.4 The anaesthetic and theatre team's response time should be such that a caesarean section may be started within a time appropriate to the clinical condition.	*Local audit*	*RCOG Safer Childbirth*[28]
8.6.5 Outside the locally recommended minimum specified hours of consultant obstetrician presence on the labour ward, 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.	*Job plans*	*RCOG Safer Childbirth*[28]
8.6.6 Complicated births in obstetric units should be attended by a consultant obstetrician. Units should have guidelines specifying which clinical scenarios a consultant should be present at.	*Unit guidelines and audit*	*NICE Clinical Guideline 190*[65]
8.6.7 Junior medical staff (obstetricians, anaesthetists and paediatricians) of appropriate competencies, as determined by College curricula, and the type of maternity unit, should be immediately available on the labour ward	*Critical incident review* *Medical rotas*	*BAPM*[73] *BAPM*[74]

8 Intrapartum care

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
8.6.8 Junior doctor rotas should incorporate a formal verbal and written handover from one team to another.	*Medical rotas* *Local audit*	*RCOG Safer Childbirth*[28]
8.6.9 A duty anaesthetist must be immediately available for emergency work on the delivery suite 24 hours a day and there should be a clear line of communication from the duty anaesthetist to the supervising consultant at all times.	*Medical rotas*	*RCoA*[64]
8.6.10 The staffing of the anaesthetic team should allow response times for emergency caesarean section to be appropriate to the clinical condition.	*Local audit*	*RCOG Safer Childbirth*[28]
8.6.11 Anaesthetic staffing levels should ensure that the duty anaesthetist for labour ward is not primarily responsible for elective obstetric work or solely responsible for the ICU or cardiac arrests.	*Rota review*	*RCOG Safer Childbirth*[28] *AAGBI & OAA*[69]
8.6.12 Units providing neonatal care must be appraised against and meet BAPM staffing standards.	*Local review of rotas and training logs*	*BAPM*[73] *BAPM*[74]
8.6.13 The provider should ensure that a professional (midwife, neonatal nurse, advanced neonatal nurse practitioner (ANNP), paediatrician) trained and regularly assessed as competent in neonatal basic life support must be immediately available for all births, in any setting.	*Local audit and critical incident review* *Training logs*	*BAPM*[74]
8.6.14 In a hospital setting, there must be immediate, on-site availability of clinicians (doctors, ANNPs or midwives) with advanced neonatal life support skills.	*Local audit* *Critical incident review*	*RCOG Safer Childbirth*[28]

8 Intrapartum care

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
8.6.15 There must be 24-hour availability in obstetric units of senior paediatric nurse or medical practitioners who are trained and assessed as competent in neonatal advanced life support who are able to attend within 10 minutes.	*Local audit* *Critical incident review*	*RCOG Safer Childbirth*[21]
8.6.16 There must be 24-hour availability in obstetric units of a consultant paediatrician or neonatologist (or equivalent SAS grade) trained and assessed as competent in neonatal advanced life support who are able to attend within 30 minutes.	*Local audit* *Critical incident review*	*RCOG Safer Childbirth*[28]
8.6.17 There should be standardised operational policies for when more senior paediatric support should be requested by junior doctors and nurse practitioners attending births.	*Local guidelines*	*RCOG Safer Childbirth*[28]
8.6.18 There should be a suitably-trained senior member of either nursing, midwifery or operating department practitioner staff who has responsibility for the safe running of obstetric theatres.	*Job specifications*	*RCOG Safer Childbirth*[28]
8.6.19 Women in labour who require anaesthesia have the right to the same standards of peri-operative care as other surgical patients. Skilled anaesthetic assistance and post-anaesthetic recovery care are of particular importance in obstetrics.	*Review of composition of elective and emergency obstetric theatre teams*	*AAFP*[70] *RCoA*[64]
8.6.20 Employers must ensure that maternity care assistants have received accredited training for the appropriate competencies expected of them.	*Job specifications and training logs*	*RCOG Safer Childbirth*[28]
8.6.21 A ward clerk, or receptionist, should be available at all times on labour ward.	*Rotas*	*RCOG Safer Childbirth*[28]

8 Intrapartum care

8.7 Communication across the multi-disciplinary maternity team.

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
8.7.1 There should be a clear line of communication from the duty obstetrician and coordinating midwife to the supervising consultant at all times. Consultant support and on-call availability are essential 24 hours per day.	*Local policy*	*RCOG Safer Childbirth*[28] *RCoA*[64]
8.7.2 There should be a clear line of communication from the duty anaesthetist to the supervising consultant at all times, and consultant support and on-call availability are essential 24 hours per day.	*Local policy*	*RCOG Safer Childbirth*[28] *RCoA*[64]
8.7.3 There should be a clear line of communication between the duty anaesthetist, theatre staff and ODP/N once a decision is made to undertake an emergency caesarean section.	*Local policy*	*RCoA*[64]
8.7.4 Guidelines should be available to obstetricians and midwives on conditions requiring antenatal referral to the anaesthetist.	*Local guidelines*	*RCoA*[64]
8.7.5 There should be clear guidelines available for whom to call if two emergencies occur simultaneously.	*Local guidelines* *Critical incident review*	*Group consensus*
8.7.6 There should be regular channels of communication between labour ward and the neonatal/paediatric service and between postnatal wards and the neonatal/paediatric service with regular meetings scheduled (at least quarterly) with multidisciplinary input to review practice and facilitate improvements in patient care.	*Annual review of Local SOPs, protocols* *Quaterly review of relevant adverse events and complaints* *Quarterly review of meeting minutes and action plans*	*Group consensus*

8 Intrapartum care

8.8 Training.

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
8.8.1 There should be regular multiprofessional development and training, including obstetric and neonatal resuscitation and emergencies, and CTG interpretation, by all who are involved in intrapartum care of the woman and her baby. This training and development should occur in realistic settings.	*Skills drills training registers* *Registers of other multidisciplinary training*	*RCOG Safer Childbirth*[28] *NICE Clinical Guideline 190*[65] *RCoA*[64]
8.8.2 Each obstetric unit with an anaesthetic service should have a nominated consultant anaesthetist responsible for a training programme in obstetric anaesthesia.	*Job plans*	*RCoA*[64]
8.8.3 New staff, including locum staff, and those returning from a period of absence, should undergo an induction programme, relevant training and on the job support to ensure their competence.	*Induction programmes and registers*	*RCOG Safer Childbirth*[28]
8.8.4 Midwifery and medical trainers should have these training roles recognized in their job plans and be appraised on a regular basis to ensure they are fulfilling these roles.	*Job plans and appraisal evidence*	*Group consensus*

9 Postnatal care

9.1 Commissioners and service providers must attach sufficient importance to securing high quality neonatal and postnatal care in order to give women and their babies the best start in family life.

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
9.1.1 Secondary care providers should provide data on postnatal systems, processes and outcomes through a robust maternity dataset.	*Maternity Dashboard*	*Annual Report of the Chief Medical Officer, 2014*[45]
9.1.2 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 whether in the community or a clinical unit.	*Audit of care plans* *Feedback*	*Previous RCOG Maternity Standards*[5]
9.1.3 Commissioners and service providers should ensure that they commission services that offer a review of the woman's physical, emotional and social wellbeing by the coordinating healthcare professional at the end of the postnatal period (6-8 weeks).	*Local audit*	*Group consensus*
9.1.4 Physical examination and screening of the newborn should be arranged according to national guidance postnatal care guidelines.	*Local audit* *Review of adverse incidents/ any misses*	*RCOG Safer Childbirth*[28] *NICE Clinical Guideline 37*[61]
9.1.5 Commissioners and service providers must ensure that systems are in place to provide women and their babies with an individualised postnatal care plan, which is reviewed and documented at each postnatal contact. This care plan should be developed with the woman, ideally in the antenatal period or as soon as possible after birth.	*Local audit*	*NICE Quality Standard 37*[61]

9 Postnatal care

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
9.1.6 Follow up appointments should be arranged with the appropriate services before the women is discharged and not left to the general practitioner to arrange.	*Local policy* *Local audit*	*MBRRACE 2015*[42]
9.1.7 Women with complex medical problems require additional care following delivery and discharge from hospital. There is a need for senior review prior to discharge, with a clear plan for the postnatal period. This review should include input from obstetricians and all relevant clinicians where appropriate.	*Local policy* *Local audit*	*MBRRACE 2015*[42]
9.1.8 Where a woman remains in hospital following delivery, her postnatal care plan should be reviewed on a daily basis until her transfer home, and then reviewed at each subsequent contact.	*Local policy*	*Group consensus*
9.1.9 Local or national checklists should be used at each postnatal visit/check to ensure that all potential health and social needs are considered and addressed.	*Local audit*	*Group consensus*
9.1.10 Providers of postnatal care must have, and follow, a series of comprehensive clinical guidelines, decided locally but based on national guidance.	*Local policy* *Local audit*	*Group consensus*
9.1.11 Commissioners and service providers must ensure that systems are in place for women with a BMI of 30 kg/m^2 or more at the 6–8 week postnatal check to be offered a referral for advice on healthy eating and physical activity.	*Local policy* *Local audit*	*Group consensus*
9.1.12 Commissioners and service providers must ensure that providers of neonatal and transitional care make adequate provision for accommodation for parents.	*Local audit*	*NHS England*[76]

9 Postnatal care

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
9.1.13 Providers must have guidelines for the postnatal care of women who have babies being cared for on the neonatal unit.	*Local guidelines*	*Group consensus*

9.2 Maternity services should ensure smooth transition between midwifery, obstetric and neonatal care, and ongoing care in the community from their GP and health visitor.

9.2.1 A comprehensive summary by the senior obstetrician of the maternity care episode should be sent to the GP who should be responsible for co-ordinating care after discharge from maternity services.	*Local policy* *Local audit*	*MBRRACE 2015*[42]
9.2.2 There should be local protocols about written communication, in particular about the transfer of care between clinical services and healthcare professionals.	*Local protocols*	*NICE Clinical Guideline 37*[61]
9.2.3 Healthcare professionals should use hand-held maternity records, the postnatal care plans and personal child health records, to promote communication with women.	*Local audit*	*NICE Clinical Guideline 37*[61]
9.2.4 Where a woman suffers a pregnancy or birth related trauma, there should be a multi-professional de-brief and handover between labour and postnatal care, and her personalised care plan should be updated in discussion with the woman to ensure that her physical, psychological and emotional needs are met.	*Local policy*	*National Maternity Review*[8]

9 Postnatal care

9.3 Safeguarding standard.

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
9.3.1 Women should be offered an opportunity to talk about their birth experiences and to ask questions about the care they received during labour.	*Local audit* *Local policy*	*NICE Clinical Guideline 37*[61]

9.4 Women should be offered relevant and timely information to enable them to promote their own and their babies' health and well-being and to recognise and respond to problems.

9.4.1 All women should be given written information either on admission to the post-natal ward or at discharge.	*Local policy*	*NICE Clinical Guideline*[61]
9.4.2 At each postnatal contact, parents should be offered information and advice to enable them to: • Assess their baby's general condition. • Identify signs and symptoms of common health problems seen in babies. • Contact a healthcare professional or emergency service if required.	*Local audit* *Feedback*	*NICE Clinical Guideline 37*[61]
9.4.3 Women should be offered information and reassurance on: • The physiological process of recovery after birth (within the first 24 hours). • Normal patterns of emotional changes in the postnatal period and that these usually resolve within 10–14 days of giving birth (within three days). • Common health concerns as appropriate (weeks 2–8).	*Local policy* *Local audit*	*NICE Clinical Guideline 37*[61]
9.4.4 Women should be provided with contact phone numbers, enabling them to readily access advice and reassurance at all times and signposting them to local groups and community support structures.	*Local policy* *Local audit*	*NICE Clinical Guideline*[61]

9 Postnatal care

9.5 Postnatal complications.

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
9.5.1 Service providers should monitor and report postnatal readmission rates for women and infants.	*Readmission rates of babies within one month of birth*	*Annual Report of the Chief Medical Officer, 2014*[45]
9.5.2 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.	*Local policy* *Local audit*	*Previous RCOG Maternity Standards*[5]
9.5.3 Local maternity systems need to be organised to support midwives to identify and respond to complications, including ongoing hypertension, deep vein thrombosis, developing sepsis of mother and baby and postnatal mental health concerns.	*Local policy*	*National Maternity Review*[8]
9.5.4 Women with potentially life threatening conditions should be cared for by health care professionals with expertise in this area.	*Local policy* *Local audit*	*NICE Clinical Guideline 37*[61]
9.5.5 Targeted follow up must take place for women with complex medical needs, to ensure that the expected recovery has occurred and that the need for any on-going care is being met. A single individual should take a leadership role in this respect.	*Local policy* *Job plans* *Local audit*	*MBRRACE 2015*[42]
9.5.6 Policy makers and service planners should ensure that there are no barriers in place that prevent clinicians seeking directly the advice and/or involvement of experts in other specialties for women with multiple morbidities, particularly on discharge from maternity care. Email dialogue between GPs and appropriate consultants should be straightforward, rapid and universally available.	*Local policy* *Job plans* *Local audit*	*MBRRACE 2015*[42]

9 Postnatal care

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
9.5.7 If the woman is under maternity team care and she has had a complicated birth, she should be reviewed on a daily basis by the obstetric team until they transfer her back to midwife care.	*Local policy*	*Group consensus*
9.5.8 Women should be provided with contact phone numbers, enabling them to readily access postnatal medical review.	*Local policy*	*Group consensus*
9.5.9 Women with postpartum complications should have ready access to critical care facilities if these are needed.	*Local policy*	*Group consensus*
9.6 **Infant feeding.**		
9.6.1 All maternity care providers (whether working in hospital or in primary care) should implement an externally evaluated, structured programme that encourages breastfeeding, using the Baby Friendly Initiative as a minimum standard.	*Local strategy review*	*NICE Clinical Guideline 37*[61]
9.6.2 All healthcare providers (hospitals and community) should have a written breastfeeding policy that is communicated to all staff and parents.	*Local policy*	*Previous RCOG Maternity Standards*[5]
9.6.3 Each provider should identify a lead healthcare professional responsible for implementing the breastfeeding policy.	*Job plan*	*Previous RCOG Maternity Standards*[5]
9.6.4 Where postnatal care is provided in hospital, attention should be paid to facilitating an environment conducive to breastfeeding.	*Local service review*	*Previous RCOG Maternity Standards*[5]

9 Postnatal care

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
9.6.5 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.	*Written information*	*Previous RCOG Maternity Standards*[5]
9.6.6 Women who are taking medicines should be able to receive specialist advice, based on best available evidence, in relation to breastfeeding.	*Local audit* *Feedback*	*Previous RCOG Maternity Standards*[5]
9.6.7 Breastfeeding support should be made available regardless of the location of care.	*Network and Local audit*	*NICE Clinical Guideline 37*[61]
9.7 **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.**		
9.7.1 Group based parent-training programmes designed to promote emotional attachment and improve parenting skills should be available to parents who wish to access them.	*Local review*	*NICE Clinical Guideline 37*[61]
9.7.2 Healthcare providers should offer fathers and partners information and support in adjusting to their new role and responsibilities within the family unit.	*Local review*	*NICE Clinical Guideline 37*[61]
9.7.3 The woman should be given the opportunity to talk about her birth and ask questions about the care she received whilst an in-patient on the post-natal ward. If required she should be offered a post-natal appointment with the consultant for additional discussions/follow up.	*Local review*	*National Maternity Review*[8]
9.7.4 At each postnatal contact, women should be asked about their emotional well-being, what family and social support they have and their usual coping strategies for dealing with day-to-day matters.	*Local audit*	*NICE Clinical Guideline 37*[61]

9 Postnatal care

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
9.7.5 Postnatal care must be resourced appropriately. Women should have access to their midwife (and where appropriate obstetrician) as they require after having had their baby. Those requiring longer care should have appropriate provision and follow up in designated clinics.	*Patient questionnaires and feedback*	*National Maternity Review*[8]
9.8 **Training of staff – standards.**		
9.8.1 Relevant healthcare professionals should have demonstrated competency and sufficient ongoing clinical experience in undertaking maternal and newborn physical examinations and recognising abnormalities.	*Network and local polices and audits* *Review of adverse incidents/ misses*	*NICE Clinical Guideline 37*[61]
9.8.2 All maternity care team members should be competent in recognising the risks, signs and symptoms of child abuse and whom to contact for advice and management.	*Training logs* *Review of adverse incidents/ misses*	*Previous RCOG Maternity Standards*[5]
9.8.3 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.	*Clinic appointment schedules*	*NICE Clinical Guideline 110*[49]
9.8.4 Commissioners and service providers responsible for the organisation of local antenatal services should provide for flexibility in the length and frequency of antenatal appointments, over and above those outlined in national guidance to allow more time for women to discuss social and health complexity they are experiencing.	*Clinic appointment schedules*	*NICE Clinical Guideline 110*[49]

10 Fetal medicine

10.1 All women whose fetus (or fetuses) has a suspected or confirmed disorder should have timely access to patient-focused high quality evidence-based care.

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
10.1.1 Following the identification of a confirmed or suspected fetal anomaly or disorder, women should receive immediate basic information from the sonographer, a specialist midwife, or an obstetrician with appropriate competencies.	*Local review* *FASP standards*	*Group consensus*
10.1.2 Women with a suspected or confirmed fetal anomaly should be seen by an obstetrician with a special interest in fetal medicine locally within three working days or by a fetal medicine sub specialist in a tertiary fetal medicine centre within five working days, depending on the abnormality found.	*Network audit* *FASP standards*	*Public Health England*[77]
10.1.3 Individual maternity networks must develop referral pathways and clinical guidelines to facilitate the provision of appropriate care across the network. These guidelines should recognise and manage the sometimes competing aims of highly specialised care and provision of care close to home.	*Network guidelines*	*Group consensus*
10.1.4 A fetal medicine service should work in partnership with the referring/base multidisciplinary team to maintain effective communication of information and to ensure good standards of care.	*Documented feedback from referring units*	*NHS England*[78]
10.1.5 All cases of suspected fetal cardiac abnormality must be seen by a fetal cardiology specialist within five working days of referral by a fetal medicine (sub)specialist, and preferably within two working days if possible.	*Local audit*	*BCCA*[79]

10 Fetal medicine

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
10.1.6 If the required expertise is not available through the provider network, or if the problem is too complex, then the woman is referred to a specialist fetal or maternal medicine centre with the required skills and resources.	*Network guidelines*	*NHS England*[78]
10.2 The providers of fetal medicine should be suitably qualified and have sufficient relevant clinical exposure to maintain and develop competencies.		
10.2.1 Any person undertaking an ultrasound scan, for the purpose of screening and diagnosis of a fetal condition should be suitably qualified, as defined by FASP.	*Job specifications*	*Public Health England*[77]
10.2.2 A subspecialist in MFM will have completed RCOG accredited subspecialty training in maternal and fetal medicine and will have a job plan containing at least two subspecialty service sessions per week (even accounting for new ways of working, i.e. resident on call) and will be expected to show ongoing professional development in this field with regular attendance at network multidisciplinary and educational meetings.	*Job plans*	*NHS England*[78]
10.2.3 An obstetrician with a special interest in fetal medicine will have completed the fetal medicine ATSM and will be expected to show ongoing professional development in this field with regular attendance at network multidisciplinary and educational meetings. They will be expected to have at least one session each week dedicated to this special interest.	*Job plans*	*NHS England*[78]
10.3 A fetal medicine service service should be multidisciplinary and holistic in its approach to the care of women who have suspected or confirmed fetal disorders, or a relevant history in a previous pregnancy.		
10.3.1 A specialist fetal medicine centre is one staffed by at least two subspecialist consultants (i.e. those who have completed subspecialty training in maternal and fetal medicine) who provide prenatal diagnosis and fetal therapy services in collaboration (and co-located) with other specialist services. The service will have specialist midwifery support.	*Network and local policy/ audit* *Service review*	*NHS England*[78]

10 Fetal medicine

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
10.3.2 A specialist fetal medicine service will work closely with neonatology, paediatric surgery, paediatric cardiology, clinical genetics and molecular/ cytogenetics. It is anticipated that most/all of these services will be co-located.	*Service review*	*NHS England*[78]
10.3.3 Care for women with suspected or confirmed fetal disorders will be provided by a multidisciplinary team, co-ordinated by a consultant obstetrician with a special interest in fetal medicine, or a subspecialist in MFM.	*Service review*	*NHS England*[78]
10.3.4 There must be systems in place to facilitate communication between fetal medicine and neonatal services.	*Local review and documentation*	*Group consensus*
10.3.5 It is also acknowledged that smaller fetal medicine units (staffed by obstetricians with a special interest in fetal medicine) may provide elements of specialised care. Where an organisation provides specialised fetal medicine services these must be compliant with standards which have been discussed and agreed at a network level, and there must be a named consultant with expertise in fetal medicine.	*Job plans* *Local service review*	*NHS England*[78]
10.3.6 Fetal medicine services must facilitate reproductive choice. Pathways must be in place for women wishing to terminate their pregnancies. This should incorporate late feticide.	*Local pathways*	*Group consensus*
10.3.7 Participation in regional congenital anomaly registers and/or UK National Screening Committee approved audit systems is recommended in order to facilitate an audit of detection rates and to aid learning.	*Local audit*	*NICE Clinical Guideline 62*[80]
10.3.8 Fetal medicine services must provide postnatal follow-up to support women's physical and emotional needs following complex pregnancy outcomes.	*Local service provision*	*Group consensus*

11 Perinatal loss

11.1 Preventing perinatal loss.

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
11.1.1 All maternity providers must adopt strategies laid out in NHS England's stillbirth bundle and the RCOG guidance on detection and management of fetal growth restriction.	*Local guidelines*	*NHS England*[81] *RCOG Green-top Guideline 31*[82]
11.1.2 The quality and effectiveness of hospital level perinatal mortality review must be audited.	*Review of local processes*	*Sands*[83]
11.1.3 Following a standardised multidisciplinary review of all stillbirths, a local action plan should be generated for any improvements required.	*Review of local processes*	*RCOG Each Baby Counts*[19]

11.2 Care and support when perinatal loss occurs.

11.2.1 Managers and service providers must fund and organise bereavement services in line with Sands guidelines.	*Local guidelines*	*Group consensus*
11.2.2 In a climate where resources are limited, maternity units should protect the funding directed towards bereavement care to ensure the quality of the support provided is not compromised for this vulnerable group of women and their families.	*Local review*	*MBRRACE 2015*[42]

Perinatal loss

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
11.2.3 There must be a bereavement care pathway, outlining minimum standards of care for bereaved families.	*Local pathway*	*Sands*[83]
11.2.4 All maternity unit staff should have access to a specially trained bereavement midwife who is responsible for the staff training and support, and for monitoring policies and procedures to ensure that bereaved parents receive good quality care.	*Midwifery job plans* *Review of local training*	*Sands*[83]
11.2.5 Religious and spiritual advisors should be available upon request.	*Local service provision*	*BAPM*[73]
11.2.6 There should be at least one dedicated bereavement room or suite, away from celebrating families and the sounds of live babies, where a woman whose baby has died can labour and/or be cared for afterwards.	*Review of local environment*	*Sands*[83] *RCOG Safer Childbirth*[28]
11.2.7 All members of staff who could potentially interact with bereaved parents should have access to basic bereavement skills training.	*Training registers*	*MBRRACE*[43]
11.2.8 Sands support booklets for parents and the Sands guidelines for professionals should be available on every maternity unit.	*Local review*	*Sands*[83]
11.2.9 Continuing midwifery support, following discharge from hospital, should be offered and documented for all women after the birth of a stillborn baby.	*Audit of cases*	*MBRRACE*[43]

Perinatal loss

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
11.2.10 All parents should be offered a follow up appointment, in an appropriate setting, with a consultant obstetrician, to discuss events leading to their baby's stillbirth, the actual or potential cause, the chance of recurrence and plans for any future pregnancy.	*Audit of cases*	*MBRRACE*[43]
11.3 Learning lessons from perinatal loss.		
11.3.1 All maternity care providers must contribute to national audits and enquiries, including MBRRACE and the RCOG 'Each Baby Counts' initiative.	*Review of local processes* *Evidence of lead professionals*	*Group consensus*
11.3.2 All organisations should implement the standardised approach to perinatal death review developed by the Sands/DoH Perinatal Mortality Review Task and Finish Group.	*Review of local processes*	*MBRRACE*[43]
11.3.3 All term stillbirths should be investigated using a standardised multidisciplinary review.	*Review of local processes*	*MBRRACE*[43]
11.3.4 Service providers must fund high quality perinatal pathology services.	*Comparison of local consent forms with Human Tissue Authority (HTA)-approved documentation*	*Sands*[83]
11.3.5 Providers must ensure that a post mortem consent form is used which is based on the form developed by Sands and approved by the Human Tissue Authority (HTA), and that all parents should have the opportunity to discuss post mortem examination with a doctor or midwife who has undergone specialised training in bereavement care.	*Local review*	*Sands*[83]

Perinatal loss

11.4 Communication when perinatal loss occurs.

STATEMENTS & STANDARDS	MEASUREMENT CRITERIA	REFERENCE
11.4.1 Maternity care providers must have a written guideline documenting who, when and how the perinatal loss is communicated to primary and other secondary care providers.	*Local guidelines*	*Previous RCOG Maternity Standards*[83]
11.4.2 A summary of the follow up appointment, written in plain English, should be sent to the parents and also to the GP.	*Audit of cases*	*MBRRACE*[43]

A framework for maternity service standards

Appendix 1

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A framework for maternity service standards

Appendix 2

GLOSSARY

Maternity care pathway: a tool which describes the care women can expect during their journey through pregnancy, labour and childbirth, and the postnatal period until they are discharged to primary care services.

Maternity service provider: an organisation registered to provide regulated maternity health care services (e.g. NHS Trust or NHS Hospital).

Maternity service commissioner: the body responsible in England for continually analysing a community's needs and designing, specifying and procuring maternity services to meet these needs, within the resources available.

Maternity network: group of health professionals and organisations (from primary, secondary and tertiary care, and social services) linked to ensure equitable and cost-effective provision of high quality, clinically effective care.

Co-productive partnership: collaboration between a professional or technical provider and a service user, e.g. person-centred care, individual budgets.

Emergency admission: woman admitted to inpatient facility for a matter which requires clinical assessment by a consultant with the appropriate competencies as soon as possible, according to the woman's clinical condition, and at the latest within 14 hours from the time of arrival at hospital.

Small hospital: Maternity unit which delivers less than 3.500 births per year.

All four birth settings: all four of the following options for planned for place of birth and the associated benefits and risks should be offered to women during pregnancy: home birth; alongside midwifery unit; free-standing midwifery unit; obstetric unit.

Maternity team: team of health care professionals including midwives and support workers who offer care to all women and their babies during pregnancy, labour and childbirth and the postnatal period until discharge to primary care. Women with complex needs the team will require a team which also includes contributions from obstetricians, and may involve fetal medicine, neonatology and other medical specialists, and social and primary care professionals.

A framework for maternity service standards

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