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NCT Document Summary: Standards for Maternity Care Report of a Working Group

*Standards for Maternity Care Report of a Working Group*¹ was published on 2 July by the Royal College of Obstetricians and Gynaecologists (RCOG) with the Royal College of Midwives (RCM), the Royal College of Anaesthetists (RCA) and the Royal College of Paediatrics and Child Health (RCPCH). It is applicable across the UK.

The report contains 30 individual standards for care for the maternity care pathway from 'preconception' to the 'transition into parenthood' in one document. There are also standards on the organisation of services, including 'staffing' and 'maternity and neonatal networks', and on particular groups of women, such as 'needs'. The report emphasises that 'Each step of the pathway includes a mix of organisational and clinical standards which is needed to ensure comprehensive, seamless and high-quality care.'

The standards were developed from 50 original source documents which produced a database of 800 separate, often overlapping, standards. The working party combined similar standards from different sources to create a succinct, comprehensive set of standards. The standards for intrapartum care have been taken directly from *Safer Childbirth*², published in 2007. Each standard is supported by audit indicators which are also published in a separate slimmer document.

The Standards

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

Some key standards in the document include:

Standard 5 – Maternity booking and planning of care:

Booking should take place over two visits in early pregnancy and women should have had their first full booking visit and hand held maternity record completed by 12 completed weeks of pregnancy.

Standard 6 – Pre-existing medical conditions in pregnancy:

Migrant women may be at risk from previously undiagnosed existing medical conditions. Clinicians should ensure that a comprehensive medical history has been taken at booking and, where appropriate, a full clinical assessment of their overall health, including a cardiovascular examination, is undertaken as soon as possible thereafter.

Standard 7 – Women with social needs:

Maternity services must have in place inter-agency arrangements (through clinical and local social services networks) including protocols for information sharing and a lead professional, to ensure that women from disadvantaged groups have adequate support and benefit from other agencies (such as housing) referring women, with consent to local maternity services.

Interpreting services should be provided for women where English is not their first language. Relatives should not act as interpreters. Funding must be made available for interpreting services in the community, especially in emergency or acute situations.

Standard 8 – Pre-existing and developing mental health conditions in pregnancy:

All pregnant women should be asked about any previous history of psychiatric disorder and/or family history of serious mental illness early in their pregnancy and provided with information on pregnancy and mental health which helps them to disclose and discuss mental health issues.

Women who require to be admitted to a psychiatric hospital following delivery should be admitted to a specialist psychiatric mother and baby unit.

Standard 9 - Antenatal screening:

All maternity care providers should ensure that where women request or decline services or treatment, their decision is respected and documented to avoid repetition.

Standard 10 – Routine antenatal care:

All women should be offered the support of a named midwife throughout pregnancy including those with complex pregnancies and those who receive care from a number of specialists or agencies. All women should be able to contact a midwife day or night at any stage in pregnancy if they have concerns.

Standard 11 - Pregnancy-related conditions:

Maternity services should comply with evidence-based guidelines (e.g. NICE, SIGN) for the provision of high-quality clinical care including the provision of antenatal, intrapartum and postpartum care, induction of labour and caesarean section.

Standard 12 - Intrapartum care:

The rationale for the standards in this section states: ‘Promoting normal birth is an important philosophy of maternity care, with intervention only if necessary for the benefit of the mother or child. The principles of normality have been presented in the normal birth consensus statement developed by the Maternity Care Working Party and published by the National Childbirth Trust (NCT), RCOG and Royal College of Midwives.³ The All Wales Clinical Pathway for Normal Labour has been developed to reduce unnecessary intervention in normal labour and birth.⁴ The birth environment influences the birthing experience. The NCT has produced a tool for auditing the environment and resources available for women in labour.⁵’

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.

Standard 14 - Postnatal assessment and care of the mother:

A documented, individualised postnatal plan of care should be developed with the woman, ideally in the antenatal period or as soon as possible after birth. This should take into account relevant factors from the antenatal, intrapartum and immediate postnatal period details of the healthcare professionals involved in her care and that of her baby, including roles and contact details plans for the postnatal period including choice of place of care. This should be reviewed at each postnatal contact.

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.

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.

Standard 15 - Supporting infant feeding:

Maternity services should adhere to the principles and work toward the recommendations of UNICEF/WHO Baby Friendly status.

Attention should be paid to facilitating an environment that supports skin-to-skin contact where possible. Skin-to-skin should last until after the first breastfeed or until the mother chooses to end it. Babies should remain with their mothers unless there is a medical indication not to.

All healthcare providers (hospitals and community) should have a written breastfeeding policy that is communicated to all staff and parents.

Standard 16 - Care of babies requiring additional support:

Any concerns expressed by the parents as to the wellbeing of the baby, or identified through clinical observations, should be assessed.

Particular support in breastfeeding should be provided for mothers who have had a multiple birth or have a premature or sick baby.

Parents of babies with identifiable medical or physical problems should receive timely and appropriate care and support in an appropriate environment.

Standard 17 - Care of babies born prematurely:

Managed maternity and neonatal care networks should include effective arrangements for managing the prompt transfer and treatment of women and their babies experiencing problems or complications.

Standard 18 - Promotion of healthy parent–infant relationships:

Maternity services should provide postnatal care to facilitate the transition to motherhood by making sure that ill health is prevented or detected and managed appropriately. Women and their partners should be supported to make a confident and effective transition to parenthood.

Standard 19 - Transition to parenthood:

The postnatal plan of care should be documented to identify and promote the health and wellbeing of the mother and her baby and plan for her continuing care and support needs. It should be reviewed at each postnatal contact.

Postnatal care should include provision of information to both mothers and fathers on infant care, parenting skills and accessing local community support groups.

Standard 20 - Supporting families who experience bereavement, pregnancy loss, stillbirth or early neonatal death:

Maternity care providers should ensure there are comprehensive, culturally sensitive, multidisciplinary policies, services and facilities for the management and support of families (and staff) who have experienced a maternal loss, early or mid pregnancy loss, stillbirth or neonatal death.

Standard 21 - Choice and appropriate care:

All pregnant women should be offered information on the full range of options available to them throughout pregnancy, birth and early parenthood, including locally available services, place of birth (including home birth), screening tests and types of antenatal and postnatal care.

The promotion of normality of childbirth should be integral to a quality maternity service but it is essential that recognition of the ill mother and infant is paramount.

Where women request or decline services or treatment, their decision should be respected.

Standard 22 – Communication:

Training on how to communicate information in an effective sensitive manner should be provided to all healthcare professionals.

Communication and information should be provided in a form that is accessible to pregnant women who have additional needs, such as those with physical, cognitive, or sensory disabilities.

Standard 26 - Development, implementation and review of local maternity services strategy:

The provision of maternity services should be based on an up-to-date assessment of the needs of the local population.

Maternity care providers and commissioners should ensure that the capacity of the midwife-led and home birth services are developed to meet the needs of the local population.

Maternity care providers and commissioners should ensure that maternity services develop the capacity for every woman to have a designated midwife to provide care for them when in established labour for 100% of the time.

In every area there should be an effective multidisciplinary maternity services forum such as a maternity services liaison committee (MSLC), where commissioners, providers and users of maternity services bring together their different perspectives in partnership to plan, monitor and improve local maternity services.

Maternity providers should arrange for staff to participate in and support the work of the MSLC and they should take account of the MSLC's advice in operating and delivering services.

Standard 30 – Staffing:

An experienced midwife (shift coordinator) should be available for each shift on the labour ward.

Maternity care providers and commissioners should ensure that maternity services develop the capacity for every woman to have a designated midwife to provide care for them when in established labour for 100% of the time.

NCT Comment

On the whole this document will be extremely useful for commissioners and providers of maternity services, and for user representatives as it sets out standards in one place for the whole maternity care pathway. It is genuinely comprehensive, including issues around access, communication, safety, choice, midwife-led care, obstetric and medical problems, ectopic pregnancy, breastfeeding and bereavement, to name a tiny number of key examples. There is much of value here. The standards for care, together with the audit indicators, should really help to drive up standards for women and families from all social backgrounds.

We are delighted that the Normal Birth Consensus Statement and the NCT's Better Birth Environment work is referred to as the central rationale for the care standards for labour and birth.

Unfortunately the choice of words in relation to home birth is ambiguous and unhelpful. Women are entitled to have their baby at home and they should be supported even if health professionals feel that the level of risk is inappropriate. Risk is relative, rather than black and white and some women's priorities and values will mean that they choose not to go to hospital even when advised to do so. Health professionals should give clear, evidence-based information, including the extent of any additional risk, in a neutral, non-confrontational way. If parents feel supported even when professionals disagree with their decisions, there is likely to be greater trust and more opportunity for negotiation and reassessment if circumstances change.

We particularly welcome the standard, introduced in *Maternity Matters*, on the need for all women to have had two antenatal care visits and their hand held maternity record completed by 12 completed weeks of pregnancy. We also appreciate the detailed focus on postnatal care, much of which reflects what was recommended in the NICE *Postnatal Care* guideline. However, there is no recommended number of postnatal care consultations, nor a standard for how soon after discharge from hospital a new mother should be visited at home by a community midwife. Several of the audit standards for postnatal care are also weak. Unfortunately, there is a big gap in many areas between the agreed standards for postnatal care policy and practical implementation.

The working party noted that there were gaps where no standards had previously been written. One such gap that the NCT can identify is the lack of a standard on the information, support and communication needs for parents of a premature baby. The NCT leads a coalition of organisations working on the POPPY research project, funded by the Big Lottery Fund, due to report findings and recommendations on improving communication during 2009.

References

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The NCT wants all parents to have an experience of pregnancy, birth and early parenthood that enriches their lives and gives them confidence in being a parent.

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