



## NCT Document Summary: Safer Childbirth

In October 2007 *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour*<sup>1</sup> was published by the Royal College of Obstetricians and Gynaecologists (RCOG). The report focuses on improving the safety and quality of maternity by; 'clearly setting out informed and considered views about the essential minimum staffing standards required to support women in labour and provide safe care for them and their babies'. While in general the data and information used originates from England, the report states that it; 'should be seen as being applicable to the whole of the UK because it deals with standards of care which should apply wherever a woman gives birth.'

This document provides a summary of *Safer Childbirth* based on the report's executive summary and presents the recommended minimum standards set by the report.

### Background

*Safer Childbirth* is a joint report by the Royal Colleges of Anaesthetists (RCOA), Midwives (RCM), Obstetricians and Gynaecologists (RCOG), and Paediatrics and Child Health (RCPCH). The report follows previous reports published by the RCOG on minimum standards of care in labour, the most recent being *Towards Safer Childbirth*<sup>2</sup>, published in 1999.

A review of *Towards Safer Childbirth* showed that progress had been made in many areas to achieving its recommendations but staffing problems remained a problem for many units. Reports by the Confidential Enquiry into Maternal and Child Health (CEMACH) have continued to express various concerns regarding care provision for women in labour and their babies.<sup>3,4</sup> Poor outcomes related to multiprofessional working, staffing and training have also been highlighted by other national audits and reviews of maternity services, such as the findings of Healthcare Commission enquiries. These have provided the impetus for the update of *Towards Safer Childbirth*, in recognition of the 'need for a fresh look at the organization of care in labour'.

The report recommends baseline standards the following ten categories or key aspects of care provision:

1. Organisation and documentation
2. Multidisciplinary working
3. Communication
4. Staffing levels
5. Leadership
6. Core responsibilities
7. Emergencies and transfers
8. Training and education
9. Environment and facilities
10. Outcomes

## Staffing roles

The report acknowledges:

- 'the central role of midwives as autonomous practitioners of normal labour and birth, together with their role as partners with obstetricians, anaesthetists and paediatricians, in the care of women with complex and complicated labours'
- 'the importance of team working, as well the respective roles of midwives, obstetricians, anaesthetists, paediatricians, support staff and managers, as part of the local maternity care team'
- 'the increased involvement of consultant obstetricians on the labour ward in the care of women with complex or complicated pregnancies and in the supervision and education of medical staff'.

## Staffing levels

A number of factors which influence staffing levels and have serious implications for the service are identified and addressed in the report. These include:

- greater focus on woman-centred care
- an extension to the midwife's teaching role with multidisciplinary staff
- recruitment and retention crises in midwifery staffing
- changes in the experience of medical staffing at junior level
- demand for increasing consultant involvement in the labour ward.

The report emphasises that it is important to match resources and facilities with workload and states clearly that the proposals made by *Safer Childbirth*; 'can only be achieved if there is a considerable expansion in numbers of both midwifery and medical staff concerned with the care of women in labour'. It outlines minimum staffing and training requirements for midwives and doctors (presented below) while stressing that; 'additional staff over and above this will be needed in specific situations'.

## Communication and multidisciplinary working

The need to improve communications and working **relationships** between healthcare professionals and multi-disciplinary teams, and improve communication between professionals and women, are key themes of the report. It recommends that; 'units should foster a team approach, based on mutual respect, a shared philosophy of care and a clear organisational structure for both midwives and medical staff, with explicit and transparent lines of communication.'

## Governance Structures and Management

The report states that; a maternity network, which includes births at home, in midwifery units and in obstetric units, should have a common governance structure, including robust systems and clear guidelines for monitoring the safety, quality and performance of the maternity services and transfer arrangements within the network should problems arise'.

It also provides healthcare planners, unit managers and clinical directors with guidelines on which to base realistic costing of the maternity service. And identifies various quality and clinical effectiveness issues are identified, including clinical supervision and statutory supervision of

midwives, and basic and continuing training of all staff. It recognises that; 'each provider will need to adapt the model suggested to achieve the standards in their own circumstances'.

## **Recommended minimum standards**

Safer Childbirth makes the following baseline standard recommendations:

### Standard 1: Organisation and documentation

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

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

### Standard 2: Multidisciplinary working

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

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

### Standard 3: Communication

*Communication is a keystone of good clinical practice.*

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

### Standard 4: Staffing levels

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

- Staffing levels are audited annually
- Midwifery staffing levels are calculated and implemented according to birth setting and case mix categories to provide the midwife-to-woman standard ratio in labour (1.0–1.4 WTE (whole time equivalent) midwives to woman) with immediate effect
- The duration of prospective consultant obstetrician presence on the labour ward are in line with the *Safer Childbirth* recommendations (see below).

Note: Units should work towards the targets contained in *The Future Role of the Consultant*<sup>6</sup> and with immediate effect:

- units with more than 6000 births a year should provide 60 hours of consultant presence
  - units with between 2500 and 6000 births a year or classed as high risk should provide at least 40 hours a week of consultant presence
  - units with up to 2500 births a year are strongly recommended to have 40 hours of consultant obstetric presence but should conduct a risk assessment exercise to determine their individual requirements
- Junior obstetric staffing levels will depend on the training opportunities as defined in the trainee's logbook
  - Junior medical staff (obstetricians, anaesthetists and paediatricians) of appropriate competence are immediately available on the labour ward
  - A duty anaesthetist of appropriate competency and dedicated only to the labour ward must be immediately available
  - Units providing neonatal care must be appraised against and meet BAPM staffing standards

#### Standard 5: Leadership

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

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

#### Standard 6: Core responsibilities

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

#### Standard 7: Emergencies and transfers

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

- There are local agreements with the ambulance service on attendance at emergencies or when transfer is required
- Complicated births in obstetric units are attended by a consultant obstetrician
- The consultant obstetrician must be contacted prior to emergency caesarean

section and must be involved when a patient's condition gives rise for concern and attend as required

- The anaesthetic team's response time is such that a caesarean section may be started within a time appropriate to the clinical condition (this requires all team members to be informed of the case appropriately)
- As a target for best practice (because regional anaesthesia is safer than general anaesthesia for caesarean section) more than 95% women should receive regional anaesthesia for elective caesarean section and more than 85% women should receive regional anaesthesia for emergency
- There must be 24-hour availability in obstetric units of senior paediatric colleagues who have advanced skills for immediate advice and urgent attendance, who will attend within 10 minutes
- There must be 24-hour availability in obstetric units within 30 minutes of a consultant paediatrician (or equivalent SAS grade) trained and assessed as competent in neonatal advanced life support
- A consultant obstetrician should be available within 30 minutes outside the hours of consultant presence.

#### Standard 8: Training and education

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

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

#### Standard 9: Environment and facilities

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

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

#### Standard 10: Outcomes

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

- Normal births without interventions
- Inductions – indications, outcomes and success
- Augmentation of labour
- Percentage of labours lasting longer than 18 hours
- Instrumental births, ventouse, rotational or non-rotational forceps.
- Third- and fourth-degree tears
- Epidural rates, including dural taps
- Failed maternal intubation
- Total births

- Elective caesarean section – incidence and indications
- Emergency caesarean sections – incidence and indications
- Intrapartum stillbirths
- Apgar scores less than 7 at 5 minutes in babies below 37 weeks of gestation
- Need for neonatal resuscitation of babies below 37 weeks of gestation
- Admissions to a neonatal unit for babies weighing more than 2.5 kg
- Incidence of primary postpartum haemorrhage
- Maternal transfer to intensive care unit
- Maternal transfers to other units
- Transfers of babies to other units
- Caesarean hysterectomy and other haemostatic methods
- Percentage of complicated births attended by a consultant obstetrician
- Breastfeeding rates at birth and discharge
- Antenatal steroids prior to preterm birth
- Maternal deaths
- Neonatal deaths
- Neonatal birth injury, such as Erb's palsy
- Neonatal encephalopathy

## Implementation

*Safer Childbirth* is intended to be used to review the organisation of care in labour in all settings, and where necessary changes should be made to implement the report's recommendations. Providers of intrapartum care are expected to audit the outcome measures and standards recommended in the report, and publish them in the form of an annual report. This should include an evaluation of women's views of the care they received and should be made publicly available. Implementation of the standards will also be audited by The Royal Colleges, beginning in December 2009.

The report states that adoption and implementation of the staffing standards, facilities and governance structures made in *Safer Childbirth*; 'should help to ensure the best outcome for women and their babies regardless of the birth setting.'

## NCT comment

The NCT welcomes this report and its recommendations which, if implemented, would bring improvements to the safety of maternity care and quality of care, and great benefits to women, their children and families.

The emphasis placed on the need to invest in sufficient numbers of midwives and obstetricians is especially important and only if this takes place will the standards recommended by the report be fully met. Also welcome is the recognition of the central role that consultant midwives play in; 'promoting normality in labour and underpinning provision of safe and effective care'.

Another particularly positive aspect is the recommendation that, amongst other important measures, 'normal births without interventions' should be audited and reported by each unit in all birth settings annually. This is also a recommendation of the *Normal Birth Consensus Statement*<sup>6</sup> recently published by the Maternity Care Working Party in collaboration with the NCT. As recommended by the consensus statement, we would emphasise that a standard definition of normal labour and birth is necessary so that normal birth rates can be audited in all birth settings and compared with confidence, and across all four countries of the UK. Safer Childbirth's recommendation that; 'Women in established labour must receive individual one-to-one care from a midwife' will help promote and achieve greater levels of normality.

## Further information and references:

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