Clinical Negligence Scheme for Trusts

Maternity

Clinical Risk Management Standards

Version 1

2013/14
Introduction

The NHS LA is changing its approach to the risk management standards and assessment process. From 1 April 2013 to 31 March 2014, the NHS LA will undertake a limited assessment programme.

During this time the NHS LA will continue to work with members to ensure that any revised process is focused on helping organisations reduce harm to patients and the number and cost of claims that they receive.

Feedback from a recent risk management survey conducted in 2012 was extremely valuable.

The headline findings are that although the NHS LA has a generally high level of satisfaction, there are opportunities for us to improve our approach to the standards and assessment process, in particular by:

- sharing more data and learning with members;
- ensuring that any standards we look at are focused on outcomes;
- minimising burden and duplication; and
- ensuring that any assessments are proportionate to the organisation's risk.

The frequently asked questions (FAQs) in the Addendum 2013-14 aim to address any queries in relation to the revised process. The addendum supersedes information about the standards and assessment process included in this manual, and the content within the individual criteria has not changed.

The limitations of the standards and assessments process have also been recognised. The assessment process checks for compliance against a set of standards that aim to drive improvements in processes and risk management systems. The existence of a risk management system, even one complying with the NHS LA standards, does not of itself mean that a trust is safe. There are lots of other factors that are relevant when considering safety. Although effective risk management processes are important, they are only one of the many things that should be considered when assessing whether practices are safe for staff and patients.

If you have any questions, please contact a member of the NHS LA Risk Management Team on 020 7811 2826 or riskmanagement@nhsla.com.

Best wishes,

Catherine Dixon  
Chief Executive

Suzette Woodward  
Director of Safety, Learning & People
2013-14 Risk Management Standards and Assessments

Frequently Asked Questions (FAQs)

What are the plans for assessments?
Assessments will be undertaken in the following circumstances:

- where a trust wants an assessment;
- where an trust has failed an assessment in 2012-13 and dropped to Level 0; or
- for a trust for which we have significant concerns.

What should we do if we want an assessment?
If your trust is due a mandatory assessment, DNV will be in touch with you to book a date. If you wish to have an optional assessment, please notify DNV of your intention to be assessed by no later than 31 May 2013 by emailing nhsla@dnv.com.

What about maternity services?
Because of the high risk nature of the service, maternity services due for an assessment will continue to be assessed at Levels 2 and 3 within the CNST maternity standards. In the coming months the CNST maternity standards and assessments will be reviewed. This review will not impact on assessments due between 1 April 2013 and 31 March 2014.

Why are you not undertaking assessments for maternity services at Level 1?
Nearly all maternity services have achieved Level 1, so it is recognition that most already have the documentation in place to manage clinical risks, whereas at Levels 2 and 3 we are more directly supporting better outcomes. Additionally, maternity services at Level 1 will have last been assessed only two years ago, whereas in most cases those at the higher levels will not have been assessed for three years.

Will we still have our named assessor?
Our contract with DNV to provide risk management services has been extended for a year, but on a significantly reduced basis covering assessments that will be carried out in 2013-14. As a result, the assessment team will be smaller, and this will mean a change of assessor for some trusts. All assessments will now be booked centrally and a named assessor will be allocated when assessment dates have been confirmed. Named assessors will only be allocated to trusts being assessed in 2013-14.

What will happen to informal visits?
If you are a trust going to be assessed, you will still be offered an informal visit. We do not plan to offer informal visits where a trust will not be assessed, as the primary purpose of an informal visit is to provide guidance in preparing for an assessment. If, however, you do require the support of an assessor, please email nhsla@dnv.com and we can discuss your requirements.
Should we continue to work towards meeting the standards even though they are changing?

Any activity you are currently doing in working towards achieving the requirements set out in the standards will not be wasted effort. They remain good practice and will ensure you are still contributing towards safer care.

We are in the process of going through a merger or acquisition. What should we do?

A new approach has been agreed for dealing with risk management discount in these circumstances. Our commitment is that trusts will no longer be financially disadvantaged by losing a risk management discount.

In most cases the component parts of the new trust will retain their assessment level and discounts in proportion to their gross contributions.

For example:

Trust A and B merge to form C. At the time the merger takes place:

- trust A is at Level 1 (10% discount) in the NHS LA standards and its gross contributions represent 40% of the new organisation; and
- trust B is at Level 2 (20% discount), with 60% of contributions.

Therefore, trust C will receive a discount of 10% on 40% of its contributions and 20% on the balance of 60%.

The new trust will be in the same financial position in respect of its net contributions paid to the schemes as if the organisational changes had not taken place.

This will apply until the NHS LA revised approach to standards and assessment has been agreed. If you have any additional queries, please email riskmanagement@nhsla.com.

What will happen to my contribution discount if I apply for assessment at a higher level and fail?

Under usual scheme rules, trusts and maternity services that fail to achieve compliance at the level assessed are required to be assessed in the following financial year at the level attained or a lower level.

Due to the changes the NHS LA is making to the standards and assessment process, this rule no longer applies. If a trust or maternity service fails an assessment in 2012-13 or 2013-14 it will not need to be re-assessed.

The exceptions to this rule are trusts or maternity services that fail to achieve compliance and drop to a Level 0 in which case an assessment at a Level 1 will take place within six months of the unsuccessful assessment.

What will happen to the contribution discount?

Any risk management discount which has been earned as at 1 April 2013 will continue to be applied until a new process has been agreed. If for any reason a trust drops to Level 0 the risk management discount to be applied will be reviewed by the NHS LA.
If we pass a Level 2 or 3 assessment before 1 April 2014 will the 2/3 year assessment period and discount hold, regardless of the new standards coming in?
The NHS LA will ensure that any changes to the assessment process, including periods of discount, are transitioned appropriately and with due notice.

What will happen to assessment levels from 1 April 2014?
The future of assessment levels is currently being reviewed. Once the revised approach has been agreed and subsequently tested, we will communicate with members to explain the changes.

What will the assessment process be like from April 2014?
A number of options are being considered for the future. These will be tested to ensure they meet our aim of focusing on improving outcomes of care, reducing harm, reducing claims and costs associated with claims, together with ensuring a reduction in duplication and bureaucracy.

The aim is to test the revised process in the autumn, provide as much advance notice as we are able, and introduce the new approach from 1 April 2014.

Can we register to become a pilot site?
We welcome interest from organisations willing to test our new approach. If you are interested, please contact riskmanagement@nhsla.com. Please note that expressing an interest does not guarantee you to be chosen, nor does it commit you to participating in the testing phase when it has been decided.

I have a question – who should I contact?
Please contact your named assessor or DNV as usual for all matters relating to an assessment, including an informal visit and queries about the standards and assessment process. Please direct all other risk management enquiries to the NHS LA Risk Management Team by emailing riskmanagement@nhsla.com or call 020 7811 2826.
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2. CONTACTS

If you have a query on the standards or assessment process, which is not covered by this manual, please contact your allocated assessor in the first instance. An up to date list of assessors and other contacts from the DNV and NHSLA teams can be obtained from www.nhsla.com or from the DNV Healthcare UK - General Enquiries and Support Team.

DNV Healthcare UK - General Enquiries and Support Team

General Enquiries: 0161 475 7048  
nhsla@dnv.com

DNV Healthcare  
Highbank House  
Exchange Street  
Stockport  
Cheshire  
SK3 0ET

Website: www.dnv.com/healthcare

NHSLA Risk Management

Risk Management Enquiries: 020 7811 2808  
riskmanagement@nhsla.com

NHS Litigation Authority  
2nd Floor  
151 Buckingham Palace Road  
London  
SW1W 9SZ

Website: www.nhsla.com
3. INTRODUCTION

3.1. The NHS Litigation Authority (NHSLA) is a Special Health Authority, which was established in 1995. The NHSLA administers the Clinical Negligence Scheme for Trusts (CNST) and the Liabilities to Third Parties Scheme (LTPS) and Property Expenses Scheme (PES), together known as the Risk Pooling Schemes for Trusts (RPST). Information about the NHSLA can be found at www.nhsla.com and Factsheet 1 provides background information about the organisation.

3.2. Membership of CNST is voluntary and open to a range of NHS organisations in England. Funding is on a pay-as-you-go non-profit basis, and organisations receive a discount on the maternity element of their CNST scheme contributions where they can demonstrate compliance with the CNST Maternity Clinical Risk Management Standards.

3.3. Maternity services in England account for a significant proportion of the number and cost of claims reported to the NHSLA each year. In response to this fact, the CNST Maternity Clinical Risk Management Standards were developed and are set out in this manual.

3.4. The NHSLA also issues separate standards, encompassing organisational, clinical and non-clinical/health and safety risks, against which most scheme members providing healthcare services are assessed. The NHSLA risk management standards for organisations providing acute, ambulance, community, mental health & learning disability services and non-NHS providers of NHS care can be found in separate manuals. All are available to download on the NHSLA website at www.nhsla.com.

3.5. The standards and assessment process are designed to:
   - improve the safety of women and their babies;
   - provide a framework within which to focus risk management activities in order to support the delivery of quality improvements in patient care, organisational governance, and the safety of women and their babies;
   - assist in the identification of risk;
   - contribute to embedding risk management into the maternity service’s culture;
   - focus maternity services on increasing incident reporting whilst decreasing the overall severity of incidents;
   - encourage awareness of and learning from claims;
   - reflect risk exposure and enable maternity services to determine how to manage their own risks;
   - encourage and support maternity services in taking a proactive approach to improvement;
   - provide information to the organisation, other inspecting bodies and stakeholders on how areas of risk covered by the standards are being managed at the time of the assessment.

3.6. Assessors are employed by Det Norske Veritas (DNV) to provide risk management services on behalf of the NHSLA. Assessors will not visit a maternity service where they have been employed by the organisation in the past five years or where there is any other apparent or suspected conflict of interest.

The DNV assessors work within regional pools and each maternity service will have a named assessor from the relevant regional pool as their main point of contact.
DNV will endeavour to have the maternity service’s assessment carried out by the named assessor but in some circumstances this may not be possible.

The named assessor will:
- be the maternity service’s primary contact point;
- be responsible for conducting assessments and other visits;
- answer any queries about the standards and assessment process.

Maternity services will be notified in advance if their named assessor changes.

3.7. It is vital that maternity services ensure that DNV have up to date contact details of a nominated individual who will be responsible for arranging and coordinating assessments. Any important announcements will be sent to this individual.

3.8. As a specialist provider of services for managing risks, DNV may bid for and undertake work for organisations and maternity services that are subject to assessment against the NHSLA standards. The contract between the NHSLA and DNV contains a clause on managing conflicts of interest and procedures to be followed in the event of an actual, potential or perceived conflict of interest have been agreed between the two parties. Further information on this subject can be obtained from the NHSLA Risk Management Director.

3.9. A wide range of NHS and other organisations, risk managers and healthcare professionals have contributed to and been consulted on the development and revision of these standards and the assessment process. The NHSLA gratefully acknowledges their valuable input. A full list can be found at Appendix E: Maternity Stakeholders.

3.10. The NHSLA is committed to providing organisations with help to achieve compliance with the standards. Frequently asked questions and answers on the standards, template policy documents and copies of various risk management publications, including “Risk E-News”, an NHSLA and DNV risk management newsletter, can be found on the NHSLA website at www.nhsla.com.

3.11. All maternity services that undergo assessment against the CNST Maternity Standards will be invited to complete a web based survey to provide feedback on the experience. Feedback from the survey will be used to inform the development of the standards and assessment process.

3.12. The NHSLA is constantly striving to improve the usability of its risk management standards manuals, and would welcome your feedback. Please email nhsla@dnv.com to tell us of known or suspected errors or omissions, suggestions for improvement, general comments or queries relating to any of the standards, criteria, or supporting information. Any resulting changes will be incorporated into the next version of the manual.
4. GENERAL PRINCIPLES

Standards

4.1. Throughout this manual the term ‘maternity service’ includes the following, whether provided in an acute, primary or community care setting:

- antenatal services;
- intrapartum services;
- postnatal services including care of the newborn;
- midwifery led care;
- obstetric anaesthetics; and
- obstetric ultrasonography.

4.2. The standards contained within this manual will be updated on an annual basis, with a revised version available on the NHSLA website in January, to be assessed against from the following April.

On occasion, criteria may be removed from the standards. This may be due to the risk being well controlled by maternity services, it being looked at by other bodies reviewing the management of the risk area, or to allow the inclusion of increasing or emergent areas of risk. Criteria that have been removed from the standards in their entirety are included in Appendix F: Criteria Removed from the Standards. The NHSLA reserves the right to reinstate these criteria at any time.

Where a criterion is removed from the standards in its entirety the NHSLA would still expect a maternity service to have in place appropriate systems to manage the relevant area(s) of risk.

4.3. All NHS organisations providing maternity services will be assessed against these CNST Maternity Clinical Risk Management Standards. Most NHS organisations, including their maternity services, will also be assessed against the relevant NHSLA risk management standards described in 3.4.

Organisations which provide maternity services will, therefore, also need to demonstrate application of the relevant NHSLA standards to all services, including maternity.

4.4. It is important to remember that a maternity service cannot operate in isolation from the rest of the organisation and will need to share many systems and procedures with the whole organisation. It is recommended that maternity services liaise with the organisation’s governance and/or risk leads in their preparation for assessment. This will help to ensure that local documents reflect organisational-wide requirements.

4.5. Independent midwives operate outside the NHS and are therefore not entitled to NHS Indemnity. This means they are not covered by CNST, even if working on NHS premises. Notwithstanding this situation, it is still considered good practice to offer ALL staff working within an organisation an opportunity to attend the induction and orientation programme, and to be made aware of clinical policies and guidelines.

4.6. The standards are based on national guidance and recommendations; therefore each criterion includes relevant reference sources.
4.7. When significant changes are made to an existing criterion, for example, a new minimum requirement is added, the new element(s) will be piloted for one year. Pilot minimum requirements are clearly identified within the standards using the following symbol:

Maternity services will be encouraged to submit evidence for the pilot minimum requirement to ensure that it can be rigorously tested but failure to submit evidence will not impact upon the assessment. Where evidence is submitted the assessor(s) will review the information and, if it would be non-compliant, comment on it in the assessment report.

Information on risk areas which may be piloted in future years, including the approach to piloting new criteria, and other possible changes to the standards and assessment process is contained in Section 8 - Overview of Proposed Changes and Risk Areas.

Assessments

4.8. Maternity services that are due an assessment must be assessed no later than the anniversary date of their last assessment. Maternity services that request an early assessment may choose to be assessed at any time.

4.9. Maternity services other than those subject to improvement measures may only be assessed against the standards once in any financial year.

4.10. Refusal by a maternity service to be assessed in accordance with the principles outlined within this manual may result in the maternity service being deemed to be at Level 0 and may lead to a refusal by the NHSLA to provide indemnity.

4.11. Assessment against the standards, in accordance with the following conditions, is a mandatory requirement of scheme membership for most maternity services.

Level 0 maternity services:

The aim of the CNST Maternity Standards and assessments is to improve the safety of women and their babies and thus where a maternity service is deemed to be at Level 0 following an assessment the approach taken will be to encourage, monitor and support the service as it works towards achieving Level 1 compliance.

Maternity services that drop to Level 0 or fail to attain Level 1 will be placed under improvement measures and must undertake a Level 1 assessment within six months of the date of their unsuccessful assessment. The NHSLA Risk Management Director will write to the organisation to explain the timescales and nature of the improvement measures. This would normally necessitate at least one informal visit but more visits may be deemed necessary by the NHSLA. Maternity services will be provided with an interim report which will be shared with regulatory bodies such as the Care Quality Commission and, where relevant, Monitor, and with the local Strategic Health Authority cluster.

The date of the subsequent assessment will be determined by the NHSLA Risk Management Director but, assuming the maternity service achieves Level 1 at the end of the improvement measures, this will normally be two years from the date of the failed assessment.
Level 1, 2 and 3 maternity services

Maternity services at Level 1 must be assessed against the standards at least once in any two year period. Maternity services at Level 2 or 3 must be assessed against the standards at least once in any three year period.

When a maternity service has achieved Level 1 or 2, it may apply for assessment at the next level from the following financial year. However, in order to ensure that systems are embedded and being implemented at Level 2 and monitored at Level 3, organisations are advised to wait at least 18 months before being assessed at the next level. Organisations being assessed at Level 3 must evidence that where deficiencies have been identified, appropriate recommendations and action plans have been developed and changes implemented.

New maternity services or those that have undergone significant external restructuring:

Restructuring in the context of this manual involves more than one maternity service (i.e. mergers, acquisitions of services, etc.) and not internal restructuring. Maternity services undergoing significant restructuring will be allocated an assessment level by the NHSLA immediately post event. To assist the NHSLA in determining the level to be allocated and future arrangements for assessment, maternity services undergoing restructuring are asked to write to the NHSLA Risk Management Director, copying in their allocated assessor and providing information on the scope and nature of the restructuring.

All maternity services:

Maternity services that achieved compliance at the level assessed at their previous assessment may be assessed at their existing level or may choose to be assessed at a lower or the next highest level at their subsequent assessment.

Maternity services that failed to achieve compliance at the level assessed at their previous assessment will be required to be assessed in the following financial year at the level attained or at a lower level (see table in 5.14).

Maternity services are strongly recommended to discuss the level at which they are planning to be assessed with their named assessor to determine the maternity service’s readiness for assessment. As detailed in 5.14, it is important to note that maternity services which perform badly at assessment will drop to a lower level and can potentially drop to Level 0.

In exceptional circumstances, such as when there are concerns about performance, the NHSLA may visit or require maternity services to be assessed outside the specified schedule.

If a maternity service cancels an assessment visit without good reason and/or giving reasonable notice, the NHSLA reserves the right to recharge non-refundable accommodation and travel expenses incurred by the assessor(s).

4.12. Maternity services complying with the standards will receive a discount from the maternity element of their CNST contributions. The discounts are:

Level 1  10%
Level 2  20%
Level 3  30%
The appropriate discount will be applied from the beginning of the financial quarter following the date of the assessment visit.

In exceptional circumstances, extra time known as a clarification period may be allowed after a Level 1 assessment visit to enable the maternity service to forward additional evidence to demonstrate compliance. In such circumstances the appropriate discount will be applied from the beginning of the financial quarter following the date of the assessment visit. Due to the nature of the Level 2 and 3 assessment processes, which rely heavily on evidence of implementation and monitoring, via the review of health and other records by the assessors, clarification periods will not under any circumstances be offered at Levels 2 and 3.

Those maternity services assessed as complying with the standards at Level 1 will receive a discount for 24 months. Those assessed as complying with the standards at Level 2 or 3 will receive a discount for 36 months.

Where a maternity service drops to a lower level before expiry of the 24 or 36 month period, the risk management discount will be determined by the new level and be applied from the beginning of the following financial quarter.

Support

4.13. All maternity services that are subject to assessment or have a valid assessment level, can request one informal visit from their assessor in each financial year, subject to a reasonable notice period, to provide focused advice and guidance in relation to the standards and to monitor progress against the maternity service’s action plan. Informal visits may not take place within three months of a forthcoming assessment. Maternity services due to be assessed between April and June may have two informal visits during the previous financial year instead of one in the year of assessment.

Following the visit, the maternity service should update their action plan to incorporate any recommendations agreed with the assessor.

4.14. Each maternity service has its own particular needs and potential areas of difficulty in relation to the standards which an informal visit will aim to address. To ensure that the visit meets the needs of the maternity service, an agenda for the day should be developed to include, as a minimum, the following:

- General update on the standards and assessment process - This will include an update on the manual, “hotspots”, the evidence template, the template documents and frequently asked questions.
- Action plan - This may be from the previous CNST maternity assessment, or alternatively the maternity service may have completed its own action plan. This will form the basis for the discussion and will be reviewed for progress and development.
- If beneficial, meetings with the maternity service’s leads on risk areas addressed by the standards could be arranged. These staff may have particular concerns regarding aspects of future assessments and require advice on preparing for the next assessment and the evidence that may be required.

4.15. Many maternity services will request an education session or presentation from their assessor during the informal visit. Where possible this will be accommodated but the exact nature of this should be agreed with the maternity service’s assessor in advance of the informal visit. It will not be possible for the assessor to develop a
bespoke presentation or education session for the maternity service. The assessment team has a number of standard education packages which can be used and these can be discussed in further detail with the assessor.

4.16. If a maternity service cancels an informal visit without good reason and/or giving reasonable notice, the NHSLA reserves the right to recharge non-refundable accommodation and travel expenses incurred by the assessor(s).

4.17. For some maternity services the annual informal visit is sufficient to help them maintain and move through the levels of the standards and implement safe systems and processes, but for others it is not. For this reason, and in response to requests from maternity services, the NHSLA has agreed that DNV may provide an opportunity for such maternity services to purchase a limited number of additional support visits. For further information about the additional support visits, please contact your assessor or email nhsla@dnv.com.

4.18. Networking and sharing between maternity services is important. On request, your assessor may be able to provide you with information about maternity services that have demonstrated clear and comprehensive systems for achieving compliance with specific criteria.

4.19. The assessment team is always happy to answer questions by email or telephone on specific aspects of the standards. However, the assessors are not in a position to be able to review in full documentation submitted to them outside of a formal assessment or informal visit.

It is always best to contact the named assessor for the maternity service, although other members of the assessment team will be able to provide some assistance. There is a contacts list for the assessors and NHSLA risk management team on the NHSLA website at www.nhsla.com.

In order to ensure that the independence of the assessors is not compromised, and that all maternity services are dealt with on an equitable basis, general risk management advice cannot be given to individual maternity services.

4.20. Appendix G: Clarification of Terms has been compiled to define the words and phrases used in this manual to which a specific meaning applies in the context of the standards and assessments. These terms appear in colour and italics in the standards.

4.21. This manual contains references to documentation which supports the rationale for including the criterion (such as national recommendations and claims information), and materials to assist maternity services in achieving compliance with the criterion. In addition, template documents have been developed to assist maternity services in demonstrating compliance with the NHSLA risk management standards. These can be found at www.nhsla.com/publications.

The template documents provide a framework within which to develop policies, procedures, etc. to support best practice and references to assist maternity services in complying with the standards, but their use is entirely optional.

4.22. Frequently asked questions, which are update quarterly are also available on the NHSLA website at www.nhsla.com/publications and provide answers to common questions on the standards and assessment process.
Sharing Assessment Information

4.23. The NHSLA will publish assessment results, on both an individual and aggregate basis, on its website.

Assessment results can be found on Factsheet 4 which is updated monthly and provides details of the current levels achieved by maternity services at assessment against the CNST Maternity Clinical Risk Management Standards and other NHSLA standards.

In addition, the NHSLA will also publish on its website the reports which are produced following assessments. If the maternity service wishes to raise any concerns as to the wording and/or factual accuracy of the report, these should be notified to their assessor within 20 working days of receipt of the report. It will not be possible to make any additions to the report.

Further information about assessments may be disclosed under the Freedom of Information Act 2000.

4.24. Where the NHSLA has concerns about a maternity service it will share them with regulators such as the Care Quality Commission and Monitor, and with the local Strategic Health Authority cluster. Additionally, the NHSLA may on occasion be invited to participate in meetings to review concerns that have been raised about organisations. These meetings are usually led by the Care Quality Commission and may involve a range of regulators, audit and risk management bodies working with the Strategic Health Authority cluster and others to review plans and activity to:

- ensure the safety, quality and effective use of resources;
- target activity to be more effective and efficient;
- jointly agree prospective, risk-based regulatory plans.

4.25. Maternity services may wish to publish information relating to their assessments on their own public websites. Such information might include assessment reports or minutes of meetings where assessments are discussed. The NHSLA recognises this as good practice but would request that neither NHSLA nor DNV staff be named in such documents. In publishing assessment related information on their websites, maternity services are reminded that they have a duty to ensure the accuracy of such information.
5. **MEASURING PERFORMANCE**

5.1. The progression of organisations through the standards is logical and follows the development, implementation, monitoring and review of policies and procedures.

<table>
<thead>
<tr>
<th>Level 3 - Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>The process for managing risk, as described in the approved documentation at Level 1, is working across the entire maternity service. Where deficiencies have been identified through monitoring, action plans must have been drawn up and changes made to reduce the risks.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 2 - Practice</th>
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</thead>
<tbody>
<tr>
<td>The process for managing risks, as described in the approved documentation at Level 1 is in use.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 1 - Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>The process for managing risks has been described and documented.</td>
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</table>

5.2. Each level contains five standards and within each standard there are ten criteria which are equally weighted. An overview of the criteria can be found in Section 9 - Overview of Risk Areas of this manual.

5.3. Each criterion has a title, which outlines the risk issue to be addressed, followed by a list of the minimum requirements that the assessor(s) would expect to see being met in order to award compliance with the criterion.

The minimum requirements at Level 1 which are carried forward to Levels 2 and 3 are highlighted in **bold**. Minimum requirements which are carried forward to higher levels but with a slightly different emphasis are highlighted in **bold italics**. It is important to note that the NHSLA may change the Level 1 requirements carried forward for assessment at Levels 2 and 3, either wholly or in part at any time in the future. Changes such as these will not be piloted.

5.4. Maternity services undergoing an assessment against the standards, excluding those which solely provide midwifery led care, will be assessed against each of the criteria.

Maternity services which solely provide midwifery led care will only be assessed against those criteria which are relevant to the care that they provide. The criteria that are relevant will be agreed between the assessor and the maternity service in advance of the assessment and prior to an assessment date being booked.

Whilst for the purposes of the assessment some criteria will be deemed not applicable as a whole, services providing midwifery led care are still encouraged to self-assess against the requirements within them that are relevant to the care provided.
5.5. Maternity services undergoing an assessment against the standards, excluding those which solely provide midwifery led care, will be scored in accordance with the table at 5.14. The pass mark at each level is 40 out of 50 criteria with no fewer than seven criteria passed in any one standard. The level of compliance achieved will be determined in accordance with the table at 5.14.

Maternity services which solely provide midwifery led care will be scored in accordance with the number of criteria assessed. The overall pass mark at each level and number of criteria to be passed in each standard will be agreed between the assessor and the maternity service in advance of the assessment and prior to an assessment date being booked.

Assessment requirements at all levels

5.6. At all levels of assessment maternity services should provide evidence for all care settings (including home births), all staff groups and all patient groups. Where a maternity service provides services across one or more sites evidence should be presented from all sites and should be proportional to the number of births per site. The onus is on the maternity service to highlight to the assessor(s) where the evidence has come from.

5.7. All of the criteria require an approved clinical guideline/documentation to be in place. These could include care pathways, standard operating procedures or protocols. Such evidence provided in support of a criterion must be in place and effective at the time of assessment and been approved by the agreed method as per the organisation/maternity services procedure that covers the relevant clinical area. Draft documentation, or planned or proposed systems that have not been implemented, will not be admissible.

It is expected that all clinical guidelines/documentation will be referenced, evidenced based and where applicable include and reflect national guidance. Some of the criteria expect maternity services as a minimum to follow NICE or other national guidance. For these particular criteria, which are clearly identifiable within the manual, the assessors will be checking the maternity service’s guideline against the relevant and most up to date NICE or other national guidance. Where the NICE or other national guidance is not met in full compliance will not be awarded.

In instances where the maternity service has chosen not to implement national guidance the reasons for this should be fully documented, approved by the relevant committee and provided in the evidence portfolio. The maternity service must also provide evidence of how the relevant risk area is being addressed. The evidence provided must be relevant to the assessment level, e.g. an approved document at Level 1, evidence of implementation at Level 2 and monitoring at Level 3.

5.8. At all levels the evidence presented at assessment must be in use and reflective of day to day practice within the maternity service. To test this, the assessor(s) will randomly select ten documents from the maternity service’s evidence portfolio and ask to see evidence of their approval. Additionally the assessor(s) will review the maternity service’s intranet and/or policy folders to ensure that the ten documents are readily available for use by staff. If the maternity service is unable to evidence that a document is approved and in use then it will fail the relevant criterion even if all the minimum requirements for this criterion have been met. For example, a maternity service meeting the Level 1 requirements of criterion 2.2 – Intermittent Auscultation would fail that criterion if it were unable to evidence that the guideline presented was in use and available within the maternity service.
Assessment requirements at Level 1

5.9. The Level 1 assessment is only concerned with the existence of the minimum requirements for each criterion in the approved documentation and as such the quality of these will not be rigorously tested until a Level 2 assessment. Therefore, compliance at Level 1 should not be seen as an indication that the maternity service will be able to demonstrate compliance at Level 2 or that it is effectively managing risks.

Assessment requirements at Levels 2 and 3

5.10. At Levels 2 and 3, the service must provide 12 months of evidence to demonstrate compliance. In such instances, the 12 month period must reflect the maternity services own data collection systems. Therefore, the 12 month period must reflect one of the following:

- the 12 calendar months preceding assessment - if this option is chosen the last month in the data collection period must be no later than 12 months before the assessment e.g. if the maternity service is being assessed in December 2012, the last month in the data collection period must not pre-date December 2011;
- the financial year immediately preceding assessment;
- the calendar year immediately preceding assessment.

The maternity service should indicate to the assessors on the evidence template the data collection period being used.

The evidence presented to the assessors must be reflective of the full time period i.e. in presenting evidence for a calendar year it would not be acceptable to present health records for births during September to December only. Failure to provide such evidence will result in non-compliance being awarded.

In circumstances where processes are new, evidence of previous processes may be acceptable. The maternity service should discuss such instances with the assessors prior to assessment.

5.11. The assessment process for each level is different and the principles are described below:

**Level 1 - Documenting (Policy)**

Only the approved documents that demonstrate that the processes for managing risks have been described and documented are requested at Level 1. The documents presented as evidence at assessment must be in use and reflective of day to day practice within the maternity service and this will be tested via the random selection of documents as described under 5.8 above.

Evidence relating to implementation is not required and will not be assessed if presented.
**Level 2 - Implementing (Practice)**

The documents presented as evidence at assessment must be in use and reflective of day to day practice within the maternity service and this will be tested via the random selection of documents as described under 5.8 above.

The Level 2 assessment process seeks to demonstrate that the processes for managing risks as described in the approved documentation have been implemented. Therefore, unless specifically stated in individual criteria, audits and other monitoring tools will not be acceptable as evidence of implementation at Level 2. Whilst monitoring tools will give the organisation assurance that systems are being implemented they would by themselves be unable to provide practical evidence of implementation and as such the assessor will need to see health records, risk assessments, incident reports, meeting minutes, rotas, training records, etc.

As indicated in 5.12 the majority of the Level 2 criteria require maternity services to demonstrate via their health records that the processes for managing risk have been implemented. Maternity services should select health records for review by assessors in accordance with the principles outlined in 5.12.

To achieve compliance at Level 2 maternity services will need to demonstrate via their health records that processes to manage risk have been implemented in a minimum of 75% of cases.

For criterion 1.10: Skills Drills, maternity services will need to demonstrate that 75% of eligible staff have received multidisciplinary training in skills drills.

For those criteria which do not specifically require evidence in the form of health records, maternity services will be required to demonstrate via evidence that may include risk assessments, incident reports, meeting minutes, rotas, training records, etc. that processes are being implemented.

For any of the Level 2 criteria, the assessors may ask to interview staff to seek clarification on the evidence reviewed and may also ask to visit clinical areas to verify whether systems are in place.

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**Level 3 - Monitoring (Performance)**

The documents presented as evidence at assessment must be in use and reflective of day to day practice within the maternity service and this will be tested via the random selection of documents as described under 5.8 above.

At Level 3 maternity services will be expected to demonstrate through monitoring that their processes to manage risk have been implemented. In monitoring those processes, which specifically utilise health records, maternity services should select health records for review in accordance with the principles outlined in 5.12.

For all criteria and/or minimum requirements that specifically utilise health records maternity services will need to demonstrate, via monitoring, that their processes to manage risk have been implemented in a minimum of 75% of cases.
In monitoring those processes which do not specifically utilise health records as part of the assessment process, maternity services must demonstrate that the processes for managing risk, as described in the Level 1 approved documentation, are implemented and effective across the entire maternity service.

Monitoring should reflect all care settings (including home births), all staff groups and all patient groups.

Where deficiencies have been identified action plans must have been drawn up and changes made to reduce the risks. It is expected in all cases that maternity services should be striving to achieve 100% implementation rates, therefore action plans should detail those actions required to achieve 100% compliance.

For any of the Level 3 criteria, the assessors may ask to interview staff to seek clarification on the evidence reviewed and may also ask to visit clinical areas to verify whether systems are in place and working.

5.12. At Levels 2 and 3, the assessors will review a number of health records. To ensure consistency in the assessment process, where health records are assessed, a sample size and minimum level of implementation have been set and are detailed within each criterion. In addition to the sample records provided, assessors will select further health records to review at random.

In all instances assessors should be provided with full sets of health records representing complete episodes of care. Therefore, they must include hand held records and antenatal, intrapartum and postnatal records. Photocopies of records or the presentation of sections of health records will not be acceptable.

**Level 2**

To assure themselves as to the extent of the maternity service’s level of implementation of the risk management processes described in their approved documentation, the assessors will assess a minimum sample size based on either:

- 100% of cases from the year preceding the assessment; or
- 0.5% of (or a maximum of 50) health records; or
- a set number of health records relating to a particular clinical condition.

The required sample sizes are highlighted within the ‘method of assessment’ section which can be found within each criterion. In preparing for an assessment, maternity services should closely refer to this information. A summary of the method of assessment for Level 2 can be found at Appendix D: Method of Assessment.

For all Level 2 assessments maternity services will be required to pre-select a number of health records for review by the assessors on the following basis:

- where the ‘method of assessment’ section requires a 100% of cases the maternity service should select all sets of health records which relate to the specific area being assessed;
- in instances where the ‘method of assessment’ section requires a set number of health records, only that set number should be selected, other than where a maternity service has had fewer than the required number of incidences of the particular clinical condition being assessed when it should provide the assessors with all the health records that are available.

For those criteria which rely on health records as evidence **and** require a 0.5% sample the assessors will visit clinical areas and randomly select health records. At
least half of the health records used for the spot check will be selected from clinical areas on the day of assessment. The health records will not be removed from the clinical area and at no time will the assessors compromise clinical care. If the health records available in clinical areas do not provide the required sample, the assessors will supplement them by random selection from those pre-selected by the maternity service and included in the evidence portfolio.

It will not be possible for the assessors to view additional health records if those selected at random are found to be non-compliant.

To award a score the assessors will need to be assured that the records reviewed for each criterion meet all of the relevant minimum requirements. For example in assessing 2.3: Continuous Electronic Fetal Monitoring 75% of CTG traces reviewed would need to meet all of minimum requirement b. regarding the minimum data that should be recorded on the tracing.

Maternity services should note that if the assessors, during their review of health records, identify loose records, results, etc. this will result in non-compliance being awarded for criterion 1.7: Maternity Records.

**Level 3**

At Level 3 maternity services will be expected to demonstrate through monitoring that their processes to manage risk have been implemented. In monitoring those processes, which specifically utilise health records, maternity services will be expected to utilise one of the following sample sizes, which will be either:

- 100% of cases from the year preceding the assessment; or
- 1% or 10 sets (whichever is the greater) of health records.

The required sample sizes are highlighted within the Level 3 ‘method of assessment’ section which can be found within each criterion. In preparing for an assessment, maternity services should closely refer to this information. A summary of the method of assessment for Level 3 can be found at Appendix D: Method of Assessment.

For all Level 3 assessments maternity services will be required to pre-select a number of health records for review by the assessors on the following basis. These should be selected using the same principles as for a Level 2 assessment, i.e.:

- where the Level 2 ‘method of assessment’ section requires a 100% of cases the maternity service should select all sets of health records which relate to the specific area being assessed;
- in instances where the Level 2 ‘method of assessment’ section requires a set number of health records, only that set number should be selected, other than where a maternity service has had fewer than the required number of incidences of the particular clinical condition being assessed when it should provide the assessors with all the health records that are available.

At Level 3 the assessors will select criterion 1.7 and a further 16 criteria (four criteria each from standards 2-5) and will spot check health records, training records, etc. to assure themselves as to the validity of the maternity service’s monitoring results. The assessors will spot check a maximum of eight records for each criterion.

For those criteria which rely on health records as evidence the assessors will visit clinical areas and randomly select health records. At least half of the health records used for the spot check will be selected from clinical areas on the day of assessment. The health records will not be removed from the clinical area and at no time will the
assessors compromise clinical care. If the health records available in clinical areas
do not provide the required sample, the assessors will supplement them by random
selection from those pre-selected by the maternity service and included in the
evidence portfolio.

If any of the spot checked health records do not demonstrate 75% compliance these
findings will override the evidence provided by the maternity service and will result in
no score being awarded for that criterion.

Maternity services should note that if the assessors, during their review of records,
identify loose records, results, etc. this could result in non-compliance being awarded
for criterion 1.7: Maternity Records.

5.13. The assessor(s) will endeavour to inform the maternity service of the assessment
outcome at the end of the two day visit. In exceptional circumstances, at Level 1
extra time or a clarification period may be allowed after the assessment visit to
enable the maternity service to forward additional evidence to demonstrate
compliance. If this is the case, the assessor will discuss the arrangements with the
maternity service at the time of the assessment.

As indicated under 4.12, due to the nature of the Level 2 and 3 assessment
processes, which relies heavily on evidence of implementation, via the review of
health and other records by the assessors, clarification periods will not under any
circumstances be offered at these levels.
Assessment scoring table for maternity services excluding those which solely provide midwifery led care:

<table>
<thead>
<tr>
<th>Existing CNST Level</th>
<th>2</th>
<th>3</th>
<th>3</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level Applied for</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

| Score Range         | 40 - 50 | | 30 - 39 | | 29 or less | |
|---------------------|---------|---------|---------|---------|---------|
| Outcome*            | Pass    | Pass    | Fail    | Fail    | Fail    | |
| Level achieved      | 1       | 1       | 2       | 1       | 2       | 3   |
| Time frame for reassessment | 2yrs | 2yrs | 3yrs | 2yrs | 3yrs | 3yrs |
| Level(s) organisation can next be assessed at | 1 or 2 | 1 or 2 | 1, 2 or 3 | 1 or 2 | 1, 2 or 3 | 1, 2 or 3 |

| Score Range         | 40 - 50 | | 30 - 39 | | 29 or less | |
|---------------------|---------|---------|---------|---------|---------|
| Outcome*            | Fail    | Fail    | Fail    | Fail    | Fail    | Fail |
| Level achieved      | 0       | 0       | 1       | 0       | 1       | 2   |
| Time frame for reassessment | 6 months | 6 months | 1yr | 6 months | 1yr | 1yr |
| Level(s) organisation can next be assessed at | 1 | 1 | 1 | 1 | 1 | 1 or 2 |

* To pass a maternity service must score no fewer than seven criteria in any one standard.
6. **ASSESSMENT PROCEDURE**

6.1. To assist maternity services in preparing for assessment, an evidence template has been produced which is in electronic spreadsheet format. There is a single template workbook encompassing the three assessment levels. The template allows maternity services to conduct self-assessments and is also used by the assessors at assessment to record scores and findings. Further guidance on the use of the template can be found on the NHSLA website at [www.nhsla.com/publications](http://www.nhsla.com/publications).

**Self-Assessment**

6.2. In the year(s) between formal assessments, maternity services are encouraged to undertake a self-assessment against the standards using the appropriate level(s) on the evidence template. This template can be used to create action plans to assist the maternity service in preparing for future assessments and/or informal visits. It is recommended that action plans should be completed following each assessment and/or informal visit, and that these should include realistic timescales and designated responsibilities for taking the actions forward. After completion the maternity service should confirm the actions with their assessor as these will be reviewed at subsequent assessments and may be requested by other bodies for their reviews. The action plan should therefore be kept up to date and readily available.

6.3. The maternity service should carefully study the report from the last assessment which will detail areas requiring attention.

**Pre-Assessment**

6.4. Where a mandatory assessment is due, the assessor will contact the maternity service, giving a minimum of three months’ notice of the intended assessment. However, the maternity service may choose to contact their assessor to book a date for the assessment. All mandatory assessments must be booked at the very latest by 31st May of the financial year in which they are to be conducted.

If a maternity service wishes to be assessed at a higher level between mandatory assessments, the onus is on the maternity service to contact their assessor to book an assessment date.

Assessors will do their best to accommodate requests for visits at a time most convenient for the maternity service, but to improve the choice of dates maternity services should discuss this with their assessor as early as possible. Assessments may not however be booked more than twelve months in advance.

6.5. When booking an assessment, maternity services must state the level at which they wish to be assessed. All requests for a change to a lower level assessment will be accepted, but must be notified to the assessor at least 20 working days before the assessment. Maternity services wishing to change to an assessment at a higher level must put their request in writing to their assessor for consideration a minimum of three months prior to the assessment date.

6.6. Assessments at all levels comprise two consecutive days on site. When dates for the assessment have been agreed, the assessor will send a booking letter to the contact within the maternity service confirming the dates and setting out a proposed programme for the assessment. Whilst other documentation will not be reviewed in advance of the assessment visit, the maternity service must email its risk
management strategy, service profile and the background information sheet to the assessor ten working days prior to the assessment date to enable the assessor(s) to prepare for the assessment. The maternity service’s assessor will provide a blank service profile and background information sheet for completion.

6.7. The standards are set out in full in this manual, and it is essential that in preparing for assessment maternity services refer to these and the minimum requirements therein. In addition, maternity services are advised to consider the Level 2 and 3 requirements when addressing the Level 1 criteria, to ensure that the objectives the maternity service sets itself at Level 1 are measurable and achievable.

6.8. The evidence template must be completed. The template and guidance on its completion can be found at www.nhsla.com/publications.

Each of the three levels is a distinct assessment containing its own individual question sets and scored on a stand-alone basis. Although lower level(s) will not be reassessed as the maternity service progresses, a completed evidence template and Level 1 documents must be available on the assessment days irrespective of the level being assessed to enable the assessor to check that the processes being implemented at Level 2 are those in the approved documentation, and at Level 3 that monitoring of the processes implemented also reflects the approved documentation.

6.9. The onus is on the maternity service to demonstrate compliance with the risk management criteria. The maternity service must draw to the attention of the assessor(s) the evidence for each of the risk areas. The time available for the assessment will not permit the assessor(s) to search for evidence.

The reference column of the appropriate evidence template must be completed to alert the assessor(s) to where each of the minimum requirements can be found within the documents submitted.

If the evidence template has not been fully completed, and the maternity service is unable to signpost the assessor(s) to the relevant evidence (in either electronic or hard copy format) within the time allowed, the assessor(s) may be unable to complete the assessment. This may result in the maternity service being deemed to be at Level 0 and may lead to a refusal by the NHSLA to provide indemnity.

6.10. Documentary evidence, where required, may be provided in electronic or paper format (or a combination of both). If the maternity service has electronic health records, these will be viewed by the assessor(s) on the maternity service’s electronic system and do not need to be printed.

6.11. It is assumed that responsibility for the assessment will rest with the executive director responsible for risk management within the maternity service. The executive director or delegated contact person should use the notification period to ensure that all staff involved are fully briefed on the purpose of the assessment, their specific role, and the role of the assessor(s).

6.12. Section 251 approval has been obtained for assessors to see confidential patient information as part of the NHSLA assessment process, subject to certain conditions. One of these conditions is that the NHSLA should provide some text for maternity services to include in their own patient information about how patient records and incident forms are used as part of the NHSLA assessment process. The following words are recommended:

“Use of patient information by the NHS Litigation Authority

The NHSLA has a statutory duty to manage and raise the standards of risk management throughout the NHS. In order to achieve this, all NHS trusts are assessed every few years against a set of risk management standards which are
based on those factors which give rise to the greatest number and cost of claims. More information about the NHSLA risk management programme is available on its website at www.nhs-la.com/riskmanagement.

As part of the assessment process, the assessors will look at health records and a selection of incident report forms. None of these documents will be removed from the premises. The aim is to ensure that these documents are created and managed in accordance with appropriate policies and procedures: for example whether they are written clearly, signed and dated, stored securely, etc. The assessors are not concerned with individual patient details. They are all professional people who have previously worked in NHS organisations and are now employed on behalf of the NHSLA under strict principles of confidentiality.

If you wish to object to your records being made available during an NHSLA assessment, please just notify the trust.”

Assessment

6.13. Where assessments are carried out by more than one assessor, the named assessor will lead the assessment and make decisions on the outcome. The lead assessor is responsible for making all arrangements for the assessment and ensuring that it is completed within the specified time frames. Responsibilities of the lead assessor include:

- acting as the spokesperson for the team on site;
- managing the assessment;
- encouraging communication among team members;
- evaluating team progress and coordinating meetings with team members and maternity service staff as needed;
- coordinating any ongoing discussions with the maternity service and providing feedback, as appropriate, to the maternity service on the status of the assessment;
- facilitating opening and closing meetings; and
- coordinating and preparing the assessment report.

In most circumstances Level 1 assessments will be conducted by one assessor. All Level 2 and 3 assessments will be conducted by two or three assessors. The exact number of assessors will be determined by the size and complexity of the maternity service.

As part of the ongoing development and quality assurance process of the assessment team, the assessor(s) may be accompanied by another assessor or manager, or a representative from the NHSLA or other relevant body. If this is proposed the maternity service will be notified in advance.

6.14. For the duration of the visit, the assessor(s) will need an office to work in (with electrical power sockets for the assessor(s) laptop(s)) which is of sufficient size to accommodate interviews with relevant staff. In preparing an office for the visit the maternity service is asked to consider the requirements of the Health and Safety (Display Screen Equipment) Regulations 1992 and provide a suitable desk(s) or table(s) with adjustable chair(s). If the assessor(s) is unable to work safely in the office provided they may ask for alternative accommodation. If suitable accommodation and furniture cannot be found the assessor(s) may be unable to undertake the assessment.
6.15. The executive director or delegated contact person should be available during the visit to provide the necessary detail and information.

6.16. On arrival at the assessment the evidence template will need to be made available to transfer onto the assessor(s) laptop(s), e.g. via a data stick. If any problems are foreseen with this data transfer the maternity service should contact the assessor in advance of the assessment.

6.17. The assessor(s) will work through the standards, evaluating the evidence provided and recording the findings on the evidence template completed by the maternity service.

6.18. During the visit, the assessor(s) may need to talk to a number of people from the maternity service to clarify and support the documentation reviewed. It is preferable if these interviews can take place in the office allocated to the assessor(s) (if this is not convenient please discuss the arrangements with the assessor(s)). In addition at Level 2 and 3, the assessor(s) will ask to visit areas of the maternity service to review evidence in practice. Where maternity services are provided at two or more sites, the assessor(s) may ask to visit more than one site. Please note that at no time should the arrangements for the assessment visit compromise patient care in any way.

6.19. In some circumstances the evidence provided by the maternity service may not be sufficient and the assessor(s) may seek further documentary evidence. To enable the assessor(s) to determine an assessment outcome, the maternity service will be required to submit additional evidence well in advance of the feedback session at the end of the assessment visit.

6.20. The assessor(s) will not normally need to take paper copies of any evidence away from the site at the end of the assessment. If it is necessary to take copies (for instance, in the case of a borderline assessment), permission will be sought.

Electronic evidence is in many cases transferred to the assessor’s laptop with the evidence template. If this is the case, in accordance with good information governance practices, the assessor will delete the evidence once the report has been published on the NHSLA website. Any evidence temporarily stored on assessors’ laptops is subject to strict IT and data security protocols. If the maternity service has any concerns about evidence being kept by the assessor it should raise these with the assessor in advance of the assessment.

6.21. The assessor(s) may need some time alone during the assessment visit to study the evidence thoroughly and review their findings.

6.22. The outcome will be based on the evidence provided for review during the two day assessment period only, unless a clarification period is given.

6.23. The assessor(s) may not be able to inform the maternity service of the outcome at the end of the assessment visit as on some occasions it may be necessary for the assessor(s) to review their findings with colleagues to ensure consistency.

6.24. In the suggested timetable a short period is allowed at the end of days one and two of the assessment visit for informal feedback. These sessions should be limited to a maximum of six representatives from the maternity service (other than with the express permission of the assessor), which should ideally include an executive director. The assessor(s) and the maternity service should use this time as an opportunity to discuss any outstanding issues or concerns.
Post-Assessment

6.25. Within 20 working days of the assessment date, or end of improvement measures or a clarification period if given, the maternity service will receive a detailed report of the assessment outcome.

6.26. If the maternity service has any concerns about the assessment or report it should raise these with their assessor or the DNV Head of Resources as soon as possible and no later than 20 working days after receipt of the report. If the concerns are not resolved to the maternity service’s satisfaction and it feels that the assessment outcome is unjust, it may refer the matter to the NHSLA. An email or letter should be sent to the Risk Management Director as soon as possible, and no later than 40 working days following receipt of the assessment report.

6.27. Any allegations regarding the improper conduct of risk management assessments will be dealt with in accordance with the NHSLA Complaints Policy. A leaflet is available on the NHSLA website.

6.28. Rare instances of inappropriate behaviour towards risk management assessors in performing their duties have made it necessary for DNV to introduce a Procedure for Dealing with Abusive or Threatening Behaviour from External Sources. A copy of this procedure can be obtained on request from DNV.

6.29. DNV, as part of its commitment to the provision of a quality service to the NHSLA and its scheme members, aims to gather feedback on the services provided. All maternity services that undergo assessment against the CNST Risk Management Standards will be invited to complete a web based survey. Feedback from the survey will be used to inform the development of the standards and assessment process.
7. Changes to Standards since Previous Version

Introductory Sections

The paragraph numbers below are those in this 2012/13 manual.

3.5 The objectives of the standards have been revised to take into account feedback from the NHSLA Risk Management Forum. Additionally the NHSLA was a core participant at the Mid Staffordshire NHS Foundation Trust Public Inquiry and as a result of the questions raised during that inquiry changes were made to the objectives to clarify the overall purpose of the standards.

3.6 DNV have reviewed their approach to allocating assessors. The majority of assessments continue to be booked for quarters 3 and 4. Combined with winter pressures and an increasing number of higher level assessments, which require more assessors, this means that DNV can no longer guarantee that assessments will be conducted by the maternity service’s named assessor.

As such maternity services will have a named assessor from a regional pool of assessors.

4.2 When a criterion has been removed in full from the standards the NHSLA still expects a maternity service to have in place appropriate systems to manage the relevant area(s) of risk. Therefore, the NHSLA has reviewed its approach to removing criteria from the standards. In previous years criteria were removed in full from the standards and thus from the assessment manual. Going forward criteria that are removed from the standards will be placed in Appendix F of the manual along with the date of and rational for their removal.

Reference sources for these criteria will be removed due to the administrative difficulties of ensuring their continuing relevance.

The NHSLA reserves the right to reinstate these criteria at any time.

4.11 As previously, maternity services undergoing significant restructuring will be allocated an assessment level by the NHSLA immediately post event. The level allocated and future arrangements for assessment will be determined by the specific circumstances of the changes and maternity services undergoing restructuring are asked to write to the NHSLA Risk Management Director, copying in their allocated assessor and providing information on the scope and nature of the restructuring.

5.4, 5.5 and 5.14 The NHSLA has reviewed its approach to assessing maternity services which solely provide midwifery led care. These services will continue be assessed against those criteria which are relevant to the care that they provide however the exact criteria and scoring process will be decided on an individual basis.

5.7 Revised to emphasise that maternity services must ensure their guidelines follow the most up to date NICE or other national guidance. Where maternity services have chosen not to follow national guidance they must still evidence how the relevant risk area is being addressed.

5.8 The current assessment practice of randomly selecting ten documents from the maternity service’s evidence portfolio to determine if they are in use and available within the maternity service, will be extended from Level 1 to Levels 2 and 3.

5.12 To ensure a more robust assessment of health records, assessors will visit clinical areas and randomly select health records for those criteria which rely on health records as evidence and require a 0.5% sample. At least half of the health records used for the spot check will be selected from clinical areas on the day of assessment. If the records available in clinical areas do not provide the required sample, the assessors will supplement them by random selection from those pre-selected by the maternity service and included in the evidence portfolio.
Section 8  Pilot criteria will no longer be included in the standards manual but published in a separate document at the beginning of the financial year. Comments on the pilot criteria will be welcomed and testing is to take place outside of the formal assessment process.

Section 11  The appendices section has been expanded to include criteria that have been removed from the standards, a list of stakeholders who have been involved in the development and review of the standards, and a summary of the method of assessment at Level 2 and 3.

Detailed Standards

Information on the changes made to the 2011/12 version of the standards in this 2012/13 version is set out below.

In a number of the criteria the wording of the statement relating to the process for documentation has been changed to ensure consistency throughout the standards but this has not changed what is required.

Changes to whole criteria

STANDARD 1

1.6: Guideline Development has been removed
1.11: Labour Ward Staffing, which was assessed on a pilot basis in 2011/12, has replaced 1.6. It will be formally assessed in 2012/13.

STANDARD 3

3.3: Operative Vaginal Delivery has a change in the order of the minimum requirements
3.7: Postpartum Haemorrhage (Midwifery Led Units) has been removed

STANDARD 4

4.4: Patient Information and Discussion is now called Patient Information
4.9: Maternal Transfer by Ambulance has a change in the order of the minimum requirements

STANDARD 5

5.2: Neonatal Resuscitation is now called Newborn Life Support

Pilot minimum requirements

Pilot minimum requirements are listed in the table below. These will be assessed on a pilot basis only in 2012/13 and failure to meet them will not result in the maternity service failing the relevant criterion.

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Pilot Minimum Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.6: Labour Ward Staffing</td>
<td>vi. uterine rupture</td>
</tr>
</tbody>
</table>
Criterion | Pilot Minimum Requirement
---|---
2.3: Continuous Electronic Fetal Monitoring | e. fresh eyes review of minimum requirement d) by another healthcare professional
5.2: Newborn Life Support | c. deliveries to be attended by a clinician (doctors, advanced neonatal nurse practitioner, midwives) with newborn life support skills

Minimum requirements have been added to the following criteria (for clarification, not pilot)

STANDARD 2
2.3: Continuous Electronic Fetal Monitoring

STANDARD 4
4.8: Handover of Care (Onsite)

Minimum requirements have been removed from the following criteria

STANDARD 1
1.6: Labour Ward Staffing

STANDARD 3
3.3: Operative Vaginal Delivery

STANDARD 4
4.8: Handover of Care (Onsite)

STANDARD 5
5.2: Newborn Life Support

Wording of the minimum requirements has changed in the following criteria (not piloted)

STANDARD 1
1.1: Risk Management Strategy (Organisation)
1.2 Risk Management Strategy (Leadership)
1.6: Labour Ward Staffing

STANDARD 2
2.2: Intermittent Auscultation

STANDARD 3
3.1: Severe Pre-Eclampsia
3.2: Eclampsia
3.4: Multiple Pregnancy & Birth
3.5: Perineal Trauma
3.10: Obesity
STANDARD 4
   4.1: Booking Appointments
   4.4: Patient Information
   4.8: Handover of Care (Onsite)
   4.10: Non-Obstetric Emergency Care

STANDARD 5
   5.1: Referral when a Fetal Abnormality is Detected
   5.2: Newborn Life Support
   5.5: Newborn Feeding
   5.6: Examination of the Newborn
   5.8: Support for Parent(s)

Minimum requirements which are carried forward have changed in the following criteria

The NHSLA has previously indicated that the Level 1 requirements carried forward for assessment at Levels 2 and 3 may be changed either wholly or in part at any time. These changes will not, therefore, be piloted and assessment against the minimum requirements will be scored and form part of the assessment.

STANDARD 2
   2.9: High Dependency Care

STANDARD 3
   3.7: Postpartum Haemorrhage
   3.10: Obesity

STANDARD 4
   4.8: Handover of Care (Onsite)

STANDARD 5
   5.2: Newborn Life Support
   5.6: Examination of the Newborn
   5.7: Bladder Care

Changes to the ‘Method of Assessment’ have been made in the following criteria

STANDARD 1
   1.6: Labour Ward Staffing

STANDARD 2
   2.2: Intermittent Auscultation
   2.4: Fetal Blood Sampling

STANDARD 3
   3.2: Eclampsia
   3.8: Venous Thromboembolism
3.10: Obesity

STANDARD 4
   4.6: Mental Health
   4.8: Handover of Care (Onsite)

STANDARD 5
   5.6: Examination of the Newborn
   5.8: Support for Parent(s)
8. **OVERVIEW OF PROPOSED CHANGES AND RISK AREAS**

During 2012/13 the NHSLA will continue to explore proposals to further develop its risk management standards and assessments, including:

- Proportional assessments
- Assessment frequency
- Assessment dates

Updates on progress with the proposals will be provided in the NHSLA’s e-newsletter ‘Risk E-News’.

During 2012/13, the NHSLA will also continue its review of the discounts from schemes contributions given to maternity services for demonstrating compliance with the risk management standards at assessment. Any changes are likely to favour organisations achieving the higher levels.

The NHSLA Risk Management Standards have recently been revised to simplify the language used in both the standards and the introduction. During 2012/13, the CNST Maternity Standards will be going through a similar revision process.

The NHSLA is aware of concerns raised by some maternity services about the Level 3 audit requirements for maternity records. It has been suggested that for audits to be useful they need to cover a short timescale to allow for any deficiencies to be identified and rectified at an early stage. Thus the NHSLA’s requirement for audits to cover a twelve month period limits their usefulness. The NHSLA does not, however seek to prevent audits from being carried out on a more frequent and regular basis and would encourage maternity services to audit practice in accordance with their own predetermined timescales. Nevertheless for the NHSLA to award its highest level of compliance (Level 3) to a maternity service it needs to be assured that the systems and processes described within a service’s guidelines have been in place and working for a minimum of twelve months. The NHSLA will continue to look at alternative ways of seeking assurance that systems are in use and would welcome suggestions on how this can be achieved from maternity services or other stakeholders.

**Detailed Standards**

The standards and assessment process are reviewed annually to ensure that they continue to meet their objectives. The review process is continuous with a key aim being to ensure that each year the standards are published on time, allowing maternity services to prepare for assessment in a timely manner.

Throughout the year a DNV and NHSLA project group reviews national guidance, consults with stakeholders and reviews feedback on the standards and assessment process. Feedback from maternity services and the assessment team has the most significant impact on the standard review process. In addition assessment data is reviewed to identify trends.

This review process often highlights the need for new criteria to cover new or emerging risk areas. When new criteria are to be introduced they are piloted for one year to enable them to be tested and allow maternity services preparation time before being formally assessed against them.

In future, pilot criteria will no longer be included in the standards manual but published in a separate document on the NHSLA website at the beginning of the financial year. Maternity services and other stakeholders will have the opportunity to comment on them and influence
their development. More information on this will be provided when the pilot criteria for 2012/13 are published.

Pilot criteria will be tested in a small number of maternity services. The NHSLA plans to ask those organisations that are members of the NHSLA Risk Management Forum to participate in the pilot process but other volunteers would be welcomed.

**Criteria that may change in 2013/14:**

3.1: Severe Pre-Eclampsia and 3.2: Eclampsia may be merged.

4.5: Maternal Antenatal Screening Tests may be revised to include a new minimum requirement on scanning interpretation.

4.1: Booking Appointments may be revised to require that women have their first full booking visit and hand held record completed by ten completed weeks of pregnancy.

**Risk areas identified for possible inclusion in future standards:**

- Weighing Babies
- Sepsis
- Pre-Existing Medical Conditions
- Second Stage Caesarians Sections
- Specialist Training for Temporary Staff
- Jaundice
- Scanning Interpretation
- Elective and Emergency Theatre Workflow

**Assessment Process**

The NHSLA may change the Level 1 requirements carried forward for assessment at Levels 2 and 3 wholly or in part at any time in the future. These and other minor changes to individual criteria or minimum requirements will not be piloted.

The NHSLA may also increase or decrease the health and training records sample size required at Levels 2 and 3 at any time in the future.

The NHSLA may also move towards a random selection of all health records at any time in the future.

The need for maternity services to demonstrate that processes to manage risks have been implemented in 75% of cases to achieve compliance at Level 2 and 3 may be increased in the future.

The NHSLA may also introduce an appropriate standard of compliance for some criteria. For example in relation to criterion 1.9 – Training Needs Analysis, the maternity service may be expected to demonstrate a set percentage of relevant staff have attended training.
### 9. Overview of Risk Areas

All maternity services will be assessed against all of the criteria below.

<table>
<thead>
<tr>
<th>Standard</th>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Criterion</strong></td>
<td><strong>Organisation</strong></td>
<td><strong>Clinical Care</strong></td>
<td><strong>High Risk Conditions</strong></td>
<td><strong>Communication</strong></td>
<td><strong>Postnatal &amp; Newborn Care</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Risk Management Strategy (Organisation)</td>
<td>Care of Women in Labour</td>
<td>Severe Pre-Eclampsia</td>
<td>Booking Appointments</td>
<td>Referral When a Fetal Abnormality is Detected</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Risk Management Strategy (Leadership)</td>
<td>Intermittent Auscultation</td>
<td>Eclampsia</td>
<td>Missed Appointments</td>
<td>Newborn Life Support</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Staffing Levels (Midwifery &amp; Nursing Staff)</td>
<td>Continuous Electronic Fetal Monitoring</td>
<td>Operative Vaginal Delivery</td>
<td>Clinical Risk Assessment (Antenatal)</td>
<td>Admission to Neonatal Unit</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Staffing Levels (Obstetricians)</td>
<td>Fetal Blood Sampling</td>
<td>Multiple Pregnancy &amp; Birth</td>
<td>Patient Information</td>
<td>Immediate Care of the Newborn</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Staffing Levels (Anaesthetists &amp; Assistants)</td>
<td>Use of Oxytocin</td>
<td>Perineal Trauma</td>
<td>Maternal Antenatal Screening Tests</td>
<td>Newborn Feeding</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Labour Ward Staffing</td>
<td>Caesarean Section</td>
<td>Shoulder Dystocia</td>
<td>Mental Health</td>
<td>Examination of the Newborn</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Maternity Records</td>
<td>Induction of Labour</td>
<td>Postpartum Haemorrhage</td>
<td>Clinical Risk Assessment (Labour)</td>
<td>Bladder Care</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Incidents, Complaints &amp; Claims</td>
<td>Severely Ill Women</td>
<td>Venous Thromboembolism</td>
<td>Handover of Care (Onsite)</td>
<td>Support for Parent(s)</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Training Needs Analysis</td>
<td>High Dependency Care</td>
<td>Pre-Existing Diabetes</td>
<td>Maternal Transfer by Ambulance</td>
<td>Postnatal Care</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Skills and Drills</td>
<td>Vaginal Birth after Caesarean Section</td>
<td>Obesity</td>
<td>Non-Obstetric Emergency Care</td>
<td>Recovery</td>
<td></td>
</tr>
</tbody>
</table>
## Standard 1 - Criterion 1: Risk Management Strategy (Organisation)

The maternity service has an approved maternity service risk management strategy which reflects the organisation-wide strategy and is implemented and monitored.

<table>
<thead>
<tr>
<th>Level</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| **1.1.1** | The maternity service has an approved maternity service risk management strategy, which as a minimum must include:  
  a. maternity service’s measurable objectives for managing risk  
  b. process for managing the maternity service’s risk register  
  c. maternity service’s risk management structure, detailing all the committees/groups within the organisation (not just the maternity service), which have some responsibility for risk within the maternity service  
  d. process for receipt and review of the Local Supervising Midwifery Officers’ annual audit and action plan  
  e. process for immediately escalating risk management issues at any time, from the maternity service to board level  
  f. process for monitoring compliance with all of the above requirements, review of results and subsequent monitoring of action plans. |

**Method of assessment at Level 1:** Approved documentation.

<table>
<thead>
<tr>
<th>Level</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| **2.1.1** | The maternity service can demonstrate implementation of the approved maternity service risk management strategy, as described at Level 1, in relation to the:  
  - process for managing the maternity service’s risk register  
  - process for immediately escalating risk management issues at any time from the maternity service to board level. |

**Method of assessment at Level 2:** Evidence provided by maternity service demonstrating implementation.

<table>
<thead>
<tr>
<th>Level</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| **3.1.1** | The maternity service can demonstrate that it is monitoring compliance with the approved maternity service risk management strategy, as described at Level 1, in relation to the:  
  - process for managing the maternity service’s risk register  
  - process for immediately escalating risk management issues at any time from the maternity service to board level.  
  Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented. |

**Method of assessment at Level 3:** Evidence provided by maternity service demonstrating monitoring compliance.
<table>
<thead>
<tr>
<th><strong>Standard 1 - Criterion 1: Risk Management Strategy (Organisation)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rationale:</strong> Everyone involved in risk management within the maternity service should understand the service’s objectives and the way in which they are to be achieved. Failure to do so may render any risk management activity ineffective. Risk management objectives, leadership arrangements and management/reporting structures should be clearly documented within an approved risk management strategy. The organisation’s risk management strategy (or equivalent) will influence and complement the maternity service’s risk management strategy.</td>
</tr>
<tr>
<td><strong>References:</strong></td>
</tr>
</tbody>
</table>
## Standard 1 - Criterion 2: Risk Management Strategy (Leadership)

The maternity service has a system for ensuring that accountability arrangements are documented, approved, implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 1.1.2   | The maternity service has an approved risk management strategy detailing the maternity service’s leadership arrangements for the management of risk, which as a minimum must include:  
  a. leadership arrangements, detailing all those individuals within the organisation (not just the maternity service) who have management responsibility for risk within the maternity service  
  b. process by which the board lead executive communicates with and obtains assurance from the maternity service  
  c. description of the duties of the named individuals with responsibility for risk within the maternity service, which must include the following:  
    i. lead executive at board level  
    ii. professional lead(s)  
    iii. clinical risk coordinator  
    iv. lead consultant obstetrician for labour ward matters  
    v. clinical midwife manager for labour ward matters  
    vi. lead obstetric anaesthetist for anaesthetic services  
    vii. supervisors of midwives  
  d. process for monitoring compliance with all of the above requirements, review of results and subsequent monitoring of action plans. |

### Method of assessment at Level 1:

Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 2.1.2   | The maternity service can demonstrate implementation of the approved risk management strategy detailing the maternity service’s leadership arrangements for the management of risk, as described at Level 1, in relation to the:  
  - process by which the board lead executive communicates with and obtains assurance from the maternity service  
  - description of the duties of the named individuals with responsibility for risk within the maternity service, which must include the following:  
    i. lead executive at board level  
    ii. professional lead(s)  
    iii. clinical risk coordinator  
    iv. lead consultant obstetrician for labour ward matters  
    v. clinical midwife manager for labour ward matters  
    vi. lead obstetric anaesthetist for anaesthetic services  
    vii. supervisors of midwives. |
### Standard 1 - Criterion 2: Risk Management Strategy (Leadership)

#### Method of assessment at Level 2:
Evidence provided by maternity service demonstrating implementation.
The assessor will select two individuals from the above list at random to assess the maternity service’s compliance with the second minimum requirement.

#### Level 3  Minimum Requirements

3.1.2 The maternity service can demonstrate that it is monitoring compliance with the approved risk management strategy detailing the maternity service’s leadership arrangements for the management of risk, as described at Level 1, in relation to the:
- process by which the board lead executive communicates with and obtains assurance from the maternity service
- description of the duties of the named individuals with responsibility for risk within the maternity service, which must include the following:
  - lead executive at board level
  - professional lead(s)
  - clinical risk coordinator
  - lead consultant obstetrician for labour ward matters
  - clinical midwife manager for labour ward matters
  - lead obstetric anaesthetist for anaesthetic services
  - supervisors of midwives.
Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

#### Method of assessment at Level 3:
Evidence provided by maternity service demonstrating monitoring compliance.
The assessor will select two individuals from the above list at random to assess the maternity service’s compliance with the second minimum requirement.

**Rationale:** It is imperative that every maternity service has good leadership, within an open and supportive culture, which will provide a service that can fulfil the needs and expectations of women and their families. Positive leadership can contribute to the engagement of staff, support job satisfaction and raise morale. To ensure effective leadership, senior managers and clinicians should have all relevant information and an ability to act upon it where necessary.

**References:**
Standard 1 - Criterion 2: Risk Management Strategy (Leadership)

Standard 1 - Criterion 3: Staffing Levels (Midwifery & Nursing Staff)

The maternity service has approved safe staffing levels for all midwifery, nursing and support staff, which are in line with *Safer Childbirth* (RCOG 2007) recommendations and are implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.3</td>
<td>The maternity service has approved documentation governing safe staffing levels for all midwifery, nursing and support staff, which as a minimum must include:</td>
</tr>
<tr>
<td></td>
<td>a. midwifery, nursing and support staff groups utilised by the maternity service in all care settings</td>
</tr>
<tr>
<td></td>
<td>b. required staffing levels for all midwifery, nursing and support staff for each care setting (which should be calculated using the figures identified in Table 6 of <em>Safer Childbirth</em> (RCOG 2007))</td>
</tr>
<tr>
<td></td>
<td>c. process for how and when the annual review under minimum requirement e) will be conducted</td>
</tr>
<tr>
<td></td>
<td>d. process for monitoring compliance with all of the above requirements, review of results and subsequent monitoring of action plans.</td>
</tr>
<tr>
<td></td>
<td>In addition, the maternity service is required to provide:</td>
</tr>
<tr>
<td></td>
<td>e. an annual review of midwifery, nursing and support staff staffing levels in the maternity service to establish whether they are in line with the recommendations in <em>Safer Childbirth</em> (RCOG 2007)</td>
</tr>
<tr>
<td></td>
<td>f. business plan(s) which reflect the results of the annual review to address staffing shortfalls, if any*</td>
</tr>
<tr>
<td></td>
<td>g. contingency plan(s) to address ongoing staffing shortfalls, if any*</td>
</tr>
<tr>
<td></td>
<td>h. contingency plan(s) to address short term staffing shortfalls, for example due to increased workload or sickness.</td>
</tr>
<tr>
<td></td>
<td>The maternity service’s approved documentation governing safe staffing levels for all midwifery, nursing and support staff, must also include a description of the:</td>
</tr>
<tr>
<td></td>
<td>i. process for monitoring progression of business plan(s) and contingency plan(s), review of results and subsequent monitoring of action plans.</td>
</tr>
<tr>
<td></td>
<td>* Those maternity services with staffing levels in line with the recommendations from the annual review will not be required to produce a business plan or contingency plan to address ongoing staffing shortfalls.</td>
</tr>
</tbody>
</table>

Method of assessment at Level 1:
Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.3</td>
<td>The maternity service can demonstrate implementation of the approved documentation governing safe staffing levels for all midwifery, nursing and support staff, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• annual review of midwifery, nursing and support staff staffing levels in the maternity service to establish whether they are in line with the recommendations in <em>Safer Childbirth</em> (RCOG 2007)</td>
</tr>
<tr>
<td></td>
<td>• business plan(s) which reflect the results of the annual review to address staffing shortfalls, if any*</td>
</tr>
<tr>
<td></td>
<td>• contingency plan(s) to address ongoing staffing shortfalls, if any*</td>
</tr>
<tr>
<td></td>
<td>• contingency plan(s) to address short term staffing shortfalls, for example due</td>
</tr>
</tbody>
</table>
Standard 1 - Criterion 3: Staffing Levels (Midwifery & Nursing Staff)

<table>
<thead>
<tr>
<th>to increased workload or sickness.</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Those maternity services with staffing levels in line with the recommendations from the annual review will not be required to produce a business plan or contingency plan to address ongoing staffing shortfalls.</td>
</tr>
</tbody>
</table>

Method of assessment at Level 2:
Evidence provided by maternity service demonstrating implementation.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.3</td>
<td>The maternity service can demonstrate that it is monitoring compliance with the approved documentation governing safe staffing levels for all midwifery, nursing and support staff, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>annual review of midwifery, nursing and support staff staffing levels in the maternity service to establish whether they are in line with the recommendations in Safer Childbirth (RCOG 2007)</td>
</tr>
<tr>
<td></td>
<td>progression of business plan(s) which reflect the results of the annual review to address staffing shortfalls, if any*</td>
</tr>
<tr>
<td></td>
<td>contingency plan(s) to address ongoing staffing shortfalls, if any*</td>
</tr>
<tr>
<td></td>
<td>contingency plan(s) to address short term staffing shortfalls, for example due to increased workload or sickness.</td>
</tr>
<tr>
<td></td>
<td>* Those maternity services with staffing levels in line with the recommendations from the annual review will not be required to produce a business plan or contingency plan to address ongoing staffing shortfalls.</td>
</tr>
<tr>
<td></td>
<td>Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.</td>
</tr>
</tbody>
</table>

Method of assessment at Level 3:
Evidence provided by maternity service demonstrating monitoring compliance.

Rationale: Assessments of current and future workforce requirements should be made locally to identify the number and experience of staff required to provide appropriate and safe cover in all care settings. Appropriate staffing levels and skill mix across all midwifery, nursing and support staff are essential for providing a safe maternity service.

Staffing levels flowchart:
A flowchart is included at Appendix A: Standard 1 - Staffing Levels to assist with this criterion.

Template document:
A template document has been created to assist maternity services in complying with the criterion, but its use is entirely optional. It is available for downloading from the NHSLA website at www.nhsla.com/publications, under Risk Management Publications followed by Document Templates.

References:

Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. (2007). Safer Childbirth:
<table>
<thead>
<tr>
<th>Standard 1 - Criterion 3: Staffing Levels (Midwifery &amp; Nursing Staff)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Standards For The Organisation And Delivery Of Care In Labour. London: RCOG Press. Available at: <a href="http://www.rcog.org.uk">www.rcog.org.uk</a></td>
</tr>
</tbody>
</table>
## Standard 1 - Criterion 4: Staffing Levels (Obstetricians)

The maternity service has approved safe staffing levels for prospective consultant obstetrician presence on the labour ward, which are in line with *Safer Childbirth* (RCOG 2007) recommendations and are implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 1.1.4   | The maternity service has approved documentation governing prospective consultant obstetrician presence on the labour ward, which as a minimum must include:  
   a. consultant obstetricians utilised on each labour ward  
   b. established prospective consultant obstetrician presence on each labour ward (which should be calculated using the figures identified in Table 8 of *Safer Childbirth* (RCOG 2007))  
   c. process for how and when the annual review under minimum requirement e) will be conducted  
   d. process for monitoring compliance with all of the above requirements, review of results and subsequent monitoring of action plans.  
In addition, the maternity service is required to provide:  
   e. an annual review to establish whether prospective consultant obstetrician presence on each labour ward is in line with *Safer Childbirth* (RCOG 2007)  
   f. business plan(s) which reflect the results of the annual review to address staffing shortfalls, if any*  
   g. contingency plan(s) to address ongoing staffing shortfalls, if any*  
   h. contingency plan(s) to address short term staffing shortfalls, for example due to increased workload or sickness.  
The maternity service’s approved documentation governing prospective consultant obstetrician presence on the labour ward, must also include a description of the:  
i. process for monitoring progression of business plan(s) and contingency plan(s), review of results and subsequent monitoring of action plans.  
* Those maternity services with staffing levels in line with the recommendations from the annual review will not be required to produce a business plan or contingency plan to address ongoing staffing shortfalls. |

### Method of assessment at Level 1:

Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 2.1.4   | The maternity service can demonstrate implementation of the approved documentation governing prospective consultant obstetrician presence on the labour ward, in relation to the:  
   - annual review to establish whether prospective consultant obstetrician presence on each labour ward is in line with *Safer Childbirth* (RCOG 2007)  
   - business plan(s) which reflect the results of the annual review to address staffing shortfalls, if any*  
   - contingency plan(s) to address ongoing staffing shortfalls, if any*  
   - contingency plan(s) to address short term staffing shortfalls, for example due to increased workload or sickness. |
### Standard 1 - Criterion 4: Staffing Levels (Obstetricians)

<table>
<thead>
<tr>
<th>to increased workload or sickness.</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Those maternity services with staffing levels in line with the recommendations from the annual review will not be required to produce a business plan or contingency plan to address ongoing staffing shortfalls.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 2:**
Evidence provided by maternity service demonstrating implementation.

### Level 3  Minimum Requirements

<table>
<thead>
<tr>
<th>3.1.4</th>
<th>The maternity service can demonstrate that it is monitoring compliance with the approved documentation governing prospective consultant obstetrician presence on the labour ward, in relation to the:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>annual review to establish whether prospective consultant obstetrician presence on each labour ward is in line with Safer Childbirth (RCOG 2007)</td>
</tr>
<tr>
<td></td>
<td>progression of business plan(s) which reflect the results of the annual review to address staffing shortfalls, if any*</td>
</tr>
<tr>
<td></td>
<td>contingency plan(s) to address ongoing staffing shortfalls, if any*</td>
</tr>
<tr>
<td></td>
<td>contingency plan(s) to address short term staffing shortfalls, for example due to increased workload or sickness.</td>
</tr>
<tr>
<td></td>
<td>* Those maternity services with staffing levels in line with the recommendations from the annual review will not be required to produce a business plan or contingency plan to address ongoing staffing shortfalls.</td>
</tr>
</tbody>
</table>

Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

**Method of assessment at Level 3:**
Evidence provided by maternity service demonstrating monitoring compliance.

### Rationale:
Assessments of current and future workforce requirements should be made locally to identify the number and experience of staff required to provide appropriate and safe cover on labour wards. Appropriate consultant obstetrician staffing levels are essential for providing a safe service.

### Staffing levels flowchart:
A flowchart is included at Appendix A: Standard 1 - Staffing Levels to assist with this criterion.

### Template document:
A template document has been created to assist maternity services in complying with the criterion, but its use is entirely optional. It is available for downloading from the NHSLA website at www.nhsla.com/publications, under Risk Management Publications followed by Document Templates.

### References:

Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. (2007). *Safer Childbirth: Minimum Standards For The Organisation And Delivery Of Care In Labour*. London: RCOG
<table>
<thead>
<tr>
<th>Standard 1 - Criterion 4: Staffing Levels (Obstetricians)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Press. Available at: <a href="http://www.rcog.org.uk">www.rcog.org.uk</a></td>
</tr>
</tbody>
</table>
The maternity service has approved safe staffing levels for obstetric anaesthetists and their assistants, which are in line with *Safer Childbirth* (RCOG 2007) recommendations and are implemented and monitored.

### Level 1 - Minimum Requirements

<table>
<thead>
<tr>
<th>1.1.5</th>
<th>The maternity service has approved documentation governing safe staffing levels for obstetric anaesthetists and their assistants, which as a minimum must include:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a. obstetric anaesthetist(s) and their assistant(s) utilised by each labour ward</td>
</tr>
<tr>
<td></td>
<td>b. required staffing levels for each of these groups for each labour ward in line with <em>Safer Childbirth</em> (RCOG 2007)</td>
</tr>
<tr>
<td></td>
<td>c. process for how and when the annual review under minimum requirement e) will be conducted</td>
</tr>
<tr>
<td></td>
<td>d. process for monitoring compliance with all of the above requirements, review of results and subsequent monitoring of action plans.</td>
</tr>
<tr>
<td></td>
<td>In addition, the maternity service is required to provide:</td>
</tr>
<tr>
<td></td>
<td>e. an annual review to establish whether obstetric anaesthetist staffing levels are in line with <em>Safer Childbirth</em> (RCOG 2007)</td>
</tr>
<tr>
<td></td>
<td>f. an annual review to establish whether assistant staffing levels are in line with the maternity service’s required staffing levels</td>
</tr>
<tr>
<td></td>
<td>g. business plan(s) which reflect the results of the annual review to address staffing shortfalls, if any*</td>
</tr>
<tr>
<td></td>
<td>h. contingency plan(s) to address ongoing staffing shortfalls, if any*</td>
</tr>
<tr>
<td></td>
<td>i. contingency plan(s) to address short term staffing shortfalls, for example due to increased workload or sickness.</td>
</tr>
</tbody>
</table>

The maternity service’s approved documentation governing safe staffing levels for obstetric anaesthetists and their assistants, must also include a description of the:

| j. | process for monitoring progression of business plan(s) and contingency plan(s), review of results and subsequent monitoring of action plans. |

* Those maternity services with staffing levels in line with the recommendations from the annual review will not be required to produce a business plan or contingency plan to address ongoing staffing shortfalls.

### Method of assessment at Level 1:

Approved documentation.

### Level 2 - Minimum Requirements

<table>
<thead>
<tr>
<th>2.1.5</th>
<th>The maternity service can demonstrate implementation of the approved documentation governing safe staffing levels for obstetric anaesthetists and their assistants, in relation to the:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• annual review to establish whether obstetric anaesthetist staffing levels are in line with <em>Safer Childbirth</em> (RCOG 2007)</td>
</tr>
<tr>
<td></td>
<td>• annual review to establish whether assistant staffing levels are in line with the maternity service’s required staffing levels</td>
</tr>
<tr>
<td></td>
<td>• business plan(s) which reflect the results of the annual review to address staffing shortfalls, if any*</td>
</tr>
</tbody>
</table>
**Standard 1 - Criterion 5: Staffing Levels (Anaesthetists & Assistants)**

- contingency plan(s) to address ongoing staffing shortfalls, if any*
- contingency plan(s) to address short term staffing shortfalls, for example due to increased workload or sickness.

* Those maternity services with staffing levels in line with the recommendations from the annual review will not be required to produce a business plan or contingency plan to address ongoing staffing shortfalls.

### Method of assessment at Level 2:

Evidence provided by maternity service demonstrating implementation.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.5</td>
<td>The maternity service can demonstrate that it is monitoring compliance with the approved documentation governing safe staffing levels for obstetric anaesthetists and their assistants, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>annual review to establish whether obstetric anaesthetist staffing levels are in line with Safer Childbirth (RCOG 2007)</td>
</tr>
<tr>
<td></td>
<td>annual review to establish whether assistant staffing levels are in line with the maternity service’s required staffing levels</td>
</tr>
<tr>
<td></td>
<td>progression of business plan(s) which reflect the results of the annual review to address staffing shortfalls, if any*</td>
</tr>
<tr>
<td></td>
<td>contingency plan(s) to address ongoing staffing shortfalls, if any*</td>
</tr>
<tr>
<td></td>
<td>contingency plan(s) to address short term staffing shortfalls, for example due to increased workload or sickness.</td>
</tr>
<tr>
<td></td>
<td>* Those maternity services with staffing levels in line with the recommendations from the annual review will not be required to produce a business plan or contingency plan to address ongoing staffing shortfalls.</td>
</tr>
</tbody>
</table>

Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

### Method of assessment at Level 3:

Evidence provided by maternity service demonstrating monitoring compliance.

**Rationale:** Assessments of current and future workforce requirements should be made locally to identify the number and experience of staff required to provide appropriate and safe cover in all labour wards. Appropriate staffing levels and skill mix for obstetric anaesthetists and their assistants are essential for providing a safe maternity service.

**Staffing levels flowchart:**

A flowchart is included at [Appendix A: Standard 1 - Staffing Levels](#) to assist with this criterion.

**Template document:**

A template document has been created to assist maternity services in complying with the criterion, but its use is entirely optional. It is available for downloading from the NHSLA website at www.nhsla.com/publications, under Risk Management Publications followed by Document Templates.

**References:**

Association of Anaesthetists of Great Britain and Ireland, and the Obstetric Anaesthetists'
Standard 1 - Criterion 5: Staffing Levels (Anaesthetists & Assistants)


# Standard 1 - Criterion 6: Labour Ward Staffing

The maternity service has approved documentation that describes the duties and requirements of key individuals on the labour ward that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.6</td>
<td>The maternity service has approved documentation that describes the duties and requirements of key individuals on the labour ward, which as a minimum must include:</td>
</tr>
<tr>
<td></td>
<td>a. requirement for consultant obstetrician attendance in person in the following clinical situations:</td>
</tr>
<tr>
<td></td>
<td>i. eclampsia</td>
</tr>
<tr>
<td></td>
<td>ii. maternal collapse (such as massive abruption, septic shock)</td>
</tr>
<tr>
<td></td>
<td>iii. caesarean section for major placenta praevia</td>
</tr>
<tr>
<td></td>
<td>iv. postpartum haemorrhage of more than 1.5 litres, where the haemorrhage is continuing and a massive obstetric haemorrhage protocol has been instigated</td>
</tr>
<tr>
<td></td>
<td>v. return to theatre - laparotomy</td>
</tr>
<tr>
<td></td>
<td>vi. uterine rupture</td>
</tr>
<tr>
<td></td>
<td>b. requirement to have an experienced midwife who acts as a shift coordinator on the labour ward</td>
</tr>
<tr>
<td></td>
<td>c. duties of the shift coordinator on the labour ward</td>
</tr>
<tr>
<td></td>
<td>d. arrangements for ensuring availability of a duty anaesthetist on the labour ward 24 hours a day, 7 days a week</td>
</tr>
<tr>
<td></td>
<td>e. duties of the duty anaesthetist</td>
</tr>
<tr>
<td></td>
<td>f. process for monitoring compliance with all of the above requirements, review of results and subsequent monitoring of action plans.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 1:**
Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.6</td>
<td>The maternity service can demonstrate implementation of the approved documentation that describes the duties and requirements of key individuals on the labour ward, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• requirement for consultant obstetrician attendance in person in the following clinical situations:</td>
</tr>
<tr>
<td></td>
<td>i. eclampsia</td>
</tr>
<tr>
<td></td>
<td>ii. maternal collapse (such as massive abruption, septic shock)</td>
</tr>
<tr>
<td></td>
<td>iii. caesarean section for major placenta praevia</td>
</tr>
<tr>
<td></td>
<td>iv. postpartum haemorrhage of more than 1.5 litres, where the haemorrhage is continuing and a massive obstetric haemorrhage protocol has been instigated</td>
</tr>
<tr>
<td></td>
<td>v. return to theatre - laparotomy</td>
</tr>
<tr>
<td></td>
<td>vi. uterine rupture</td>
</tr>
<tr>
<td></td>
<td>• requirement to have an experienced midwife who acts as a shift coordinator on the labour ward</td>
</tr>
</tbody>
</table>
Standard 1 - Criterion 6: Labour Ward Staffing

- arrangements for ensuring availability of a duty anaesthetist on the labour ward 24 hours a day, 7 days a week.

Method of assessment at Level 2:
Evidence provided by maternity service demonstrating implementation.
The assessor will select two of the clinical situations listed to assess compliance with the first minimum requirement.

Level 3 Minimum Requirements

3.1.6 The maternity service can demonstrate that it is monitoring compliance with the approved documentation that describes the duties and requirements of key individuals on the labour ward, as described at Level 1, in relation to the:

- requirement for consultant obstetrician attendance in person in the following clinical situations:
  i. eclampsia
  ii. maternal collapse (such as massive abruption, septic shock)
  iii. caesarean section for major placenta praevia
  iv. postpartum haemorrhage of more than 1.5 litres, where the haemorrhage is continuing and a massive obstetric haemorrhage protocol has been instigated
  v. return to theatre - laparotomy
  vi. uterine rupture
- requirement to have an experienced midwife who acts as a shift coordinator on the labour ward
- arrangements for ensuring availability of a duty anaesthetist on the labour ward 24 hours a day, 7 days a week.

Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

Method of assessment at Level 3:
Evidence provided by maternity service demonstrating monitoring compliance.
The assessor will select two of the clinical situations listed to assess compliance with the first minimum requirement.

Rationale:
High quality maternity services rely on having an appropriate workforce with the leadership, skill mix and competencies to provide excellent care at the point of delivery. Safer Childbirth (RCOG 2007) and Standards for Maternity Care (RCOG 2008) have both stated that one of the main principles for provision of safe maternity services is that intrapartum care should be provided by appropriately trained staff. The maternity service should outline the duties of the key roles on the labour ward.

References:

Royal College of Obstetricians and Gynaecologists. (2008). Standards For Maternity Care:
<table>
<thead>
<tr>
<th>Standard 1 - Criterion 6: Labour Ward Staffing</th>
</tr>
</thead>
</table>
## Standard 1 - Criterion 7: Maternity Records

The maternity service has approved documentation which describes the process for managing the risks associated with health records (including the hand held record) that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.7</td>
<td><strong>The maternity service has approved documentation</strong> which describes the process for managing the risks associated with health records (including the hand held record), which as a minimum must include:</td>
</tr>
<tr>
<td></td>
<td>a. basic record-keeping standards against which the health records must be audited for all healthcare professionals</td>
</tr>
<tr>
<td></td>
<td>b. basic clinical note keeping standards against which the health records must be audited for all healthcare professionals</td>
</tr>
<tr>
<td></td>
<td>c. <strong>storage arrangements for:</strong></td>
</tr>
<tr>
<td></td>
<td>i. cardiotocographs</td>
</tr>
<tr>
<td></td>
<td>ii. anaesthetic records, including epidural records</td>
</tr>
<tr>
<td></td>
<td>iii. fetal blood sampling results/reports</td>
</tr>
<tr>
<td></td>
<td>iv. cord pH results/reports</td>
</tr>
<tr>
<td></td>
<td>v. securing results/reports relating to previous pregnancies</td>
</tr>
<tr>
<td></td>
<td>vi. antenatal screening and ultrasound results</td>
</tr>
<tr>
<td></td>
<td>d. arrangements for documenting the name of the lead professional (to include the process for recording any changes to the lead professional)</td>
</tr>
<tr>
<td></td>
<td>e. process for ensuring a contemporaneous complete record of care</td>
</tr>
<tr>
<td></td>
<td>f. frequency of <strong>audit</strong> of health records</td>
</tr>
<tr>
<td></td>
<td>g. process for <strong>audit</strong>, multidisciplinary review of <strong>audit</strong> results and subsequent <strong>monitoring</strong> of action plans.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 1:**
Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.7</td>
<td><strong>The maternity service can demonstrate implementation of the approved documentation</strong> which describes the process for managing the risks associated with health records (including the hand held record), as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• <strong>storage arrangements for:</strong></td>
</tr>
<tr>
<td></td>
<td>i. cardiotocographs</td>
</tr>
<tr>
<td></td>
<td>ii. anaesthetic records, including epidural records</td>
</tr>
<tr>
<td></td>
<td>iii. fetal blood sampling results/reports</td>
</tr>
<tr>
<td></td>
<td>iv. cord pH results/reports</td>
</tr>
<tr>
<td></td>
<td>v. securing results/reports relating to previous pregnancies</td>
</tr>
<tr>
<td></td>
<td>vi. antenatal screening and ultrasound results.</td>
</tr>
</tbody>
</table>
Standard 1 - Criterion 7: Maternity Records

Method of assessment at Level 2:
0.5% of all health records of women who have delivered.
Minimum implementation of 75% compliance required.

Throughout the assessment should the assessor note loose documentation in any of the health records reviewed, this could result in non-compliance with this criterion, regardless of compliance with the above minimum requirements.

Level 3 | Minimum Requirements
------- | ------------------------
3.1.7 | The maternity service can demonstrate that it is monitoring compliance with the approved documentation which describes the process for managing the risks associated with health records (including the hand held record), as described at Level 1, in relation to the:
- storage arrangements for:
  - i. cardiotocographs
  - ii. anaesthetic records, including epidural records
  - iii. fetal blood sampling results/reports
  - iv. cord pH results/reports
  - v. securing results/reports relating to previous pregnancies
  - vi. antenatal screening and ultrasound results.
Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

Method of assessment at Level 3:
1% or 10 sets, whichever is the greater, of all health records of women who have delivered.
Minimum implementation of 75% compliance required.

Throughout the assessment should the assessor note loose documentation in any of the health records reviewed, this could result in non-compliance with this criterion, regardless of compliance with the above minimum requirements.

Rationale: A woman’s health record should inform any clinician who has a responsibility for her care of all the relevant information which might influence the proposed management. It should also provide a contemporaneous and complete record of the woman’s treatment and related features. In addition to ensuring good care, complete, accurate and timely records allow a clear picture of events to be obtained, which is imperative for managing claims and complaints. It is also vital for auditing practice and demonstrates that the service is proactive. The organisation’s documentation, which describes the process for managing the risks associated with healthcare records will influence and complement the maternity service’s guidance.

References:
Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. (2007). Safer Childbirth;
Standard 1 - Criterion 7: Maternity Records

*Minimum Standards For The Organisation And Delivery Of Care In Labour.* London: RCOG Press. Available at: [www.rcog.org.uk](http://www.rcog.org.uk)
Standard 1 - Criterion 8: Incidents, Complaints & Claims

The maternity service has an approved system for ensuring local and organisational learning occurs following all grades and types of incidents, complaints and claims that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.8</td>
<td>The maternity service has approved documentation for ensuring local and organisational learning occurs following all grades and types of incidents, complaints and claims, which as a minimum must include:</td>
</tr>
<tr>
<td></td>
<td>a. maternity specific data set for incident reporting</td>
</tr>
<tr>
<td></td>
<td>b. maternity service's process for learning from experience, including case reviews</td>
</tr>
<tr>
<td></td>
<td>c. arrangements for the regular review and discussion of all incidents, complaints and claims by the relevant local committee/group</td>
</tr>
<tr>
<td></td>
<td>d. arrangements for ensuring that all serious untoward incidents (SUIs) undergo a root cause analysis, involving as appropriate unbiased external input</td>
</tr>
<tr>
<td></td>
<td>e. arrangements for ensuring that lessons learnt from all incidents, complaints and claims are actively disseminated to all staff</td>
</tr>
<tr>
<td></td>
<td>f. process for providing board assurance that lessons learnt from SUIs are implemented and monitored</td>
</tr>
<tr>
<td></td>
<td>g. process for monitoring compliance with all of the above requirements, review of results and subsequent monitoring of action plans</td>
</tr>
</tbody>
</table>

Method of assessment at Level 1:
Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.8</td>
<td>The maternity service can demonstrate implementation of the approved documentation for ensuring local and organisational learning occurs following all grades and types of incidents, complaints and claims, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• arrangements for ensuring that all serious untoward incidents (SUIs) undergo a root cause analysis, involving as appropriate unbiased external input</td>
</tr>
<tr>
<td></td>
<td>• arrangements for ensuring that lessons learnt from all incidents, complaints and claims are actively disseminated to all staff</td>
</tr>
</tbody>
</table>

Method of assessment at Level 2:
Evidence provided by maternity service demonstrating implementation.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.8</td>
<td>The maternity service can demonstrate that it is monitoring compliance with the approved documentation for ensuring local and organisational learning occurs following all grades and types of incidents, complaints and claims, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• arrangements for ensuring that all serious untoward incidents (SUIs) undergo a root cause analysis, involving as appropriate unbiased external input</td>
</tr>
<tr>
<td></td>
<td>• arrangements for ensuring that lessons learnt from all incidents, complaints and claims are actively disseminated to all staff</td>
</tr>
</tbody>
</table>
### Standard 1 - Criterion 8: Incidents, Complaints & Claims

Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

#### Method of assessment at Level 3:
Evidence provided by maternity service demonstrating monitoring compliance.

**Rationale:** The maternity service should proactively use internal and external information to improve clinical care. The maternity service should demonstrate their commitment to overcoming the barriers that exist and encourage staff to report incidents so that lessons can be learnt through analysis, dissemination of the findings and implementing change. The organisation’s process for learning from all grades of incidents, complaints and claims will influence and complement the maternity service’s process.

**References:**
### Standard 1 - Criterion 9: Training Needs Analysis

The maternity service has an approved systematic approach to the delivery of specialist training for all permanent staff and medical staff in training that care for women and newborns that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.9</td>
<td>The maternity service has <strong>approved documentation</strong> which describes the process for ensuring a systematic approach to <strong>specialist training</strong> for all staff that care for women and <strong>newborns</strong>, which as a minimum must include:</td>
</tr>
<tr>
<td>a. a completed <strong>training needs analysis</strong> (TNA), which as a minimum must include the list of topics in the <strong>TNA Minimum Data Set</strong></td>
<td></td>
</tr>
<tr>
<td>b. process for checking that all staff attend and complete the relevant training programmes in accordance with the <strong>training needs analysis</strong></td>
<td></td>
</tr>
<tr>
<td>c. <strong>process for following up those who fail to attend and complete relevant training programmes</strong></td>
<td></td>
</tr>
<tr>
<td>d. system for coordinating records of training and archiving</td>
<td></td>
</tr>
<tr>
<td>e. <strong>system for ensuring that the results of audits, learning from incidents, complaints and claims and other information sources, are considered as part of the ongoing review of training by the overarching committee with responsibility for risk locally</strong></td>
<td></td>
</tr>
<tr>
<td>f. process for <strong>monitoring</strong> compliance with all of the above requirements, review of results and subsequent <strong>monitoring</strong> of action plans.</td>
<td></td>
</tr>
</tbody>
</table>

**Method of assessment at Level 1:**
Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.9</td>
<td>The maternity service can demonstrate implementation of the <strong>approved documentation</strong> which describes the process for ensuring a systematic approach to <strong>specialist training</strong> for all staff that care for women and <strong>newborns</strong>, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td>• process for following up those who fail to attend and complete relevant training programmes</td>
<td></td>
</tr>
<tr>
<td>• system for ensuring that the results of audits, learning from incidents, complaints and claims and other information sources, are considered as part of the <strong>ongoing review</strong> of training by the overarching committee with responsibility for risk locally.</td>
<td></td>
</tr>
</tbody>
</table>

**Method of assessment at Level 2:**
Evidence provided by maternity service demonstrating implementation.
The assessor will select two elements of the risk management training from the TNA Minimum Data Set at random to assess the maternity service’s compliance with the first minimum requirement.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.9</td>
<td>The maternity service can demonstrate that it is <strong>monitoring</strong> compliance with the <strong>approved documentation</strong> for ensuring a systematic approach to <strong>specialist training</strong> for all staff that care for women and <strong>newborns</strong>, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td>• process for following up those who fail to attend and complete relevant training programmes</td>
<td></td>
</tr>
</tbody>
</table>

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### Standard 1 - Criterion 9: Training Needs Analysis

- System for ensuring that the results of audits, learning from incidents, complaints and claims and other information sources, are considered as part of the ongoing review of training by the overarching committee with responsibility for risk locally.

Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

### Method of assessment at Level 3:

Evidence provided by maternity service demonstrating monitoring compliance.

The assessor will select two elements of the risk management training from the TNA Minimum Data Set at random to assess the maternity service’s compliance with the first minimum requirement.

### Rationale:

Training is an essential control measure when managing risk and there is extensive national guidance as to the types of training staff in maternity services should receive. The purpose of this criterion is to assess the approach the maternity service has taken to specialist maternity training. This criterion is supported by the TNA Minimum Data Set and it is expected that the maternity service will have considered all the topics in this list as a minimum.

### References:

# Standard 1 - Criterion 10: Skills and Drills

The maternity service has an approved system for ensuring the delivery of multidisciplinary skills and drills training for relevant staff that is implemented and monitored.

## Level 1 - Minimum Requirements

<table>
<thead>
<tr>
<th>Code</th>
<th>Requirement</th>
</tr>
</thead>
</table>
| 1.1.10 | The maternity service has approved documentation which describes the process for ensuring the delivery of multidisciplinary skills and drills training for relevant staff, which as a minimum must include a description of:  
   a. maternity service’s expectations in relation to staff training, as identified in the training needs analysis  
   b. how the maternity service intends to achieve a multidisciplinary approach to training, including emergency drills  
   c. how training will be delivered  
   d. system for ensuring that all staff attend and complete the training, as identified in the training needs analysis  
   e. system for regular review of attendance at skills and drills training, by the overarching committee with responsibility for risk locally, as a minimum six monthly  
   f. process for monitoring compliance with all of the above requirements, review of results and subsequent monitoring of action plans. |

### Method of assessment at Level 1:

Approved documentation.

## Level 2 - Minimum Requirements

<table>
<thead>
<tr>
<th>Code</th>
<th>Requirement</th>
</tr>
</thead>
</table>
| 2.1.10 | The maternity service can demonstrate implementation of the approved documentation which describes the process for ensuring the delivery of multidisciplinary skills and drills training for relevant staff, as described at Level 1, in relation to:  
   - maternity service’s expectations in relation to staff training, as identified in the training needs analysis  
   - how the maternity service intends to achieve a multidisciplinary approach to training, including emergency drills. |

### Method of assessment at Level 2:

Evidence provided by the maternity service to demonstrate implementation of training with a minimum of 75% attendance.  
Implementation of emergency drills, but 75% attendance is not required.

## Level 3 - Minimum Requirements

<table>
<thead>
<tr>
<th>Code</th>
<th>Requirement</th>
</tr>
</thead>
</table>
| 3.1.10 | The maternity service can demonstrate that it is monitoring compliance with the approved documentation which describes the process for ensuring delivery of multidisciplinary skills and drills training for relevant staff, as described at Level 1, in relation to:  
   - maternity service’s expectations in relation to staff training, as identified in the training needs analysis  
   - how the maternity service intends to achieve a multidisciplinary approach to training, including emergency drills.  
Where monitoring has identified deficiencies, there must be evidence that
### Standard 1 - Criterion 10: Skills and Drills

| recommendations and action plans have been developed and changes implemented. |

#### Method of assessment at Level 3:

Evidence provided by the maternity service to demonstrate monitoring with a minimum of 75% attendance at training.

Monitoring of emergency drills, but 75% attendance is not required.

**Rationale:** Collaborative, multidisciplinary practice sessions or ‘drills’ for dealing with emergency situations allow members of staff to know and understand their specific roles and responsibilities in an emergency. Obstetric medical staff of all grades, and midwives, together with other staff relevant to the situation, should train together to ensure efficient team working.

#### References:

## Standard 2 - Criterion 1: Care of Women in Labour

The maternity service has an approved system for improving care and learning lessons relating to the care of women in labour that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2.1</td>
<td>The maternity service has approved documentation for the care of women in labour, at term, in all care settings, which as a minimum must include:</td>
</tr>
<tr>
<td></td>
<td>a. maternal observations to be carried out on admission*</td>
</tr>
<tr>
<td></td>
<td>b. maternal observations to be carried out during established first stage of labour*</td>
</tr>
<tr>
<td></td>
<td>c. maternal observations to be carried out during second stage of labour*</td>
</tr>
<tr>
<td></td>
<td>d. maternal observations to be carried out during third stage of labour*</td>
</tr>
<tr>
<td></td>
<td>e. documentation of all of the above maternal observations*</td>
</tr>
<tr>
<td></td>
<td>f. guidance on duration of all stages of labour*</td>
</tr>
<tr>
<td></td>
<td>g. guidance on referral to obstetric care*</td>
</tr>
<tr>
<td></td>
<td>h. process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans.</td>
</tr>
<tr>
<td>* As a minimum the maternity service is expected to follow NICE guidance for these minimum requirements.</td>
<td></td>
</tr>
</tbody>
</table>

**Method of assessment at Level 1:**
Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2.1</td>
<td>The maternity service can demonstrate implementation of the approved documentation for the care of women in labour, at term, in all care settings, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• documentation of the maternal observations carried out during established first stage of labour.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 2:**
0.5% of all health records of women who have delivered.
Minimum implementation of 75% compliance required.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2.1</td>
<td>The maternity service can demonstrate that it is monitoring compliance with the approved documentation for the care of women in labour, at term, in all care settings, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• documentation of the maternal observations carried out during established first stage of labour.</td>
</tr>
<tr>
<td></td>
<td>Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 3:**
1% or 10 sets, whichever is the greater, of all health records of women who have delivered.
Minimum implementation of 75% compliance required.
<table>
<thead>
<tr>
<th><strong>Standard 2 - Criterion 1: Care of Women in Labour</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rationale:</strong> Care in labour should be aimed towards achieving the best possible outcome for the woman and baby. All maternity services should have in place approved documentation to support the staff who care for women in labour.</td>
</tr>
</tbody>
</table>

**References:**

The maternity service has an approved system for improving care and learning lessons relating to intermittent auscultation of the fetal heart in labour for women in whom this is the chosen method of monitoring the fetal heart in labour that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 1.2.2   | The maternity service has approved documentation for the intermittent auscultation of the fetal heart in labour, in all care settings, which as a minimum must include:  
|        | a. equipment that should be used  
|        | b. when to palpate the maternal pulse*  
|        | c. when to auscultate the fetal heart in the first stage and second stage of labour*  
|        | d. length of auscultation*  
|        | e. when to transfer from intermittent auscultation to continuous electronic fetal monitoring*  
|        | f. documentation of all of the above  
|        | g. process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans.  
|        | * As a minimum the maternity service is expected to follow NICE guidance for these minimum requirements. |

**Method of assessment at Level 1:** Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 2.2.2   | The maternity service can demonstrate implementation of the approved documentation for intermittent auscultation of the fetal heart in labour, in all care settings, as described at Level 1, in relation to the:  
|        | • documentation of palpation of the maternal pulse  
|        | • documentation of auscultation of the fetal heart in the first stage and second stage of labour  
|        | • documentation of transfer from intermittent auscultation to continuous electronic fetal monitoring. |

**Method of assessment at Level 2:**  
8 sets of health records of women who have delivered and needed to be transferred from intermittent auscultation to continuous electronic fetal monitoring during labour.  
Minimum implementation of 75% compliance required.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 3.2.2   | The maternity service can demonstrate that it is monitoring compliance with the approved documentation for intermittent auscultation of the fetal heart in labour, in all care settings, as described at Level 1, in relation to the:  
|        | • documentation of palpation of the maternal pulse  
|        | • documentation of auscultation of the fetal heart in the first stage and second stage of labour  
|        | • documentation of transfer from intermittent auscultation to continuous
Standard 2 - Criterion 2: Intermittent Auscultation

<table>
<thead>
<tr>
<th>electronic fetal monitoring.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.</td>
</tr>
</tbody>
</table>

Method of assessment at Level 3:

1% or 10 sets, whichever is the greater, of all health records of women who have delivered and needed to be transferred from intermittent auscultation to continuous electronic fetal monitoring during labour.

Minimum implementation of 75% compliance required.

Rationale: Intermittent auscultation of the fetal heart rate is recommended for low risk women in established labour in any birth setting.

References:


### Standard 2 - Criterion 3: Continuous Electronic Fetal Monitoring

The maternity service has an approved system for improving care and learning lessons relating to continuous electronic fetal monitoring (EFM) in labour that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2.3</td>
<td>The maternity service has approved documentation for continuous electronic fetal monitoring (EFM), in labour, in all care settings, which as a minimum must include:</td>
</tr>
<tr>
<td></td>
<td>a. date and time checks on EFM machines*</td>
</tr>
<tr>
<td></td>
<td>b. minimum data that should be recorded on the tracing, to include:*</td>
</tr>
<tr>
<td></td>
<td>i. woman's name</td>
</tr>
<tr>
<td></td>
<td>ii. date and time</td>
</tr>
<tr>
<td></td>
<td>iii. hospital number</td>
</tr>
<tr>
<td></td>
<td>iv. any intrapartum events; which should be recorded at the time of the event, signed and the time noted</td>
</tr>
<tr>
<td></td>
<td>v. the requirement for those who provide an opinion on the tracing during labour to record this on the trace as well as in the health records</td>
</tr>
<tr>
<td></td>
<td>vi. data to be included at the completion of the tracing</td>
</tr>
<tr>
<td></td>
<td>c. when to monitor in labour*</td>
</tr>
<tr>
<td></td>
<td>d. hourly systematic assessment of the trace to include:*</td>
</tr>
<tr>
<td></td>
<td>i. baseline rate</td>
</tr>
<tr>
<td></td>
<td>ii. baseline rate variability</td>
</tr>
<tr>
<td></td>
<td>iii. accelerations</td>
</tr>
<tr>
<td></td>
<td>iv. decelerations</td>
</tr>
<tr>
<td></td>
<td>e. fresh eyes review of minimum requirement d) by another healthcare professional</td>
</tr>
<tr>
<td></td>
<td>f. actions to be taken in the event that the tracing is assessed as suspicious or pathological*</td>
</tr>
<tr>
<td></td>
<td>g. maternity service’s expectations in relation to staff training, as identified in the training needs analysis</td>
</tr>
<tr>
<td></td>
<td>h. process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans.</td>
</tr>
<tr>
<td></td>
<td>* As a minimum the maternity service is expected to follow NICE guidance for these minimum requirements.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 1:**

Approved documentation.
### Standard 2 - Criterion 3: Continuous Electronic Fetal Monitoring

#### Level 2

**Minimum Requirements**

2.2.3 The maternity service can demonstrate implementation of the approved documentation for continuous electronic fetal monitoring (EFM), in labour, in all care settings, as described at Level 1, in relation to the:

- minimum data that should be recorded on the tracing, to include:
  1. woman's name
  2. date and time
  3. hospital number
  4. any intrapartum events; which should be recorded at the time of the event, signed and the time noted
  5. requirement for those who provide an opinion on the tracing during labour to record this on the trace as well as in the health records
  6. data to be included at the completion of the tracing

- hourly systematic assessment of the trace, to include:
  1. baseline rate
  2. baseline rate variability
  3. accelerations
  4. decelerations

- fresh eyes review of minimum requirement d) by another healthcare professional

- actions to be taken in the event that the tracing is assessed as suspicious or pathological

- maternity service’s expectations in relation to staff training, as identified in the training needs analysis.

#### Method of assessment at Level 2:

0.5% of all health records of women who have delivered.

8 sets of health records of women who have delivered in whom the tracing was assessed as suspicious or pathological.

Minimum implementation of 75% compliance with both of the above methods of assessment is required.

Additional evidence will be required to demonstrate implementation of training, with attendance levels at a minimum of 75%.

#### Level 3

**Minimum Requirements**

3.2.3 The maternity service can demonstrate that it is monitoring compliance with the approved documentation for continuous electronic fetal monitoring (EFM), in labour, in all care settings, as described at Level 1, in relation to the:

- minimum data that should be recorded on the tracing, to include:
  1. woman’s name
  2. date and time
  3. hospital number
  4. any intrapartum events; which should be recorded at the time of the event, signed and the time noted
Standard 2 - Criterion 3: Continuous Electronic Fetal Monitoring

v. requirement for those who provide an opinion on the tracing during labour to record this on the trace as well as in the health records
vi. data to be included at the completion of the tracing

- hourly **systematic assessment** of the trace, to include:
  - baseline rate
  - baseline rate variability
  - accelerations
  - decelerations

- **fresh eyes** review of minimum requirement d) by another healthcare professional
- actions to be taken in the event that the tracing is assessed as suspicious or pathological
- maternity service’s expectations in relation to staff training, as identified in the **training needs analysis**.

Where **monitoring** has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

**Method of assessment at Level 3:**

- 1% or 10 sets, whichever is the greater, of all health records of women who have delivered.
- 1% or 10 sets, whichever is the greater, of all health records of women who have delivered in whom the tracing was assessed as suspicious or pathological.

Minimum implementation of 75% compliance with both of the above methods of assessment is required.

Additional evidence will be required to demonstrate monitoring of training, with attendance levels at a minimum of 75%.

**Rationale:** The monitoring of the fetal heart rate in labour aims to identify hypoxia before it is sufficient to lead to long term poor neurological outcome for babies. With the development and implementation of ‘saving interventions’ by the systematic review of the EFM trace and by the intervention of another practitioner, appropriate actions can be initiated to reduce the incidence of a near miss or an adverse event.

**References:**


<table>
<thead>
<tr>
<th>Standard 2 - Criterion 3: Continuous Electronic Fetal Monitoring</th>
</tr>
</thead>
</table>
# Standard 2 - Criterion 4: Fetal Blood Sampling

The maternity service has an approved system for improving care and learning lessons when there has been concern about the fetus in labour or the newborn immediately following birth that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2.4</td>
<td>The maternity service has approved documentation for the management of fetal blood sampling (FBS) and cord pH, which as a minimum must include:</td>
</tr>
<tr>
<td></td>
<td>a. when FBS should be undertaken*</td>
</tr>
<tr>
<td></td>
<td>b. documentation of FBS results in the health record</td>
</tr>
<tr>
<td></td>
<td>c. requirement and timing of repeated FBS with appropriate documentation*</td>
</tr>
<tr>
<td></td>
<td>d. process for referral to a consultant obstetrician where a third FBS is considered necessary*</td>
</tr>
<tr>
<td></td>
<td>e. when paired cord samples should be taken*</td>
</tr>
<tr>
<td></td>
<td>f. documentation of paired cord sample results in the health record</td>
</tr>
<tr>
<td></td>
<td>g. process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans.</td>
</tr>
<tr>
<td></td>
<td>* As a minimum the maternity service is expected to follow NICE guidance for these minimum requirements.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 1:**

Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2.4</td>
<td>The maternity service can demonstrate implementation of the approved documentation for the management of fetal blood sampling (FBS) and cord pH, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• documentation of FBS results in the health record</td>
</tr>
<tr>
<td></td>
<td>• requirement and timing of repeated FBS with appropriate documentation</td>
</tr>
<tr>
<td></td>
<td>• documentation of paired cord sample results in the health record.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 2:**

4 sets of health records of women who have delivered in whom fetal blood sampling and paired cord sampling have been undertaken.

4 sets of health records of women who have delivered in whom paired cord sampling only has been undertaken (i.e. fetal blood sampling has not been undertaken), where there has been concern about the baby in labour or immediately following birth.

Minimum implementation of 75% compliance with both of the above methods of assessment is required.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2.4</td>
<td>The maternity service can demonstrate that it is monitoring compliance with the approved documentation for the management of fetal blood sampling (FBS) and cord pH, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• documentation of FBS results in the health record</td>
</tr>
<tr>
<td></td>
<td>• requirement and timing of repeated FBS with appropriate documentation</td>
</tr>
</tbody>
</table>
### Standard 2 - Criterion 4: Fetal Blood Sampling

- documentation of paired cord sample results in the health record.

Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

#### Method of assessment at Level 3:

1% or 10 sets, whichever is the greater, of all health records of women who have delivered in whom fetal blood sampling **and** paired cord sampling have been undertaken.

1% or 10 sets, whichever is the greater, of all health records of women who have delivered in whom paired cord sampling **only** has been undertaken (i.e. fetal blood sampling has not been undertaken), where there has been concern about the baby in labour or immediately following birth.

Minimum implementation of 75% compliance with both of the above methods of assessment is required.

#### Rationale:

Obstetric litigation is expensive, not solely due to the number of obstetric litigation cases, but due to the nature of the injury or disabilities caused by obstetric incidents. In particular, neurological damage to a fetus, which may result in the cost of the provision of a lifetime of care, makes this an area of high risk and high claims costs. Whilst the number of such cases are small, the potential in terms of cost is massive.

#### References:


**Standard 2 - Criterion 5: Use of Oxytocin**

The maternity service has an approved system for improving care and learning lessons relating to the use of Oxytocin in the first and second stages of labour that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2.5</td>
<td>The maternity service has approved documentation for the use of Oxytocin in the first and second stages of labour, which as a minimum must include:</td>
</tr>
<tr>
<td></td>
<td>a. assessment prior to commencement of Oxytocin*</td>
</tr>
<tr>
<td></td>
<td>b. dose schedules including frequency of increment*</td>
</tr>
<tr>
<td></td>
<td>c. monitoring arrangements for both the woman and the fetus*</td>
</tr>
<tr>
<td></td>
<td>d. requirement to document an individual management plan in the health record when Oxytocin commences</td>
</tr>
<tr>
<td></td>
<td>e. when Oxytocin should be stopped*</td>
</tr>
<tr>
<td></td>
<td>f. documentation of all of the above</td>
</tr>
<tr>
<td></td>
<td>g. process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans.</td>
</tr>
<tr>
<td></td>
<td>* As a minimum the maternity service is expected to follow NICE guidance for these minimum requirements.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 1:**

Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2.5</td>
<td>The maternity service can demonstrate implementation of the approved documentation for the use of Oxytocin in the first and second stages of labour, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• documentation of assessment prior to commencement of Oxytocin</td>
</tr>
<tr>
<td></td>
<td>• documentation of when Oxytocin should be stopped.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 2:**

8 sets of health records of women who have delivered who have received Oxytocin in labour. 8 sets of health records of women who have delivered who have received Oxytocin which required stopping in labour. Minimum implementation of 75% compliance with both of the above methods of assessment is required.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2.5</td>
<td>The maternity service can demonstrate that it is monitoring compliance with the approved documentation for the use of Oxytocin in the first and second stages of labour, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• documentation of assessment prior to commencement of Oxytocin</td>
</tr>
<tr>
<td></td>
<td>• documentation of when Oxytocin should be stopped.</td>
</tr>
<tr>
<td></td>
<td>Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.</td>
</tr>
</tbody>
</table>
## Standard 2 - Criterion 5: Use of Oxytocin

### Method of assessment at Level 3:

- 1% or 10 sets, whichever is the greater, of all health records of women who have delivered who have received Oxytocin in labour.
- 1% or 10 sets, whichever is the greater, of all health records of women who have delivered who have received Oxytocin which required stopping in labour.

Minimum implementation of 75% compliance with both of the above methods of assessment is required.

### Rationale:
Augmentation of labour is a frequently occurring procedure in obstetric units. All maternity services should have in place approved documentation that supports those staff providing this care.

### References:
## Standard 2 - Criterion 6: Caesarean Section

The maternity service has an approved system for improving care and learning lessons relating to caesarean sections that is implemented and monitored.

### Level 1 | Minimum Requirements
---|---
1.2.6 | The maternity service has approved documentation for the management of caesarean sections, which as a minimum must include the:
   
a. classification of all caesarean sections as agreed by the maternity service*
b. timing for Grade 1 classification of caesarean section as agreed by the maternity service
c. requirement to document the reason for performing a Grade 1 caesarean section in the health records by the person who makes the decision
d. need to include a consultant obstetrician in the decision making process unless doing so would be life threatening to the woman or the fetus
e. requirement to document any reasons for delay in undertaking the caesarean section
f. requirement for all women to be offered antibiotic and thrombo prophylaxis*
g. care of the mother in the first 24 hours following delivery*
h. requirement to discuss with women the implications for future pregnancies before discharge
i. process for continuous audit, multidisciplinary review of audit results and subsequent monitoring of action plans.

* As a minimum the maternity service is expected to follow NICE guidance for these minimum requirements.

### Method of assessment at Level 1:
Approved documentation.

### Level 2 | Minimum Requirements
---|---
2.2.6 | The maternity service can demonstrate implementation of the approved documentation for the management of caesarean sections, as described at Level 1, in relation to the:
   
- implementation of the classification and timings for all Grade 1 caesarean sections
- requirement to document the reason for performing a Grade 1 caesarean section in the health records by the person who makes the decision.

### Method of assessment at Level 2:
8 sets of health records of women who have delivered following a Grade 1 caesarean section. Minimum implementation of 75% compliance required.

### Level 3 | Minimum Requirements
---|---
3.2.6 | The maternity service can demonstrate that it is monitoring compliance with the approved documentation for the management of caesarean sections, as described at Level 1, in relation to the:
   
- implementation of the classification and timings for all Grade 1 caesarean sections
Standard 2 - Criterion 6: Caesarean Section

- requirement to document the reason for performing a Grade 1 caesarean section in the health records by the person who makes the decision. Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

<table>
<thead>
<tr>
<th>Method of assessment at Level 3:</th>
</tr>
</thead>
<tbody>
<tr>
<td>All health records of women who have delivered following a Grade 1 caesarean section.</td>
</tr>
<tr>
<td>Minimum implementation of 75% compliance required.</td>
</tr>
</tbody>
</table>

**Rationale:** All obstetric units undertake caesarean sections. All units should have in place referenced evidence based documentation that supports the practice of all professionals involved in a woman’s care and reflects the recommendations of national guidance.

**References:**

Standard 2 Criterion 7: Induction of Labour

The maternity service has approved documentation which describes the management of induction of labour that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 1.2.7   | The maternity service has approved documentation for the management of induction of labour, which as a minimum must include:  
|         | a. when membrane sweeping should occur*  
|         | b. gestation at which induction of labour should take place*  
|         | c. induction of labour in specific circumstances, which as a minimum must include:  
|         | i. prolonged pregnancy  
|         | ii. preterm prelabour rupture of membranes  
|         | iii. prelabour rupture of membranes at term  
|         | iv. previous caesarean section  
|         | v. fetal growth restriction  
|         | vi. maternal diabetes  
|         | vii. intrauterine death  
|         | d. methods of induction  
|         | e. maternal observations that should be carried out during induction prior to the establishment of labour  
|         | f. fetal observations that should be carried out during induction prior to the establishment of labour  
|         | g. development of an individual management plan when induction of labour fails  
|         | h. process for dealing with maternal requests for induction of labour  
|         | i. development of an individual management plan when induction of labour is declined  
|         | j. process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans.  
|         | * As a minimum the maternity service is expected to follow NICE guidance for these minimum requirements. |

Method of assessment at Level 1:  
Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 2.2.7   | The maternity service can demonstrate implementation of the approved documentation for induction of labour, as described at Level 1, in relation to the:  
|         | • induction of labour in specific circumstances to include:  
|         |   i. prolonged pregnancy  
|         |   iv. previous caesarean section  
|         | • maternal observations that should be carried out during induction prior to the establishment of labour  
|         | • fetal observations that should be carried out during induction prior to established labour |
## Standard 2 Criterion 7: Induction of Labour

- process for dealing with maternal requests for induction of labour.

### Method of assessment at Level 2:

8 sets of health records of women who have had their labour induced. Minimum implementation of 75% compliance required.

### Level 3 | Minimum Requirements
--- | ---
3.2.7 | The maternity service can demonstrate that it is monitoring compliance with the approved documentation for induction of labour, as described at Level 1, in relation to the:
- induction of labour in specific circumstances to include:
  - i. prolonged pregnancy
  - iv. previous caesarean section
- maternal observations that should be carried out during induction prior to the establishment of labour
- fetal observations that should be carried out during induction prior to established labour
- process for dealing with maternal requests for induction of labour.
Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

### Method of assessment at Level 3:

1% or 10 sets, whichever is the greater, of all health records of women who have had their labour induced. Minimum implementation of 75% compliance required.

### Rationale:
In the United Kingdom in 2009/10 approximately 21% of women had their labour induced. Whilst induction of labour is a relatively common procedure it has an impact on the birth experience of women and can place more strain on labour wards. In a study of claims relating to stillbirth conducted by the NHS Litigation Authority there were a number of claims relating to induction of labour.

### References:
Hospital Episodes Statistics. ‘Maternity Data in HES’. HES Online Database. NHS Information Centre for Health and Social Care. Available at: [www.hesonline.nhs.uk](http://www.hesonline.nhs.uk)


## Standard 2 - Criterion 8: Severely Ill Women

The maternity service has approved documentation which describes the process for ensuring the recognition of severely ill women either in pregnancy or the immediate postnatal period that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2.8</td>
<td>The maternity service has approved documentation for the management of the early recognition of severely ill women in the pregnancy or the immediate postnatal period, which as a minimum must include:</td>
</tr>
<tr>
<td></td>
<td>a. responsibilities of relevant staff groups</td>
</tr>
<tr>
<td></td>
<td>b. process for the use of a modified early obstetric warning scoring system (MEOWS)</td>
</tr>
<tr>
<td></td>
<td>c. guidance for staff on when to involve clinicians from outside the maternity service</td>
</tr>
<tr>
<td></td>
<td>d. maternity service’s expectations in relation to staff training, as identified in the training needs analysis, regarding the recognition of severely ill women</td>
</tr>
<tr>
<td></td>
<td>e. maternity service’s expectations in relation to staff training, as identified in the training needs analysis, regarding maternal resuscitation</td>
</tr>
<tr>
<td></td>
<td>f. process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 1:**
Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2.8</td>
<td>The maternity service can demonstrate implementation of the approved documentation for the management of the early recognition of severely ill women in pregnancy or the immediate postnatal period, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• process for the use of a modified early obstetric warning scoring system (MEOWS)</td>
</tr>
<tr>
<td></td>
<td>• maternity service’s expectations in relation to staff training, as identified in the training needs analysis, regarding the recognition of severely ill women.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 2:**
8 sets of health records of women who have delivered and in whom MEOWS was undertaken.
Minimum implementation of 75% compliance required.
Additional evidence will be required to demonstrate implementation of training, with attendance levels at a minimum of 75%.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2.8</td>
<td>The maternity service can demonstrate that it is monitoring compliance with the approved documentation for the management of the early recognition of severely ill women in pregnancy or the immediate postnatal period, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• process for the use of a modified early obstetric warning scoring system (MEOWS)</td>
</tr>
</tbody>
</table>
|         | • maternity service’s expectations in relation to staff training, as identified in the training needs analysis, regarding the recognition of severely ill women.
### Standard 2 - Criterion 8: Severely Ill Women

<table>
<thead>
<tr>
<th><strong>Method of assessment at Level 3:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1% or 10 sets, whichever is the greater, of all health records of women who have delivered and in whom MEOWS was undertaken.</td>
</tr>
<tr>
<td>Minimum implementation of 75% compliance required.</td>
</tr>
<tr>
<td>Additional evidence will be required to demonstrate monitoring compliance with training, with attendance levels at a minimum of 75%.</td>
</tr>
</tbody>
</table>

**Rationale:** The recognition of severely ill women either in pregnancy or the immediate postnatal period remains a challenge to all involved in their care. The introduction of a modified early obstetric warning scoring system will assist in improving the detection of life threatening illnesses.

**References:**

### Standard 2 - Criterion 9: High Dependency Care

The maternity service has approved documentation which describes the process for ensuring that women receive high dependency care/intensive care in a suitable environment that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| **1.2.9** | The maternity service has approved documentation which describes the process for ensuring that women receive high dependency care/intensive care in a suitable environment, which as a minimum must include:  
  a. responsibilities of relevant staff groups  
  b. process for ensuring the availability of medical equipment in line with national guidance  
  c. *guidance for staff on when to involve clinicians from outside of the maternity service*  
  d. *agreed criteria for transfer to a high dependency unit/intensive care unit, within or outside of the maternity service*  
  e. *requirements of each staff group when transferring women to a high dependency unit/intensive care unit*  
  f. *documentation of c), d) and e)*  
  g. process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans. |

**Method of assessment at Level 1:**  
Approved documentation.

<table>
<thead>
<tr>
<th>Level</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| **2.2.9** | The maternity service can demonstrate implementation of the approved documentation which describes the process for ensuring that women receive high dependency care/intensive care in a suitable environment, as described at Level 1, in relation to the:  
  - documentation of the involvement of clinicians from outside of the maternity service  
  - documentation of the agreed criteria for transfer to a high dependency unit/intensive care unit, within or outside of the maternity service  
  - documentation requirements for each staff group when transferring women to a high dependency unit/intensive care unit. |

**Method of assessment at Level 2:**  
8 sets of health records of women who have delivered who have required high dependency/intensive care.  
Minimum implementation of 75% compliance required.

<table>
<thead>
<tr>
<th>Level</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| **3.2.9** | The maternity service can demonstrate that it is monitoring compliance with the approved documentation which describes the process for ensuring that women receive high dependency care/intensive care in a suitable environment, as described at Level 1, in relation to the:  
  - documentation of the involvement of clinicians from outside of the maternity service |
<table>
<thead>
<tr>
<th>Standard 2 - Criterion 9: High Dependency Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• documentation of the agreed criteria for transfer to a high dependency unit/intensive care unit, within or outside of the maternity service</td>
</tr>
<tr>
<td>• documentation requirements for each staff group when transferring women to a high dependency unit/intensive care unit.</td>
</tr>
<tr>
<td>Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 3:**

1% or 10 sets, whichever is the greater, of all health records of women who have delivered who have required high dependency/intensive care.

Minimum implementation of 75% compliance required.

**Rationale:**

High dependency care should be available on or near the labour ward with appropriately trained staff or, if this is unavailable, women should be transferred to an appropriate unit.

**References:**


Maternal Critical Care Working Group. (2011). Providing Equity Of Critical And Maternity Care For The Critically Ill Pregnant Or Recently Pregnant Woman. London: RCoA. Available at: [www.rcoa.ac.uk](http://www.rcoa.ac.uk)

Standard 2 - Criterion 10: Vaginal Birth after Caesarean Section

The maternity service has an approved system for improving care and learning lessons relating to the care of all women who have a vaginal birth after a caesarean section that is implemented and monitored.

### Level 1
#### Minimum Requirements

**1.2.10** The maternity service has approved documentation for the management of vaginal birth after caesarean section, which as a minimum must include:

a. responsibilities of relevant staff groups
b. documented antenatal discussion on the mode of delivery
c. documented plan for the place of labour
d. **documented individual management plan for labour**
e. documented plan for labour should this commence early
f. documented plan for labour should this not commence as planned, that has been discussed with the consultant obstetrician
g. **documented plan for the monitoring of the fetal heart in labour**
h. process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans.

**Method of assessment at Level 1:**
Approved documentation.

### Level 2
#### Minimum Requirements

**2.2.10** The maternity service can demonstrate implementation of the approved documentation for the management of vaginal birth after caesarean section, as described at Level 1, in relation to the:

- documented individual management plan for labour
- documented plan for the monitoring of the fetal heart in labour.

**Method of assessment at Level 2:**
8 sets of health records of women who have had a vaginal birth after caesarean section.
Minimum implementation of 75% compliance required.

### Level 3
#### Minimum Requirements

**3.2.10** The maternity service can demonstrate that it is monitoring compliance with the approved documentation for the management of vaginal birth after caesarean section, as described at Level 1, in relation to the:

- documented individual management plan for labour
- documented plan for the monitoring of the fetal heart in labour.

Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

**Method of assessment at Level 3:**
1% or 10 sets, whichever is the greater, of all health records of women who have had a vaginal birth after caesarean section.
Minimum implementation of 75% compliance required.
Standard 2 - Criterion 10: Vaginal Birth after Caesarean Section

**Rationale:** An increased rate of births by caesarean section in recent years has led to an increased number of women who have a history of previous caesarean section. All maternity services should have in place approved documentation to support staff caring for women who are having a vaginal birth after a previous caesarean section.

**References:**


Standard 3 - Criterion 1: Severe Pre-Eclampsia

The maternity service has approved documentation which describes the management of severe pre-eclampsia that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 1.3.1   | The maternity service has approved documentation for the management of severe pre-eclampsia, which as a minimum must include:  
a. assessment and diagnosis of severe pre-eclampsia  
b. clear lines of communication between the consultant obstetrician, consultant anaesthetist, paediatrician and labour ward coordinator  
c. **blood pressure control and fluid balance**  
d. prevention of eclamptic seizures  
e. **fetal assessment and delivery planning**  
f. postnatal follow up  
g. process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans. |

**Method of assessment at Level 1:**
Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 2.3.1   | The maternity service can demonstrate implementation of the approved documentation for the management of severe pre-eclampsia, as described at Level 1, in relation to:  
- blood pressure control and fluid balance  
- prevention of eclamptic seizures  
- fetal assessment and delivery planning. |

**Method of assessment at Level 2:**
8 sets of health records of women who have delivered with a diagnosis of severe pre-eclampsia.  
Minimum implementation of 75% compliance required.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 3.3.1   | The maternity service can demonstrate that it is monitoring compliance with the approved documentation for the management of severe pre-eclampsia, as described at Level 1, in relation to:  
- blood pressure control and fluid balance  
- prevention of eclamptic seizures  
- fetal assessment and delivery planning.  
Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented. |

**Method of assessment at Level 3:**
1% or 10 sets, whichever is the greater, of all health records of women who have delivered with a diagnosis of severe pre-eclampsia.  
Minimum implementation of 75% compliance required.
Standard 3 - Criterion 1: Severe Pre-Eclampsia

**Rationale:** The incidence of eclampsia and its complications have decreased significantly in the United Kingdom since 1992, following the introduction of management guidelines for eclampsia and pre-eclampsia. However, eclampsia remains the second most common cause of direct deaths. In order to try and reduce the incidence of eclampsia, all maternity services should have approved documents that describe clear lines of communication between all staff groups involved in the management of severe pre-eclampsia and describe the care that should be provided to women.

**References:**


### Standard 3 - Criterion 2: Eclampsia

The maternity service has approved documentation which describes the management of eclampsia that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 1.3.2   | The maternity service has approved documentation for the management of eclampsia, which as a minimum must include:  
|         | a. assessment and diagnosis of eclampsia  
|         | b. clear lines of communication between the consultant obstetrician, consultant anaesthetist, paediatrician and labour ward coordinator  
|         | c. **blood pressure control and fluid balance**  
|         | d. **control of eclamptic seizures**  
|         | e. **fetal assessment and delivery planning**  
|         | f. postnatal follow up  
|         | g. process for **audit**, multidisciplinary review of **audit** results and subsequent **monitoring** of action plans. |

**Method of assessment at Level 1:**  
Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 2.3.2   | The maternity service can demonstrate implementation of the approved documentation for the management of eclampsia, as described at Level 1, in relation to:  
|         | • blood pressure control and fluid balance  
|         | • control of eclamptic seizures  
|         | • fetal assessment and delivery planning. |

**Method of assessment at Level 2:**  
All health records of women who have delivered with a diagnosis of eclampsia.  
Minimum implementation of 75% compliance required.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 3.3.2   | The maternity service can demonstrate that it is monitoring compliance with the approved documentation for the management of eclampsia, as described at Level 1, in relation to:  
|         | • blood pressure control and fluid balance  
|         | • control of eclamptic seizures  
|         | • fetal assessment and delivery planning.  
|         | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented. |

**Method of assessment at Level 3:**  
All health records of women who have delivered with a diagnosis of eclampsia.  
Minimum implementation of 75% compliance required.
Standard 3 - Criterion 2: Eclampsia

**Rationale:** The incidence of eclampsia and its complications have decreased significantly in the United Kingdom since 1992, following the introduction of management guidelines for eclampsia and pre-eclampsia. However, eclampsia remains the second most common cause of direct deaths. In order to try and keep the incidence of eclampsia low, all maternity services should have approved documents that describe clear lines of communication between all staff groups involved in such emergencies and describe the care that should be provided to women who suffer an eclamptic fit.

**References:**


Standard 3 - Criterion 3: Operative Vaginal Delivery

The maternity service has approved documentation which describes the management of operative vaginal delivery that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3.3</td>
<td>The maternity service has approved documentation for the management of operative vaginal delivery, which as a minimum must include:</td>
</tr>
<tr>
<td></td>
<td>a. who can perform the procedure</td>
</tr>
<tr>
<td></td>
<td>b. assessment prior to performing the procedure</td>
</tr>
<tr>
<td></td>
<td>c. documentation of why the procedure is indicated</td>
</tr>
<tr>
<td></td>
<td>d. documentation of informed consent</td>
</tr>
<tr>
<td></td>
<td>e. ensuring effective analgesia</td>
</tr>
<tr>
<td></td>
<td>f. care of the bladder</td>
</tr>
<tr>
<td></td>
<td>g. when to use sequential instruments</td>
</tr>
<tr>
<td></td>
<td>h. when the procedure should be abandoned</td>
</tr>
<tr>
<td></td>
<td>i. care following operative vaginal delivery</td>
</tr>
<tr>
<td></td>
<td>j. process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans.</td>
</tr>
</tbody>
</table>

Method of assessment at Level 1: Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.3.3</td>
<td>The maternity service can demonstrate implementation of the approved documentation for the management of operative vaginal delivery, as described at Level 1, in relation to:</td>
</tr>
<tr>
<td></td>
<td>• who can perform the procedure</td>
</tr>
<tr>
<td></td>
<td>• documentation of why the procedure is indicated</td>
</tr>
<tr>
<td></td>
<td>• documentation of informed consent</td>
</tr>
<tr>
<td></td>
<td>• care of the bladder</td>
</tr>
<tr>
<td></td>
<td>• when to use sequential instruments</td>
</tr>
<tr>
<td></td>
<td>• when the procedure should be abandoned.</td>
</tr>
</tbody>
</table>

Method of assessment at Level 2: |
4 sets of health records of women who have delivered following an operative vaginal delivery. |
4 sets of health records of women who have delivered where sequential instruments have been used. |
4 sets of health records of women who have delivered where an operative procedure has been abandoned. |

The first 4 minimum requirements will be assessed in all 12 sets of health records. |
The last 2 minimum requirements will be assessed individually in each 4 sets of health records. |
Minimum implementation of 75% compliance with all the above methods of assessment is required.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.3.3</td>
<td>The maternity service can demonstrate that it is monitoring compliance with the approved documentation for the management of operative vaginal delivery, as described at Level 1, in relation to:</td>
</tr>
</tbody>
</table>
### Standard 3 - Criterion 3: Operative Vaginal Delivery

- who can perform the procedure
- documentation of why the procedure is indicated
- documentation of informed consent
- care of the bladder
- when to use sequential instruments
- when the procedure should be abandoned.

Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

### Method of assessment at Level 3:

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage or Sets</th>
</tr>
</thead>
<tbody>
<tr>
<td>1% or 10 sets, whichever is the greater, of all health records of women who have delivered following an operative vaginal delivery.</td>
<td></td>
</tr>
<tr>
<td>1% or 10 sets, whichever is the greater, of all health records of women who have delivered where sequential instruments have been used.</td>
<td></td>
</tr>
<tr>
<td>1% or 10 sets, whichever is the greater, of all health records of women who have delivered where an operative procedure has been abandoned.</td>
<td></td>
</tr>
</tbody>
</table>

The first 4 minimum requirements will be assessed in all 12 sets of health records. The last 2 minimum requirements will be assessed individually in each 4 sets of health records. Minimum implementation of 75% compliance with each method of assessment is required.

### Rationale:

There has been increasing awareness of the potential for morbidity for both the woman and the newborn relating to operative vaginal delivery. Caesarean section in the second stage of labour, however, also carries significant risk of morbidity and implications for future births. The aim is to offer women the option of a safe operative vaginal delivery, performed by an operator with the knowledge, experience and skills necessary to use the instruments and manage complications that may arise.

### References:

<table>
<thead>
<tr>
<th><strong>Standard 3 - Criterion 3: Operative Vaginal Delivery</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.rcog.org.uk">www.rcog.org.uk</a></td>
</tr>
</tbody>
</table>
# Standard 3 - Criterion 4: Multiple Pregnancy & Birth

The maternity service has approved documentation which describes the management of multiple pregnancy and birth that is implemented and monitored.

## Level 1 Minimum Requirements

<table>
<thead>
<tr>
<th>1.3.4</th>
<th>The maternity service has approved documentation for the management of multiple pregnancy and birth, which as a minimum must include the:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a. <strong>requirement for providing information on the risks and benefits of different modes of delivery to support women in planning for birth</strong></td>
</tr>
<tr>
<td></td>
<td>b. <strong>requirement to discuss the planned and agreed place and timing of birth</strong></td>
</tr>
<tr>
<td></td>
<td>c. <strong>guidelines for managing the second stage of labour</strong></td>
</tr>
<tr>
<td></td>
<td>d. <strong>documentation of all of the above</strong></td>
</tr>
<tr>
<td></td>
<td>e. arrangements for providing all women with a multiple pregnancy ultrasound examination to assess viability, chorionicity, gestational age, major congenital malformation and nuchal translucency</td>
</tr>
<tr>
<td></td>
<td>f. routine schedule of antenatal visits and scans for women with multiple pregnancy</td>
</tr>
<tr>
<td></td>
<td>g. how the maternity service will manage suspected twin to twin transfusion, including referral to tertiary centre if appropriate</td>
</tr>
<tr>
<td></td>
<td>h. process for <strong>audit</strong>, multidisciplinary review of <strong>audit</strong> results and subsequent monitoring of action plans.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 1:**
Approved documentation.

## Level 2 Minimum Requirements

<table>
<thead>
<tr>
<th>2.3.4</th>
<th>The maternity service can demonstrate implementation of the approved documentation for the management of multiple pregnancy and birth, as described at Level 1, in relation to the:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• documentation of the provision of information on the risks and benefits of different modes of delivery to support women in planning for birth</td>
</tr>
<tr>
<td></td>
<td>• documentation of the planned and agreed place and timing of birth</td>
</tr>
<tr>
<td></td>
<td>• documentation of the management of the second stage of labour.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 2:**
8 sets of health records of women who have had multiple births (of which at least 4 are vaginal births). Minimum implementation of 75% compliance required.

## Level 3 Minimum Requirements

<table>
<thead>
<tr>
<th>3.3.4</th>
<th>The maternity service can demonstrate that it is monitoring compliance with the approved documentation for the management of multiple pregnancy and birth, as described at Level 1, in relation to the:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• documentation of the provision of information on the risks and benefits of different modes of delivery to support women in planning for birth</td>
</tr>
<tr>
<td></td>
<td>• documentation of the planned and agreed place and timing of birth</td>
</tr>
<tr>
<td></td>
<td>• documentation of the management of the second stage of labour.</td>
</tr>
<tr>
<td></td>
<td>Where the <strong>monitoring</strong> has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes</td>
</tr>
</tbody>
</table>

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**Standard 3 - Criterion 4: Multiple Pregnancy & Birth**

<table>
<thead>
<tr>
<th>Method of assessment at Level 3:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1% or 10 sets, whichever is the greater, of all health records of women who have had multiple births (of which at least half are vaginal births).</td>
</tr>
<tr>
<td>Minimum implementation of 75% compliance required.</td>
</tr>
</tbody>
</table>

**Rationale:** An increased maternal mortality rate associated with multiple births in the previous two triennia has been maintained (CMACE 2011). Compared with singletons, fetuses in a multiple pregnancy have a higher risk of complications during and after pregnancy, including discordant growth, pre-term birth and increased mortality rate. It has been shown that the rate of cerebral palsy is at least six times higher for twins and 18 times higher for triplets than for singleton babies (CMACE 2009). This is also supported by the claims data held by the NHS Litigation Authority. In a study of claims relating to stillbirth conducted by the NHS Litigation Authority there were a number of twin pregnancies.

**References:**


The maternity service has approved documentation which describes the management of all types of perineal trauma that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3.5</td>
<td>The maternity service has approved documentation for the management of all types of perineal trauma, which as a minimum must include:</td>
</tr>
<tr>
<td></td>
<td>a. who can perform the repair</td>
</tr>
<tr>
<td></td>
<td>b. systematic assessment of the perineum and lower vagina for an accurate evaluation of any trauma sustained</td>
</tr>
<tr>
<td></td>
<td>c. when non-suturing may be applicable</td>
</tr>
<tr>
<td></td>
<td>d. methods and materials used in perineal repair</td>
</tr>
<tr>
<td></td>
<td>e. documentation of consent for all types of perineal repair</td>
</tr>
<tr>
<td></td>
<td>f. management of third and fourth-degree tears</td>
</tr>
<tr>
<td></td>
<td>g. process for offering a postnatal appointment with an appropriate clinician to all women who have had a third or fourth-degree tear</td>
</tr>
<tr>
<td></td>
<td>h. standards for record-keeping in relation to all types of perineal trauma</td>
</tr>
<tr>
<td></td>
<td>i. documentation of information given regarding support following the repair</td>
</tr>
<tr>
<td></td>
<td>j. process for monitoring the rate and cause of returns of women with problems relating to all types of perineal repair</td>
</tr>
<tr>
<td></td>
<td>k. maternity service’s expectations for staff training, as identified in the training needs analysis</td>
</tr>
<tr>
<td></td>
<td>l. process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 1:**

Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.3.5</td>
<td>The maternity service can demonstrate implementation of the approved documentation for the management of all types of perineal trauma, as described at Level 1, in relation to:</td>
</tr>
<tr>
<td></td>
<td>• who can perform the repair</td>
</tr>
<tr>
<td></td>
<td>• documentation of consent for all types of perineal repair</td>
</tr>
<tr>
<td></td>
<td>• management of third and fourth-degree tears</td>
</tr>
<tr>
<td></td>
<td>• standards for record-keeping in relation to all types of perineal trauma</td>
</tr>
<tr>
<td></td>
<td>• documentation of information given regarding support following the repair</td>
</tr>
</tbody>
</table>
|         | • maternity service’s expectations for staff training, as identified in the training needs analysis.
Standard 3 - Criterion 5: Perineal Trauma

Method of assessment at Level 2:

- 8 sets of health records of women who have had a third or fourth-degree tear to assess the management of third and fourth-degree tears.
- 0.5% of all health records of women who have delivered to assess all minimum requirements.

Minimum implementation of 75% compliance with both of the above methods of assessment is required.

Additional evidence will be required to demonstrate implementation of training, with attendance levels at a minimum of 75%.

### Level 3 Minimum Requirements

<table>
<thead>
<tr>
<th>3.3.5</th>
<th>The maternity service can demonstrate that it is monitoring compliance with the approved documentation for the management of all types of perineal trauma, as described at Level 1, in relation to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- who can perform the repair</td>
</tr>
<tr>
<td></td>
<td>- documentation of consent for all types of perineal repair</td>
</tr>
<tr>
<td></td>
<td>- management of third and fourth-degree tears</td>
</tr>
<tr>
<td></td>
<td>- standards for record-keeping in relation to all types of perineal trauma</td>
</tr>
<tr>
<td></td>
<td>- documentation of information given regarding support following the repair</td>
</tr>
<tr>
<td></td>
<td>- maternity service’s expectations for staff training, as identified in the training needs analysis.</td>
</tr>
</tbody>
</table>

Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

Method of assessment at Level 3:

- All health records of women who have had a third or fourth-degree tear.
- 1% or 10 sets, whichever is the greater, of all health records of women who have delivered.

Minimum implementation of 75% compliance with both of the above methods of assessment required.

Additional evidence will be required to demonstrate monitoring compliance of training, with attendance levels at a minimum of 75%.

**Rationale:** Perineal damage can have a major adverse impact on women’s health; long term morbidity associated with anatomically incorrect approximation of wounds or unrecognised trauma to the external anal sphincter can lead to major physical, psychological and social problems. With improved awareness and training there is an increased likelihood of detection and a consistent, high standard of repair of perineal trauma and anal sphincter injury. This should contribute to reducing the extent of morbidity and litigation associated with perineal trauma and anal sphincter injury.

**References:**

<table>
<thead>
<tr>
<th>Standard 3 - Criterion 5: Perineal Trauma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Of Healthy Women And Their Babies During Childbirth. London: NICE. Available at: <a href="http://www.nice.org.uk">www.nice.org.uk</a></td>
</tr>
<tr>
<td>Royal College of Obstetricians and Gynaecologists. (2010). Repair Of Third- And Fourth-Degree Tears Following Childbirth. (Consent Advice No. 9). London: RCOG. Available at: <a href="http://www.rcog.org.uk">www.rcog.org.uk</a></td>
</tr>
</tbody>
</table>
## Standard 3 - Criterion 6: Shoulder Dystocia

The maternity service has approved documentation which describes the management of shoulder dystocia that is implemented and monitored.

### Level 1 Minimum Requirements

<table>
<thead>
<tr>
<th>1.3.6</th>
<th>The maternity service has approved documentation for the management of shoulder dystocia, which as a minimum must include:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a. identification of factors associated with shoulder dystocia</td>
</tr>
<tr>
<td></td>
<td>b. systematic emergency management of shoulder dystocia</td>
</tr>
<tr>
<td></td>
<td>c. standards for record-keeping in relation to shoulder dystocia</td>
</tr>
<tr>
<td></td>
<td>d. <strong>process for using a reporting form which contains the RCOG minimum data set</strong>*</td>
</tr>
<tr>
<td></td>
<td>e. <strong>process for the follow up of the newborn where there is actual/suspected brachial plexus injury or any other injury associated with the complications of the delivery</strong></td>
</tr>
<tr>
<td></td>
<td>f. maternity service’s expectations for staff training, as identified in the <strong>training needs analysis</strong></td>
</tr>
<tr>
<td></td>
<td>g. process for <strong>continuous audit</strong>, multidisciplinary review of <strong>audit</strong> results and subsequent <strong>monitoring</strong> of action plans.</td>
</tr>
</tbody>
</table>

* If the reporting form does not contain the RCOG minimum data set and is not stored within the health record compliance will not be awarded.

**Method of assessment at Level 1:**

Approved documentation.

### Level 2 Minimum Requirements

<table>
<thead>
<tr>
<th>2.3.6</th>
<th>The maternity service can demonstrate implementation of the approved documentation for the management of shoulder dystocia, as described at Level 1, in relation to the:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• process for using a reporting form which contains the RCOG minimum data set*</td>
</tr>
<tr>
<td></td>
<td>• process for the follow up of the newborn where there is actual/suspected brachial plexus injury or any other injury associated with the complications of the delivery.</td>
</tr>
</tbody>
</table>

* If the reporting form does not contain the RCOG minimum data set and is not stored within the health record compliance will not be awarded.

**Method of assessment at Level 2:**

8 sets of health records of women who have delivered following shoulder dystocia.
8 sets of health records of newborns where there was actual/suspected brachial plexus injury or any other injury associated with the complications of a shoulder dystocia delivery.
Minimum implementation of 75% compliance with both of the above methods of assessment required.

### Level 3 Minimum Requirements

<table>
<thead>
<tr>
<th>3.3.6</th>
<th>The maternity service can demonstrate that it is monitoring compliance with the approved documentation for the management of shoulder dystocia, as described at Level 1, in relation to the:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• process for using a reporting form which contains the RCOG minimum data set*</td>
</tr>
</tbody>
</table>

© NHS Litigation Authority
### Standard 3 - Criterion 6: Shoulder Dystocia

| set* | process for the follow up of the newborn where there is actual/suspected brachial plexus injury or any other injury associated with the complications of the delivery. Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented. |
|-----------------------------------------------|

* If the reporting form does not contain the RCOG minimum data set and is not stored within the health record compliance will not be awarded.

#### Method of assessment at Level 3:

All health records of women who have delivered following shoulder dystocia. All health records of newborns where there was actual/suspected brachial plexus injury or any other injury associated with the complications of a shoulder dystocia delivery. Minimum implementation of 75% compliance with both of the above methods of assessment required.

#### Rationale:

There can be high perinatal mortality and morbidity related to shoulder dystocia. Although it is recognised that not all brachial plexus injuries are due to excess traction and some brachial plexus injuries are not associated with clinically evident shoulder dystocia, good risk management requires that steps should be taken to address the possible prediction, prevention and management of shoulder dystocia, with good record-keeping standards throughout. A high level of awareness and training is also recommended for all birth attendants.

#### References:

Standard 3 - Criterion 6: Shoulder Dystocia

# Standard 3 - Criterion 7: Postpartum Haemorrhage

The maternity service has approved documentation which describes the management of postpartum haemorrhage that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3.7</td>
<td>The maternity service has <strong>approved documentation</strong> for the management of <em>postpartum haemorrhage</em>, which as a minimum must include:</td>
</tr>
<tr>
<td></td>
<td>a. <em>agreed local definition of</em> postpartum haemorrhage</td>
</tr>
<tr>
<td></td>
<td>b. <em>documented clear lines of communication between the consultant obstetrician, consultant anaesthetist, haematologist, blood transfusion personnel and labour ward coordinator</em></td>
</tr>
<tr>
<td></td>
<td>c. <em>description of the management of women with a</em> postpartum haemorrhage</td>
</tr>
<tr>
<td></td>
<td>d. <em>requirement to document fluid balance</em></td>
</tr>
<tr>
<td></td>
<td>e. <em>urgent access to blood, including portering arrangements</em></td>
</tr>
<tr>
<td></td>
<td>f. <em>clear and well understood trigger phrase to activate the</em> massive haemorrhage protocol</td>
</tr>
<tr>
<td></td>
<td>g. <em>requirement to document an individual management plan in the health records of women who decline blood products</em></td>
</tr>
<tr>
<td></td>
<td>h. <em>current arrangements for the use of intraoperative cell salvage</em></td>
</tr>
<tr>
<td></td>
<td>i. <em>current arrangements for the use of interventional radiology</em></td>
</tr>
<tr>
<td></td>
<td>j. <em>maternity service’s expectations for staff training, as identified in the training needs analysis</em></td>
</tr>
<tr>
<td></td>
<td>k. <em>process for continuous audit, multidisciplinary review of audit results and subsequent monitoring of action plans.</em></td>
</tr>
<tr>
<td></td>
<td><em>Where an interventional radiology service is not available, this should be documented. In hospitals with this service, treatment algorithms must have been developed which clearly identify the timing and place of interventional radiology in the management of postpartum haemorrhage.</em></td>
</tr>
</tbody>
</table>

**Method of assessment at Level 1:**
Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.3.7</td>
<td>The maternity service can demonstrate implementation of the <em>approved documentation</em> for the management of <em>postpartum haemorrhage</em>, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• documented clear lines of communication between the consultant obstetrician, consultant anaesthetist, haematologist, blood transfusion personnel and labour ward coordinator</td>
</tr>
<tr>
<td></td>
<td>• description of the management of women with a <em>postpartum haemorrhage</em></td>
</tr>
<tr>
<td></td>
<td>• requirement to document fluid balance</td>
</tr>
<tr>
<td></td>
<td>• clear and well understood trigger phrase to activate the <em>massive haemorrhage protocol</em>.</td>
</tr>
</tbody>
</table>
## Standard 3 - Criterion 7: Postpartum Haemorrhage

### Method of assessment at Level 2:
8 sets of health records of women who have had a major postpartum haemorrhage, including 4 sets where the massive haemorrhage protocol has been triggered. Minimum implementation of 75% compliance required.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.3.7</td>
<td>The maternity service can demonstrate that it is monitoring compliance with the approved documentation for the management of postpartum haemorrhage, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>documented clear lines of communication between the consultant obstetrician, consultant anaesthetist, haematologist, blood transfusion personnel and labour ward coordinator</td>
</tr>
<tr>
<td></td>
<td>description of the management of women with a postpartum haemorrhage</td>
</tr>
<tr>
<td></td>
<td>requirement to document fluid balance</td>
</tr>
<tr>
<td></td>
<td>clear and well understood trigger phrase to activate the massive haemorrhage protocol.</td>
</tr>
<tr>
<td></td>
<td>Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.</td>
</tr>
</tbody>
</table>

### Method of assessment at Level 3:
All health records of women who have had a major postpartum haemorrhage. All health records of women who have triggered the massive haemorrhage protocol. Minimum implementation of 75% compliance with both of the above methods of assessment required.

**Rationale:** There has been a decline in mortality from postpartum haemorrhage in the United Kingdom over the last 50 years. Haemorrhage dropped to sixth place as the cause of direct deaths in the last confidential enquiry (CMACE 2011). In order to try and keep the trend of postpartum haemorrhage down, maternity services should have in place approved documents that describe clear lines of communication between all staff groups involved in such emergencies and describe the care that should be provided to women who suffer a postpartum haemorrhage.

**References:**
### Standard 3 - Criterion 7: Postpartum Haemorrhage


<table>
<thead>
<tr>
<th>Standard 3 - Criterion 7: Postpartum Haemorrhage</th>
</tr>
</thead>
<tbody>
<tr>
<td>London: RCOG. Available at: <a href="http://www.rcog.org.uk">www.rcog.org.uk</a></td>
</tr>
</tbody>
</table>


Standard 3 - Criterion 8: Venous Thromboembolism

The maternity service has approved documentation which describes the management of venous thromboembolism (VTE) that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3.8</td>
<td>The maternity service has approved documentation for the management of VTE for all women, which as a minimum must include:</td>
</tr>
<tr>
<td></td>
<td>a. <strong>appropriate and timely risk assessments to identify those at risk of VTE</strong></td>
</tr>
<tr>
<td></td>
<td>b. significance of signs and symptoms in light of known risk factors</td>
</tr>
<tr>
<td></td>
<td>c. <strong>actions to be taken in response to the risk assessments once the risk of VTE has been identified</strong></td>
</tr>
<tr>
<td></td>
<td>d. <strong>requirement to document an individual management plan in the health records of women who require thromboprophylaxis or treatment for a diagnosis of VTE</strong></td>
</tr>
<tr>
<td></td>
<td>e. thromboprophylaxis during pregnancy</td>
</tr>
<tr>
<td></td>
<td>f. care during labour and delivery of women on thromboprophylaxis</td>
</tr>
<tr>
<td></td>
<td>g. thromboprophylaxis during the postnatal period</td>
</tr>
<tr>
<td></td>
<td>h. management of massive life threatening pulmonary thromboembolism in pregnancy</td>
</tr>
<tr>
<td></td>
<td>i. process for offering a postnatal appointment with an appropriate clinician to all women who have been diagnosed with VTE during pregnancy or the postnatal period</td>
</tr>
<tr>
<td></td>
<td>j. process for <a href="#">audit</a>, multidisciplinary review of <a href="#">audit</a> results and subsequent monitoring of action plans.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 1:**
Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.3.8</td>
<td>The maternity service can demonstrate implementation of the approved documentation for the management of VTE for all women, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• appropriate and timely risk assessments to identify those at risk of VTE</td>
</tr>
<tr>
<td></td>
<td>• actions to be taken in response to the risk assessments once the risk of VTE has been identified</td>
</tr>
<tr>
<td></td>
<td>• requirement to document an individual management plan in the health records of women who require thromboprophylaxis or treatment for a diagnosis of VTE.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 2:**
- 4 sets of health records of women who have delivered and received thromboprophylaxis due to identification of risk factors antenatally.
- 4 sets of health records of women who have delivered and received thromboprophylaxis due to identification of risk factors postnatally.
- 2 sets of health records of women who have delivered and received thromboprophylaxis or treatment for a diagnosis of VTE.

Minimum implementation of 75% compliance with all of the above methods of assessment required.
Standard 3 - Criterion 8: Venous Thromboembolism

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.3.8</td>
<td>The maternity service can demonstrate that it is monitoring compliance with the approved documentation for the management of VTE for all women, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• appropriate and timely risk assessments to identify those at risk of VTE</td>
</tr>
<tr>
<td></td>
<td>• actions to be taken in response to the risk assessments once the risk of VTE has been identified</td>
</tr>
<tr>
<td></td>
<td>• requirement to document an individual management plan in the health records of women who require thromboprophylaxis or treatment for a diagnosis of VTE.</td>
</tr>
<tr>
<td></td>
<td>Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 3:**

1% or 10 sets, whichever is the greater, of all health records of women who have delivered following thromboprophylaxis during the antenatal and/or postnatal period.

1% or 10 sets, whichever is the greater, of all health records of women who have delivered and received thromboprophylaxis or treatment for a diagnosis of VTE.

Minimum implementation of 75% compliance required.

**Rationale:** Thromboembolism remains the third highest cause of direct death in the latest confidential enquiry (CMACE 2011). Maternity services must develop and implement robust processes to ensure that appropriate risk assessments are undertaken and acted upon to further reduce the risk of maternal death from thrombosis and thromboembolism.

**References:**


<table>
<thead>
<tr>
<th>Standard 3 - Criterion 8: Venous Thromboembolism</th>
</tr>
</thead>
</table>
## Standard 3 - Criterion 9: Pre-Existing Diabetes

The maternity service has approved documentation which describes the management of pre-existing diabetes that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 1.3.9 | The maternity service has approved documentation for the management of pre-existing diabetes, which as a minimum must include:  
  a. involvement of the multidisciplinary team including the obstetrician, midwife, diabetes physician, diabetes specialist nurse and dietician in the provision of care when appropriate  
  b. timetable of antenatal appointments  
  c. requirement to document an individual management plan in the health records that covers the pregnancy and postnatal period up to six weeks  
  d. targets for glycaemic control  
  e. advising women with type 1 diabetes of the risks of hypoglycaemia and hypoglycaemia unawareness in pregnancy  
  f. offering antenatal ultrasound examination of the four chamber view of the fetal heart and outflow tracts at 20 weeks  
  g. how women who are suspected of having diabetic ketoacidosis are admitted immediately to a high dependency unit where they can receive both medical and obstetric care  
  h. process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans. |

**Method of assessment at Level 1:**  
Approved documentation.

<table>
<thead>
<tr>
<th>Level</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 2.3.9 | The maternity service can demonstrate implementation of the approved documentation for the management of pre-existing diabetes, as described at Level 1, in relation to:  
  • involvement of the multidisciplinary team including the obstetrician, midwife, diabetes physician, diabetes specialist nurse and dietician in the provision of care when appropriate  
  • timetable of antenatal appointments  
  • offering antenatal ultrasound examination of the four chamber view of the fetal heart and outflow tracts at 20 weeks. |

**Method of assessment at Level 2:**  
8 sets of health records of women who have delivered with a diagnosis of pre-existing diabetes. Minimum implementation of 75% compliance required.

<table>
<thead>
<tr>
<th>Level</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 3.3.9 | The maternity service can demonstrate that it is monitoring compliance with the approved documentation for the management of pre-existing diabetes, as described at Level 1, in relation to:  
  • involvement of the multidisciplinary team including the obstetrician, midwife, diabetes physician, diabetes specialist nurse and dietician in the provision of care when appropriate  
  • timetable of antenatal appointments  
  • offering antenatal ultrasound examination of the four chamber view of the fetal heart and outflow tracts at 20 weeks. |
Standard 3 - Criterion 9: Pre-Existing Diabetes

care when appropriate
- timetable of antenatal appointments
- offering antenatal ultrasound examination of the four chamber view of the fetal heart and outflow tracts at 20 weeks.

Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

Method of assessment at Level 3:

1% or 10 sets, whichever is the greater, of all health records of women who have delivered with a diagnosis of pre-existing diabetes.

Minimum implementation of 75% compliance required.

Rationale: Diabetes in pregnancy is associated with risks to both the woman and the developing fetus. Miscarriage, pre-eclampsia, pre-term labour and stillbirth are more common in women with pre-existing diabetes. Congenital malformations, macrosomia, birth injury, perinatal mortality and postnatal adaptation problems (such as hypoglycaemia) are more common in the newborn of women with pre-existing diabetes. In addition, diabetic retinopathy can worsen rapidly during pregnancy. Maternity services must ensure implementation of robust processes to manage the risks associated with pre-existing diabetes and consistently provide comprehensive, appropriate multidisciplinary care.

References:


NHS Fetal Anomaly Screening Programme. (2010). 18+0 To 20+6 Weeks Fetal Anomaly Scan - National Standards And Guidance For England. Available at: http://fetalanomaly.screening.nhs.uk


## Standard 3 - Criterion 10: Obesity

The maternity service has approved documentation which describes the management of obesity in pregnancy that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3.10</td>
<td>The maternity service has approved documentation for the management of obesity in pregnancy, which as a minimum must include:</td>
</tr>
<tr>
<td></td>
<td>a. calculation and documentation of body mass index (BMI) in the health records</td>
</tr>
<tr>
<td></td>
<td>b. calculation and documentation of the BMI in the electronic patient information system</td>
</tr>
<tr>
<td></td>
<td>c. requirement that all women with a BMI ≥30 should be advised to book for maternity team based care</td>
</tr>
<tr>
<td></td>
<td>d. requirement that all women with a BMI ≥35 should be advised to deliver in an obstetric led unit</td>
</tr>
<tr>
<td></td>
<td>e. requirement that all women with a BMI ≥40 have an antenatal consultation with an obstetric anaesthetist</td>
</tr>
<tr>
<td></td>
<td>f. requirement that a documented obstetric anaesthetic management plan for labour and delivery should be discussed with all women with a BMI ≥40</td>
</tr>
<tr>
<td></td>
<td>g. requirement that all women with a BMI ≥30 have a documented antenatal consultation with an appropriately trained professional to discuss possible intrapartum complications</td>
</tr>
<tr>
<td></td>
<td>h. requirement to assess the availability of suitable equipment in all care settings for women with a high BMI</td>
</tr>
<tr>
<td></td>
<td>i. requirement that all women with a BMI ≥40 have an individual documented assessment in the third trimester of pregnancy by an appropriately trained professional to determine manual handling requirements for childbirth and consider tissue viability issues</td>
</tr>
<tr>
<td></td>
<td>j. process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans.</td>
</tr>
</tbody>
</table>

### Method of assessment at Level 1:

Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.3.10</td>
<td>The maternity service can demonstrate implementation of the approved documentation for the management of obesity in pregnancy, as described at Level 1, in relation to:</td>
</tr>
<tr>
<td></td>
<td>• calculation and documentation of body mass index (BMI) in the health records</td>
</tr>
<tr>
<td></td>
<td>• calculation and documentation of the BMI in the electronic patient information system</td>
</tr>
<tr>
<td></td>
<td>• requirement that all women with a BMI ≥40 have an antenatal consultation with an obstetric anaesthetist</td>
</tr>
<tr>
<td></td>
<td>• requirement that a documented obstetric anaesthetic management plan for labour and delivery should be discussed with all women with a BMI ≥40</td>
</tr>
<tr>
<td></td>
<td>• requirement that all women with a BMI ≥30 have a documented antenatal consultation with an appropriately trained professional to discuss possible</td>
</tr>
</tbody>
</table>
### Standard 3 - Criterion 10: Obesity

<table>
<thead>
<tr>
<th>intrapartum complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>• requirement that all women with a booking BMI ≥40 have an individual documented assessment in the third trimester of pregnancy by an appropriately trained professional to determine manual handling requirements for childbirth and consider tissue viability issues.</td>
</tr>
</tbody>
</table>

### Method of assessment at Level 2:

0.5% of all health records of women who have delivered.

- 4 sets of health records of women who have delivered who required an antenatal consultation with an obstetric anaesthetist.
- 4 sets of health records of women who have delivered who required an antenatal consultation with an appropriately trained professional.
- 4 sets of health records of women who have delivered who required an individual documented assessment in the third trimester of pregnancy.

Minimum implementation of 75% compliance with all of the above methods of assessment required.

### Level 3 | Minimum Requirements

3.3.10 The maternity service can demonstrate that it is monitoring compliance with the approved documentation for the management of obesity in pregnancy, as described at Level 1, in relation to:

- calculation and documentation of body mass index (BMI) in the health records
- calculation and documentation of the BMI in the electronic patient information system
- requirement that all women with a BMI ≥40 have an antenatal consultation with an obstetric anaesthetist
- requirement that a documented obstetric anaesthetic management plan for labour and delivery should be discussed with all women with a BMI ≥40
- requirement that all women with a BMI ≥30 have a documented antenatal consultation with an appropriately trained professional to discuss possible intrapartum complications
- requirement that all women with a booking BMI ≥40 have an individual documented assessment in the third trimester of pregnancy by an appropriately trained professional to determine manual handling requirements for childbirth and consider tissue viability issues.

Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

### Method of assessment at Level 3:

- 1% or 10 sets, whichever is the greater, of all health records of women who have delivered.
- 1% or 10 sets, whichever is the greater, of all health records of women who have delivered who required an antenatal consultation with an obstetric anaesthetist.
- 1% or 10 sets, whichever is the greater, of all health records of women who have delivered who required an antenatal consultation with an appropriately trained professional.
- 1% or 10 sets, whichever is the greater, of all health records of women who have delivered who required an individual documented assessment in the third trimester of pregnancy.

Minimum implementation of 75% compliance with all of the above methods of assessment required.
Standard 3 - Criterion 10: Obesity

**Rationale:** The increasing prevalence of obesity in the United Kingdom has been widely publicised and the risks of maternal death among pregnant obese women has been highlighted in *Saving Mothers’ Lives* (CEMACH 2007). *Saving Mothers’ Lives* (CMACE 2011) identified that when considering obesity alone, that is a BMI of 30 or more, 30% of mothers who died from direct causes were obese, as were 24% of women who died from indirect causes. The complications of obesity during pregnancy have far reaching implications for both mother and newborn. Obesity in pregnancy is associated with an increased risk of miscarriage, fetal congenital anomaly, thromboembolism, gestational diabetes, pre-eclampsia, dysfunctional labour, postpartum haemorrhage, wound infections, stillbirth and neonatal death. There is also a higher caesarean section rate in this group of women. Maternity services must develop and implement robust processes to manage the risks associated with obesity and consistently provide sensitive, comprehensive and appropriate multidisciplinary care.

**References:**


Royal College of Obstetricians and Gynaecologists, Royal College of Anaesthetists, Royal College of Midwives, Royal College of Paediatrics and Child Health. (2008). *Standards For...*
Standard 3 - Criterion 10: Obesity

The maternity service has approved documentation which describes the process for ensuring that women have their first full booking visit and hand held record completed in line with appropriate timescales that is implemented and monitored.

**Level 1  Minimum Requirements**

1.4.1 The maternity service has approved documentation which describes the process for ensuring that women have their first full booking visit and hand held record completed in line with appropriate timescales, which as a minimum must include:
   
a. responsibilities of relevant staff groups
b. process for ensuring that women have their first full booking visit and hand held record completed by twelve completed weeks of pregnancy
c. process for ensuring that women who on referral to the maternity service are already twelve or more weeks pregnant are offered an appointment to be seen within two weeks of the referral
d. process for ensuring that migrant women who have not previously had a full medical examination in the United Kingdom have a medical history taken and clinical assessment made of their overall health, using an interpreter if necessary
e. process for identifying for which women health records from previous pregnancies are required for review by clinicians
f. process for arranging the availability of health records for women for which health records from previous pregnancies are required for review by clinicians
g. process for audit, multidisciplinary review of results and subsequent monitoring of action plans.

**Method of assessment at Level 1:**
Approved documentation.

**Level 2  Minimum Requirements**

2.4.1 The maternity service can demonstrate implementation of the approved documentation which describes the process for ensuring that women have their first full booking visit and hand held record completed in line with appropriate timescales, as described at Level 1, in relation to the:
   
   - process for ensuring that women have their first full booking visit and hand held record completed by twelve completed weeks of pregnancy
   - process for ensuring that women who on referral to the maternity service are already twelve or more weeks pregnant are offered an appointment to be seen within two weeks of the referral.

**Method of assessment at Level 2:**
0.5% of all health records of women who have delivered.
8 sets of health records of women who on referral to the maternity service are already twelve weeks or more weeks pregnant.

Minimum implementation of 75% compliance with both of the above methods of assessment required.

**Level 3  Minimum Requirements**

3.4.1 The maternity service can demonstrate that it is monitoring compliance with the approved documentation which describes the process for ensuring that women have their first full booking visit and hand held record completed in line with
**Standard 4 - Criterion 1: Booking Appointments**

appropriate timescales, as described at Level 1, in relation to the:

- process for ensuring that women have their first full booking visit and handheld record completed by twelve completed weeks of pregnancy
- process for ensuring that women who on referral to the maternity service are already twelve or more weeks pregnant are offered an appointment to be seen within two weeks of the referral.

Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

**Method of assessment at Level 3:**

- 1% or 10 sets, whichever is the greater, of all health records of women who have delivered.
- 1% or 10 sets, whichever is the greater, of all health records of women who on referral to the maternity service are already twelve or more weeks pregnant.

Minimum implementation of 75% compliance with both of the above methods of assessment required.

**Rationale:** Savings Mothers’ Lives (CEMACH 2007) identifies that around 20% of women who died from direct or indirect causes either booked for maternity care after 20 weeks gestation, missed over four routine appointments, did not seek care at all or actively concealed their pregnancies. This delay denied them the opportunities that early maternity care provides for mother, baby and family.

**References:**


# Standard 4 - Criterion 2: Missed Appointments

The maternity service has approved documentation which describes the process for ensuring that women who miss antenatal appointments are followed up appropriately and seen that is implemented and monitored.

## Level 1 Minimum Requirements

<table>
<thead>
<tr>
<th>1.4.2</th>
<th>The maternity service has approved documentation which describes the process for ensuring that women who miss antenatal appointments are followed up appropriately and seen, which as a minimum must include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>responsibilities of relevant staff groups</td>
</tr>
<tr>
<td>b.</td>
<td><strong>process for ensuring that women who miss any type of antenatal appointment are followed up</strong></td>
</tr>
<tr>
<td>c.</td>
<td><strong>documentation of follow up of women who miss any type of antenatal appointment</strong></td>
</tr>
<tr>
<td>d.</td>
<td>process for ensuring that women who miss any type of antenatal appointments are seen</td>
</tr>
<tr>
<td>e.</td>
<td>process for <strong>audit</strong>, multidisciplinary review of results and subsequent <strong>monitoring</strong> of action plans.</td>
</tr>
</tbody>
</table>

### Method of assessment at Level 1:
Approved documentation.

## Level 2 Minimum Requirements

<table>
<thead>
<tr>
<th>2.4.2</th>
<th>The maternity service can demonstrate implementation of the approved documentation which describes the process for ensuring that women who miss antenatal appointments are followed up appropriately and seen, as described at Level 1, in relation to the:</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>process for ensuring that women who miss any type of antenatal appointment are followed up</td>
</tr>
<tr>
<td>-</td>
<td>documentation of follow up of women who miss any type of antenatal appointment.</td>
</tr>
</tbody>
</table>

### Method of assessment at Level 2:
8 sets of health records of women who have delivered and have missed any type of antenatal appointment.
Minimum implementation of 75% compliance required.

## Level 3 Minimum Requirements

<table>
<thead>
<tr>
<th>3.4.2</th>
<th>The maternity service can demonstrate that it is <strong>monitoring</strong> compliance with the approved documentation which describes the process for ensuring that women who miss antenatal appointments are followed up appropriately and seen, as described at Level 1, in relation to the:</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>process for ensuring that women who miss any type of antenatal appointment are followed up</td>
</tr>
<tr>
<td>-</td>
<td>documentation of follow up of women who miss any type of antenatal appointment.</td>
</tr>
</tbody>
</table>
Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.
<table>
<thead>
<tr>
<th>Standard 4 - Criterion 2: Missed Appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Method of assessment at Level 3:</strong></td>
</tr>
<tr>
<td>1% or 10 sets, whichever is the greater, of all health records of women who have delivered and have missed any type of antenatal appointment.</td>
</tr>
<tr>
<td>Minimum implementation of 75% compliance required.</td>
</tr>
</tbody>
</table>

**Rationale:** *Savings Mothers’ Lives* (CEMACH 2007) identifies that around 20% of women who died from direct or indirect causes missed more than four routine appointments, did not seek care at all or actively concealed their pregnancies. This delay denied them the opportunities that early maternity care provides for mother, newborn and the family.

**References:**
# Standard 4 - Criterion 3: Clinical Risk Assessment (Antenatal)

The maternity service has approved documentation which describes the process for clinical risk assessment during the antenatal period that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.4.3</td>
<td>The maternity service has approved documentation which describes the process for clinical risk assessment during the antenatal period, which as a minimum must include:</td>
</tr>
<tr>
<td></td>
<td>a. <em>timing of risk assessments</em></td>
</tr>
<tr>
<td></td>
<td>b. medical conditions to be considered, including anaesthetic and psychiatric history</td>
</tr>
<tr>
<td></td>
<td>c. factors from previous pregnancies</td>
</tr>
<tr>
<td></td>
<td>d. lifestyle history to be considered</td>
</tr>
<tr>
<td></td>
<td>e. identification of women who will decline blood and blood products</td>
</tr>
<tr>
<td></td>
<td>f. risk assessment for appropriate place of birth</td>
</tr>
<tr>
<td></td>
<td>g. development of an individual management plan for women in whom risks are identified during the clinical risk assessment</td>
</tr>
<tr>
<td></td>
<td>h. <em>process for referral of women in whom risks are identified during the clinical risk assessment</em></td>
</tr>
<tr>
<td></td>
<td>i. process for referral back to midwifery led care if appropriate</td>
</tr>
<tr>
<td></td>
<td>j. <em>documentation of all the above, where clinically relevant</em></td>
</tr>
<tr>
<td></td>
<td>k. process for audit, multidisciplinary review of results and subsequent monitoring of action plans.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 1:**
Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.4.3</td>
<td>The maternity service can demonstrate implementation of the approved documentation which describes the process for clinical risk assessment during the antenatal period, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• documentation of the timing of risk assessments</td>
</tr>
<tr>
<td></td>
<td>• documentation of referral of women in whom risks are identified during the clinical risk assessment.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 2:**
0.5% of all health records of women who have delivered.
8 sets of records of women in whom risks are identified during the clinical risk assessment.
Minimum implementation of 75% compliance with both of the above methods of assessment required.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.4.3</td>
<td>The maternity service can demonstrate that it is monitoring compliance with the approved documentation which describes the process for clinical risk assessment during the antenatal period, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• documentation of the timing of risk assessments</td>
</tr>
<tr>
<td></td>
<td>• documentation of referral of women in whom risks are identified during the clinical risk assessment.</td>
</tr>
</tbody>
</table>
Standard 4 - Criterion 3: Clinical Risk Assessment (Antenatal)

Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

Method of assessment at Level 3:

1% or 10 sets, whichever is the greater, of all health records of women who have delivered.

1% or 10 sets, whichever is the greater, of all health records of women in whom risks are identified during the clinical risk assessment.

Minimum implementation of 75% compliance with both of the above methods of assessment required.

Rationale: Women should be offered a choice on place of birth. Consideration should be given to all risk factors that could affect the advice given to women when making this decision. Women with high risk factors or potential complications should be offered and advised on the referral pathways available to them. All risk assessments should be documented.

References:


# Standard 4 - Criterion 4: Patient Information

The maternity service has approved documentation which describes the process for giving information to women during the antenatal, intrapartum and postnatal periods that is implemented and monitored.

## Level 1 | Minimum Requirements
---|---
1.4.4 | The maternity service has approved documentation which describes the process for giving information to women during the antenatal, intrapartum and postnatal periods, which as a minimum must include:

a. responsibilities of relevant staff groups
b. schedule of when the information should be given
c. process for providing information to women who have communication or language support needs
d. maternity service’s expectations of staff to document clearly in the health records the information given to women as clinically indicated, in relation to:

i. place of birth options, including information on locally provided services
ii. antenatal screening tests
iii. induction of labour
iv. fetal monitoring in labour
v. pain management in labour (including regional anaesthesia)
vi. general anaesthesia
vii. vaginal birth following caesarean section
viii. caesarean section
ix. perineal repair
x. external cephalic version
xi. vitamin K prophylaxis
xii. women who decline blood and blood products
e. process for audit, multidisciplinary review of results and subsequent monitoring of action plans.

### Method of assessment at Level 1:
Approved documentation.

## Level 2 | Minimum Requirements
---|---
2.4.4 | The maternity service can demonstrate implementation of the approved documentation which describes the process for giving information to women during the antenatal, intrapartum and postnatal periods, as described at Level 1, in relation to the:

- maternity service’s expectations of staff to document clearly in the health records the information given to women as clinically indicated, in relation to:

i. place of birth options, including information on locally provided services
ii. antenatal screening tests
iii. induction of labour
Standard 4 - Criterion 4: Patient Information

iv. fetal monitoring in labour
v. pain management in labour (including regional anaesthesia)
vi. general anaesthesia
vii. vaginal birth following caesarean section
viii. caesarean section
ix. perineal repair
x. external cephalic version
xi. vitamin K prophylaxis
xii. women who decline blood and blood products.

Method of assessment at Level 2:
0.5% of all health records of women who have delivered.
Minimum implementation of 75% compliance required.

Level 3 Minimum Requirements

3.4.4 The maternity service can demonstrate that it is monitoring compliance with the approved documentation which describes the process for giving information to women during the antenatal, intrapartum and postnatal periods, as described at Level 1, in relation to:

- maternity service’s expectations of staff to document clearly in the health records the information given to women as clinically indicated, in relation to:
  i. place of birth options, including information on locally provided services
  ii. antenatal screening tests
  iii. induction of labour
  iv. fetal monitoring in labour
  v. pain management in labour (including regional anaesthesia)
  vi. general anaesthesia
  vii. vaginal birth following caesarean section
  viii. caesarean section
  ix. perineal repair
  x. external cephalic version
  xi. vitamin K prophylaxis
  xii. women who decline blood and blood products.

Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

Method of assessment at Level 3:
1% or 10 sets, whichever is the greater, of all health records of women who have delivered.
Minimum implementation of 75% compliance required.

Rationale: Women and their partners must have access to unbiased information which includes benefits, risks and alternatives (as appropriate) in order to make an informed choice regarding their care and treatment in line with national guidance. The organisation’s process for the development of patient information will influence and complement the maternity service’s process.
Standard 4 - Criterion 4: Patient Information

References:


UK National Screening Committee. ‘English antenatal & Newborn Publications’. UK Screening Portal. Available at: www.screening.nhs.uk/annbpublishations

UK National Screening Committee. ‘Information in other languages’. UK Screening Portal. Available at: www.screening.nhs.uk/languages
Standard 4 - Criterion 5: Maternal Antenatal Screening Tests

The maternity service has approved documentation which describes the process for ensuring all appropriate maternal screening tests are offered, undertaken and reported on during the antenatal period that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.4.5</td>
<td>The maternity service has approved documentation which describes the process for ensuring that all appropriate maternal screening tests (which must include all those tests listed in the Maternal Antenatal Screening Tests Minimum Data Set) are offered, undertaken and reported on during the antenatal period, which as a minimum must include:</td>
</tr>
<tr>
<td></td>
<td>a. designated lead for antenatal screening in the maternity service</td>
</tr>
<tr>
<td></td>
<td>b. antenatal screening tests, which follow the UK National Screening Committee guidance</td>
</tr>
<tr>
<td></td>
<td>c. system for ensuring that appropriate tests are undertaken within appropriate timescales</td>
</tr>
<tr>
<td></td>
<td>d. system for ensuring that appropriate tests are undertaken when women book late</td>
</tr>
<tr>
<td></td>
<td>e. process for the review of the results</td>
</tr>
<tr>
<td></td>
<td>f. process for reporting all results to women</td>
</tr>
<tr>
<td></td>
<td>g. process for reporting results to other relevant healthcare professionals</td>
</tr>
<tr>
<td></td>
<td>h. process for ensuring that women with screen positive test results are referred and managed within appropriate timescales</td>
</tr>
<tr>
<td></td>
<td>i. maternity service’s expectations for staff training, as identified in the training needs analysis</td>
</tr>
<tr>
<td></td>
<td>j. process for audit, multidisciplinary review of results and subsequent monitoring of action plans.</td>
</tr>
</tbody>
</table>

Method of assessment at Level 1: Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.4.5</td>
<td>The maternity service can demonstrate implementation of the approved documentation which describes the process for ensuring that all appropriate maternal screening tests (which must include all those tests listed in the Maternal Antenatal Screening Tests Minimum Data Set) are offered, undertaken and reported on during the antenatal period, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• process for the review of the results</td>
</tr>
<tr>
<td></td>
<td>• process for ensuring that women with screen positive test results are referred and managed within appropriate timescales.</td>
</tr>
</tbody>
</table>

The assessor will select Down’s syndrome, Hepatitis B and Rubella susceptibility from the Maternal Antenatal Screening Tests Minimum Data Set to assess the maternity service’s implementation of the above minimum requirements.
Standard 4 - Criterion 5: Maternal Antenatal Screening Tests

Method of assessment at Level 2:

0.5% of all health records of women who have delivered.

4 sets of health records of women who have delivered and who had screen positive test results for Down’s syndrome.

4 sets of health records of women who have delivered and who had screen positive test results for Hepatitis B.

4 sets of health records of women who have delivered and who had screen positive test results for Rubella susceptibility.

Minimum implementation of 75% compliance with all of the above methods of assessment required.

Level 3 Minimum Requirements

3.4.5 The maternity service can demonstrate that it is monitoring compliance with the approved documentation which describes the process for ensuring that all appropriate maternal screening tests (which must include all those tests listed in the Maternal Antenatal Screening Tests Minimum Data Set) are offered, undertaken and reported on during the antenatal period, as described at Level 1, in relation to the:

• process for the review of the results
• process for ensuring that women with screen positive test results are referred and managed within appropriate timescales.

Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

Method of assessment at Level 3:

1% or 10 sets, whichever is the greater, of all health records of women who have delivered.

1% or 10 sets, whichever is the greater, of all health records of women with screen positive test results.

Minimum implementation of 75% compliance with both of the above methods of assessment required.

Rationale: The maternity service has responsibility for ensuring that women and their partners know what screening tests are available, what has been performed and how results are communicated and acted upon following the guidance of the UK National Screening Committee.

References:


NHS Fetal Anomaly Screening Programme. (2010). 18+0 To 20+6 Weeks Fetal Anomaly Scan - National Standards And Guidance For England. Available at: http://fetalanomaly.screening.nhs.uk


Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians
Standard 4 - Criterion 5: Maternal Antenatal Screening Tests


## Standard 4 - Criterion 6: Mental Health

The maternity service has approved documentation which describes the process for ensuring that the mental health needs of women are met and is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 1.4.6   | The maternity service has approved documentation which describes the process for ensuring that the mental health needs of women are met, which as a minimum must include:   
   a. process for identifying women during the antenatal period who have a current mental health problem, or who are at risk of developing a mental health problem*
   b. process for identifying women who are at risk of developing a mental health problem or exacerbating a pre-existing mental illness during the postnatal period*  
   c. documentation of an individual management plan where appropriate* 
   d. process for the documentation of clear lines of communication between the maternity service and the following:*  
      i. mental health services 
      ii. general practitioners 
      iii. health visitor services 
      iv. interpretation services  
   e. maternity service’s expectations in relation to staff training, as identified in the training needs analysis  
   f. process for audit, multidisciplinary review of results and subsequent monitoring of action plans.  
* As a minimum the maternity service is expected to follow NICE guidance for these minimum requirements. |

**Method of assessment at Level 1:**
Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 2.4.6   | The maternity service can demonstrate implementation of the approved documentation which describes the process for ensuring that the mental health needs of women are met, as described at Level 1, in relation to the: 
- process for identifying women during the antenatal period who have a current mental health problem, or who are at risk of developing a mental health problem  
- documentation of an individual management plan where appropriate. |

**Method of assessment at Level 2:**
0.5% of all health records of women who have delivered.  
8 sets of health records of women who required a management plan.  
Minimum implementation of 75% compliance with both of the above methods of assessment required.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.4.6</td>
<td>The maternity service can demonstrate that it is monitoring compliance with the approved documentation which describes the process for ensuring that the</td>
</tr>
</tbody>
</table>
Standard 4 - Criterion 6: Mental Health

- mental health needs of women are met, as described at Level 1, in relation to the:
  - process for identifying women during the antenatal period who have a current mental health problem, or who are at risk of developing a mental health problem
  - documentation of an individual management plan where appropriate.

Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

Method of assessment at Level 3:

- 1% or 10 sets, whichever is the greater, of all health records of women who have delivered.
- 1% or 10 sets, whichever is the greater, of all health records of women who required a management plan.

Minimum implementation of 75% compliance with both of the above methods of assessment required.

Rationale: Psychiatric disorder during pregnancy and following delivery is common; both new episodes and recurrences of pre-existing conditions. 10% of new mothers are likely to develop a depressive illness in the year following delivery, of whom between a third and a half will be suffering from a severe depressive illness. At least two in every hundred new mothers will be referred to a psychiatric team during this time and four women per thousand will be admitted to a psychiatric hospital, of whom two per thousand will be suffering from a puerperal psychosis.

All mental disorders in the antenatal and postnatal period may have a significant impact on the mother-infant relationship. In addition, the mother-father/partner and family relationship may be affected. The Confidential Enquiry into Maternal Deaths (CEMD 2001) reports that psychiatric disorders contributed to 12% of all maternal deaths (10% of which were due to suicide). If untreated, women may remain depressed, sometimes for many years, with consequent negative impact not only for the mother but also for other family members. The rate of recurrence of postnatal depression after a subsequent birth is about 30%. The provision and uptake of services varies across England. In part, this reflects variation in the recognition of disorders and is also affected by the presence or absence of specialist multidisciplinary and multiagency services, particularly for the more severely unwell.

References:


Royal College of Obstetricians and Gynaecologists. (June 2011). Management Of Women With Mental Health Issues During Pregnancy And The Postnatal Period. Available at: www.rcog.org.uk
# Standard 4 - Criterion 7: Clinical Risk Assessment (Labour)

The maternity service has approved documentation which describes the process for clinical risk assessment when labour commences that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.4.7</td>
<td>The maternity service has approved documentation which describes the process for clinical risk assessment when labour commences, which as a minimum must include:</td>
</tr>
<tr>
<td></td>
<td>a. <em>timing of the clinical risk assessment in all care settings</em></td>
</tr>
<tr>
<td></td>
<td>b. medical conditions to be considered, including anaesthetic history</td>
</tr>
<tr>
<td></td>
<td>c. factors from previous pregnancies</td>
</tr>
<tr>
<td></td>
<td>d. lifestyle history to be considered</td>
</tr>
<tr>
<td></td>
<td>e. risk assessment for appropriate place of birth</td>
</tr>
<tr>
<td></td>
<td>f. <em>documentation of an individual management plan when risks are identified during the clinical risk assessment</em></td>
</tr>
<tr>
<td></td>
<td>g. <em>process for referral of women when risks are identified during the clinical risk assessment</em></td>
</tr>
<tr>
<td></td>
<td>h. <em>documentation of all the above, where clinically relevant</em></td>
</tr>
<tr>
<td></td>
<td>i. process for <em>audit</em>, multidisciplinary review of results and subsequent <em>monitoring</em> of action plans.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 1:**

Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.4.7</td>
<td>The maternity service can demonstrate implementation of the approved documentation which describes the process for clinical risk assessment when labour commences, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• documentation of the timing of the clinical risk assessment in <em>all care settings</em></td>
</tr>
<tr>
<td></td>
<td>• documentation of an individual management plan when risks are identified during the clinical risk assessment</td>
</tr>
<tr>
<td></td>
<td>• documentation for referral of women when risks are identified during the clinical risk assessment.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 2:**

0.5% of all health records of women who have delivered.

8 sets of health records of women in whom risks are identified during the clinical risk assessment.

Minimum implementation of 75% compliance with both of the above methods of assessment required.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.4.7</td>
<td>The maternity service can demonstrate that it is <em>monitoring</em> compliance with the approved documentation which describes the process for clinical risk assessment when labour commences, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• documentation of the timing of the clinical risk assessment in <em>all care settings</em></td>
</tr>
<tr>
<td></td>
<td>• documentation of an individual management plan when risks are identified during the clinical risk assessment</td>
</tr>
<tr>
<td></td>
<td>• documentation for referral of women when risks are identified during the risk</td>
</tr>
</tbody>
</table>
### Standard 4 - Criterion 7: Clinical Risk Assessment (Labour)

Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

#### Method of assessment at Level 3:

1% or 10 sets, whichever is the greater, of all health records of women who have delivered.

1% or 10 sets, whichever is the greater, of all health records of women in whom risks are identified during the clinical risk assessment.

Minimum implementation of 75% compliance with both of the above methods of assessment required.

#### Rationale:

Women with high risk factors or potential complications should be offered and advised on the referral pathways available to them during labour. All risk assessments should be documented.

#### References:


# Standard 4 - Criterion 8: Handover of Care (Onsite)

The maternity service has approved documentation which describes the process for ensuring that there is an effective system in place for handover of care onsite between healthcare professionals involved in women’s care that is implemented and monitored.

## Level 1 | Minimum Requirements
--- | ---
1.4.8 | The maternity service has approved documentation which describes the process for ensuring that there is an effective system in place for handover of care onsite between healthcare professionals involved in women’s care, which as a minimum must include:

   a. locally or nationally developed tools to ensure a consistent approach to the documentation of the handover of care, for example Situation Background Assessment and Recommendation (SBAR) or Reason Story Vital Signs and Plan (RSVP)

   b. handover at the change of shift, for each staff group, to include both giving and receiving of information

   c. handover for transfer between care settings, to include both giving and receiving of information

   d. documentation of handover between all care settings

   e. process for audit, multidisciplinary review of results and subsequent monitoring of action plans.

**Method of assessment at Level 1:**
Approved documentation.

## Level 2 | Minimum Requirements
--- | ---
2.4.8 | The maternity service can demonstrate implementation of the approved documentation which describes the process for ensuring that there is an effective system in place for handover of care onsite between healthcare professionals involved in women’s care, as described at Level 1, in relation to the:

- documentation of handover between the antenatal ward and the labour ward
- documentation of handover between the labour ward and the postnatal ward.

**Method of assessment at Level 2:**
0.5% of all health records of women who have delivered.
Minimum implementation of 75% compliance required.

## Level 3 | Minimum Requirements
--- | ---
3.4.8 | The maternity service can demonstrate that it is monitoring compliance with the approved documentation which describes the process for ensuring that there is an effective system in place for handover of care onsite between healthcare professionals involved in women’s care, as described at Level 1, in relation to the:

- documentation of handover between the antenatal ward and the labour ward
- documentation of handover between the labour ward and the postnatal ward.

Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.
<table>
<thead>
<tr>
<th>Standard 4 - Criterion 8: Handover of Care (Onsite)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Method of assessment at Level 3:</strong></td>
</tr>
<tr>
<td>1% or 10 sets, whichever is the greater, of all health records of women who have delivered.</td>
</tr>
<tr>
<td>Minimum implementation of 75% compliance required.</td>
</tr>
</tbody>
</table>

**Rationale:** An effective working relationship between the multidisciplinary team and a clear organisational structure for midwives and medical staff with explicit and transparent lines of communication is crucial to ensure optimum care for women.

**References:**


Maternal Critical Care Working Group. (2011). *Providing Equity Of Critical And Maternity Care For The Critically Ill Pregnant Or Recently Pregnant Woman*. London: RCoA. Available at: [www.rcoa.ac.uk](http://www.rcoa.ac.uk)


Student BMJ. (2006). *From Medical Student To Junior Doctor: The Medical Handover - A Good Habit To Cultivate*. Available at: [www.student.bmj.com](http://www.student.bmj.com) (free registration required)

# Standard 4 - Criterion 9: Maternal Transfer by Ambulance

The maternity service has approved documentation which describes the process for ensuring that there is an effective system in place for the safe transfer of women by ambulance that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 1.4.9   | The maternity service has [approved documentation](#) which describes the process for ensuring that there is an effective system in place for the safe transfer of women by ambulance, which as a minimum must include:  
   a. locally or nationally developed tools to ensure a consistent approach to the documentation of the transfer of care, for example [SBAR/ACCEPT](#)  
   b. agreed process for contacting the ambulance service in emergencies or when transfer is required  
   c. [documentation requirements of each staff group when undertaking an in utero transfer](#)  
   d. [documentation requirements of each staff group when transferring women into hospital from the community/midwifery led unit during the intrapartum period](#)  
   e. documentation requirements of each staff group when transferring a woman and her newborn in the postnatal period  
   f. process for [audit, multidisciplinary review of results and subsequent monitoring](#) of action plans. |

**Method of assessment at Level 1:**  
Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 2.4.9   | The maternity service can demonstrate implementation of the [approved documentation](#) which describes the process for ensuring that there is an effective system in place for the safe transfer of women by ambulance, as described at Level 1, in relation to the:  
   - documentation requirements of each staff group when undertaking an in utero transfer  
   - documentation requirements of each staff group when transferring women into hospital from the community/midwifery led unit during the intrapartum period. |

**Method of assessment at Level 2:**  
8 sets of health records of women for whom in utero transfers have been carried out.  
8 sets of health records of women who have been transferred into hospital from the community/midwifery led unit during the intrapartum period.  
Minimum implementation of 75% compliance with both of the above methods of assessment required.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 3.4.9   | The maternity service can demonstrate that it is [monitoring](#) compliance with the [approved documentation](#) which describes the process for ensuring that there is an effective system in place for the safe transfer of women by ambulance, as described at Level 1, in relation to the:  
   - documentation requirements of each staff group when undertaking an in utero transfer  
   - documentation requirements of each staff group when transferring women into hospital from the community/midwifery led unit during the intrapartum period. |
### Standard 4 - Criterion 9: Maternal Transfer by Ambulance

- documentation requirements of each staff group when transferring women into hospital from the community/midwifery led unit during the intrapartum period.

Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

### Method of assessment at Level 3:

1% or 10 sets, whichever is the greater, of all health records of women for whom in utero transfers have been carried out.

All health records of women who have been transferred into hospital from the community/midwifery led unit during the intrapartum period.

Minimum implementation of 75% compliance with both of the above methods of assessment required.

### Rationale:

An effective working relationship between the multidisciplinary team and a clear organisational structure for midwives and medical staff with explicit and transparent lines of communication is crucial to ensure optimum care for women and their newborns during transfer. Additionally, there should be local arrangements with ambulance services for attendance at emergencies or when transfer is required in order to ensure a timely transfer with appropriate personnel.

### References:

## Standard 4 - Criterion 10: Non-Obstetric Emergency Care

The maternity service has approved documentation which describes the process for improving outcomes and learning lessons for the care of pregnant women seen in the emergency department or elsewhere in the hospital that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.4.10</td>
<td>The maternity service has approved documentation which describes the process for the care of pregnant women seen in the emergency department or elsewhere in the hospital, which as a minimum must include:</td>
</tr>
<tr>
<td></td>
<td>a. which women attending the emergency department should be seen by an experienced doctor from the obstetric/gynaecology team or a midwife</td>
</tr>
<tr>
<td></td>
<td>b. requirement that the care of pregnant women with non-obstetric problem(s) who require admission should be discussed and planned with the local obstetric team</td>
</tr>
<tr>
<td></td>
<td>c. system for ensuring that the on-call obstetric consultant is aware of all sick pregnant women in the hospital who have a non-obstetric problem</td>
</tr>
<tr>
<td></td>
<td>d. system for ensuring that the on call obstetric consultant is aware of all sick pregnant women in the hospital who have a problem related to their pregnancy</td>
</tr>
<tr>
<td></td>
<td>e. process for audit, multidisciplinary review of results and subsequent monitoring of action plans.</td>
</tr>
</tbody>
</table>

### Method of assessment at Level 1:
Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.4.10</td>
<td>The maternity service can demonstrate implementation of the approved documentation which describes the process for the care of pregnant women seen in the emergency department or elsewhere in the hospital, as described at Level 1, in relation to:</td>
</tr>
<tr>
<td></td>
<td>• which women attending the emergency department should be seen by an experienced doctor from the obstetric/gynaecology team or a midwife</td>
</tr>
<tr>
<td></td>
<td>• system for ensuring that the on-call obstetric consultant is aware of all sick pregnant women in the hospital who have a non-obstetric problem.</td>
</tr>
</tbody>
</table>

### Method of assessment at Level 2:
8 sets of health records of pregnant women who have been seen in the emergency department with a non-obstetric problem.

8 sets of health records of pregnant women who have been admitted to the hospital with a non-obstetric problem.

Minimum implementation of 75% compliance with both of the above methods of assessment required.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.4.10</td>
<td>The maternity service can demonstrate that it is monitoring compliance with the approved documentation which describes the process for the care of pregnant women seen in the emergency department or elsewhere in the hospital, as described at Level 1, in relation to:</td>
</tr>
<tr>
<td></td>
<td>• which women attending the emergency department should be seen by an experienced doctor from the obstetric/gynaecology team or a midwife</td>
</tr>
<tr>
<td></td>
<td>• the system for ensuring that the on call obstetric consultant is aware of all sick</td>
</tr>
</tbody>
</table>
Standard 4 - Criterion 10: Non-Obstetric Emergency Care

pregnant women in the hospital who have a non-obstetric problem. Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

Method of assessment at Level 3:

1% or 10 sets, whichever is the greater, of all health records of pregnant women who have been seen in the emergency department with a non-obstetric problem.

1% or 10 sets, whichever is the greater, of all health records of pregnant women who have been admitted to a non-obstetric care setting in the hospital with a non-obstetric problem.

Minimum implementation of 75% compliance with both of the above methods of assessment required.

Rationale: The care of pregnant women requiring hospital attendance and admission should be discussed and planned with the local obstetric team.

Template document:

A template document has been created to assist maternity services in complying with the criterion, but its use is entirely optional. It is available for downloading from the NHSLA website at www.nhsla.com/publications, under Risk Management Publications followed by Document Templates.

References:


Standard 5 - Criterion 1: Referral when a Fetal Abnormality is Detected

The maternity service has an approved system for referral when a fetal abnormality is detected in pregnancy that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 1.5.1   | The maternity service has approved documentation for referral when a fetal abnormality is detected in pregnancy, which as a minimum must include:  
  a. referring women to a tertiary centre where appropriate*  
  b. referring women to neonatal/specialist services*  
  c. keeping the woman informed throughout the process*  
  d. communication between obstetric, neonatal and specialist staff in the antenatal period*  
  e. documentation of all of the above  
  f. process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans.  
* As a minimum the maternity service is expected to follow UK National Screening Council guidance for these minimum requirements.|

Method of assessment at Level 1:
Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 2.5.1   | The maternity service can demonstrate implementation of the approved documentation for referral when a fetal abnormality is detected in pregnancy, as described at Level 1, in relation to the process for:  
  • documentation when a woman is referred to neonatal/specialist services  
  • documentation of communication between obstetric, neonatal and specialist staff in the antenatal period.|

Method of assessment at Level 2:
8 sets of health records of women in whom a fetal abnormality has been detected.  
Minimum implementation of 75% compliance required.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 3.5.1   | The maternity service can demonstrate that it is monitoring compliance with the approved documentation for referral when a fetal abnormality is detected in pregnancy, as described at Level 1, in relation to the process for:  
  • documentation when a woman is referred to neonatal/specialist services  
  • documentation of communication between obstetric, neonatal and specialist staff in the antenatal period.  
  Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.|

Method of assessment at Level 3:
1% or 10 sets, whichever is the greater, of all health records of women in whom a fetal abnormality has been detected.  
Minimum implementation of 75% compliance required.
## Standard 5 - Criterion 1: Referral when a Fetal Abnormality is Detected

### Rationale:
The need for specialised care for a sick newborn can often be anticipated before birth. In addition, in some cases the expertise of specialist services will be needed. Good communication between professionals will ensure that these women and newborns are cared for in the most suitable environment.

### References:


NHS Fetal Anomaly Screening Programme. (2007). *Screening For Downs Syndrome In Multiple Pregnancy.* Exeter: UK NSC. Available at: [http://fetalanomaly.screening.nhs.uk](http://fetalanomaly.screening.nhs.uk)

NHS Fetal Anomaly Screening Programme. (2010). *18+0 To 20+6 Weeks Fetal Anomaly Scan - National Standards And Guidance For England.* Available at: [http://fetalanomaly.screening.nhs.uk](http://fetalanomaly.screening.nhs.uk)


UK National Screening Committee. *UK Screening Portal.* Available at: [www.screening.nhs.uk](http://www.screening.nhs.uk)
### Standard 5 - Criterion 2: Newborn Life Support

The maternity service has an approved system for improving care and learning lessons relating to newborn life support that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5.2</td>
<td>The maternity service has approved documentation for newborn life support, which as a minimum must include:</td>
</tr>
<tr>
<td></td>
<td>a. identification of a designated link paediatrician for the labour ward and neonatal service, responsible for the clinical standards in relation to the care of the newborn</td>
</tr>
<tr>
<td></td>
<td>b. process for documenting that the resuscitation equipment used by the maternity service is checked, stocked and thereby fit for use in all care settings</td>
</tr>
<tr>
<td></td>
<td>c. deliveries to be attended by a clinician (doctors, advanced neonatal nurse practitioner, midwives) with newborn life support skills</td>
</tr>
<tr>
<td></td>
<td>d. process for the availability of a clinician with newborn life support skills at a delivery if required</td>
</tr>
<tr>
<td></td>
<td>e. process for 24 hour availability in obstetric units (on site within 30 minutes), of a consultant paediatrician (or equivalent staff and associate specialist grade) trained and assessed as competent in newborn life support skills</td>
</tr>
<tr>
<td></td>
<td>f. maternity service’s expectations in relation to staff training, including newborn life support skills, as identified in the training needs analysis</td>
</tr>
<tr>
<td></td>
<td>g. process for monitoring compliance with all of the above requirements, review of results and subsequent monitoring of action plans.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 1:**
Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.5.2</td>
<td>The maternity service can demonstrate implementation of the approved documentation for newborn life support, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• process for documenting that the resuscitation equipment used by the maternity service is checked, stocked and thereby fit for use in all care settings</td>
</tr>
<tr>
<td></td>
<td>• maternity service’s expectations in relation to staff training, including newborn life support skills, as identified in the training needs analysis.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 2:**
Evidence provided by maternity service demonstrating implementation.

Additional evidence will be required to demonstrate implementation of training, with attendance levels at a minimum of 75%.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.5.2</td>
<td>The maternity service can demonstrate that it is monitoring compliance with the approved documentation for newborn life support, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• process for documenting that the resuscitation equipment used by the maternity service is checked, stocked and thereby fit for use in all care settings</td>
</tr>
</tbody>
</table>

© NHS Litigation Authority - 133 - Version 1 Publication Date March 2013
**Standard 5 - Criterion 2: Newborn Life Support**

- maternity service’s expectations in relation to staff training, including newborn life support skills, as identified in the training needs analysis.

Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

**Method of assessment at Level 3:**

Evidence provided by maternity service demonstrating monitoring compliance.

Additional evidence will be required to demonstrate monitoring compliance of training, with attendance levels at a minimum of 75%.

**Rationale:** It is expected that wherever the birth of a baby is anticipated there must be available equipment and trained personnel to initiate basic life support at birth and in the immediate postnatal period, should it be required.

**References:**


## Standard 5 - Criterion 3: Admission to Neonatal Unit

The maternity service has an approved system for managing the risks associated with the admission of a sick newborn to a local neonatal unit, neonatal intensive care unit or special care unit that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5.3</td>
<td>The maternity service has approved documentation which describes the admission of a sick newborn to a local neonatal unit (LNU), neonatal intensive care unit (NICU) or special care unit (SCU), which as a minimum must include:</td>
</tr>
<tr>
<td></td>
<td>a. responsibilities of all staff groups involved in the admission of a sick newborn to LNU/NICU/SCU</td>
</tr>
<tr>
<td></td>
<td>b. criteria for the admission of a sick newborn to LNU/NICU/SCU</td>
</tr>
<tr>
<td></td>
<td>c. transport arrangements for the movement of a sick newborn from the labour ward or postnatal ward to LNU/NICU/SCU</td>
</tr>
<tr>
<td></td>
<td>d. transport arrangements for the movement of a sick newborn into hospital from either a home birth or midwifery led unit when problems have been identified at birth</td>
</tr>
<tr>
<td></td>
<td>e. process by which the maternity unit and neonatal professionals share information about activity on a daily basis</td>
</tr>
<tr>
<td></td>
<td>f. process for reporting and learning the lessons from unanticipated admissions to LNU/NICU/SCU</td>
</tr>
<tr>
<td></td>
<td>g. process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans.</td>
</tr>
</tbody>
</table>

### Method of assessment at Level 1:
Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.5.3</td>
<td>The maternity service can demonstrate implementation of the approved documentation which describes the admission of a sick newborn to LNU, NICU or SCU, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• criteria for the admission of a sick newborn to LNU/NICU/SCU</td>
</tr>
<tr>
<td></td>
<td>• process for reporting and learning the lessons from unanticipated admissions to LNU/NICU/SCU.</td>
</tr>
</tbody>
</table>

### Method of assessment at Level 2:
8 sets of health records of newborns where admission to the neonatal unit has been required. Additional evidence provided by the maternity service demonstrating implementation of the second minimum requirement. Minimum implementation of 75% compliance required.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
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</thead>
<tbody>
<tr>
<td>3.5.3</td>
<td>The maternity service can demonstrate that it is monitoring compliance with the approved documentation which describes the admission of a sick newborn to LNU, NICU or SCU, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• criteria for the admission of a sick newborn to LNU/NICU/SCU</td>
</tr>
<tr>
<td></td>
<td>• process for reporting and learning the lessons from unanticipated admissions to LNU/NICU/SCU.</td>
</tr>
<tr>
<td></td>
<td>Where the monitoring has identified deficiencies, there must be evidence that</td>
</tr>
<tr>
<td>Standard 5 - Criterion 3: Admission to Neonatal Unit</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>recommendations and action plans have been developed and changes implemented.</td>
<td></td>
</tr>
</tbody>
</table>

**Method of assessment at Level 3:**

1% or 10 sets, whichever is the greater, of all health records of newborns where admission to the neonatal unit has been required.

Additional evidence provided by the maternity service demonstrating monitoring compliance of the second minimum requirement.

Minimum implementation of 75% compliance required.

**Rationale:** A certain proportion of newborns will need referral for specialist medical treatment and continuing specialist care. This cannot always be anticipated, but the risks can be reduced if robust evidence based arrangements are in place. This criterion relates to the transfer of the sick newborn into the local neonatal unit, neonatal intensive care unit or special care unit. It does not relate to the transfer of the sick newborn between neonatal units.

**References:**


## Standard 5 - Criterion 4: Immediate Care of the Newborn

The maternity service has an approved system for improving care and learning lessons relating to the care of newborns in the first 24 hours of life that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5.4</td>
<td>The maternity service has <strong>approved documentation</strong> for the care of the newborn in the first 24 hours of life, which as a minimum must include:</td>
</tr>
<tr>
<td></td>
<td>a. prevention, detection and management of hypoglycaemia in the newborn</td>
</tr>
<tr>
<td></td>
<td>b. prevention, detection and management of hypoglycaemia in the newborn of women with diabetes</td>
</tr>
<tr>
<td></td>
<td>c. prevention, detection and management of hypothermia in the newborn</td>
</tr>
<tr>
<td></td>
<td>d. management of a newborn with meconium-stained liquor present at delivery</td>
</tr>
<tr>
<td></td>
<td>e. management of a newborn where there is known group B haemolytic streptococcus present in either mother or newborn</td>
</tr>
<tr>
<td></td>
<td>f. management of the newborn of women known to have misused substances in pregnancy</td>
</tr>
<tr>
<td></td>
<td>g. <strong>documentation of all of the above</strong></td>
</tr>
<tr>
<td></td>
<td>h. process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans.</td>
</tr>
</tbody>
</table>

### Method of assessment at Level 1:
Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.5.4</td>
<td>The maternity service can demonstrate implementation of the approved documentation for the care of the newborn in the first 24 hours of life, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• documentation of the management of a newborn with meconium-stained liquor present at delivery</td>
</tr>
<tr>
<td></td>
<td>• documentation of the management of a newborn where there is known group B haemolytic streptococcus present in either mother or newborn.</td>
</tr>
</tbody>
</table>

### Method of assessment at Level 2:
8 sets of health records of newborns with meconium-stained liquor present at delivery.
8 sets of health records of newborns where there is known group B haemolytic streptococcus present in either mother or newborn.
Minimum implementation of 75% compliance with both of the above methods of assessment required.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.5.4</td>
<td>The maternity service can demonstrate that it is monitoring compliance with the approved documentation for the care of the newborn in the first 24 hours of life, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• documentation of the management of a newborn with meconium-stained liquor present at delivery</td>
</tr>
<tr>
<td></td>
<td>• documentation of the management of a newborn where there is known group B haemolytic streptococcus present in either mother or newborn.</td>
</tr>
</tbody>
</table>
### Standard 5 - Criterion 4: Immediate Care of the Newborn

Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

#### Method of assessment at Level 3:

1% or 10 sets, whichever is the greater, of all health records of newborns with meconium-stained liquor present at delivery.

1% or 10 sets, whichever is the greater, of all health records where there is known group B haemolytic streptococcus present in either mother or newborn.

Minimum implementation of 75% compliance with both of the above methods of assessment required.

#### Rationale:

This criterion has been included in the maternity standards as there have been a number of clinical negligence claims arising from inappropriate care during the immediate period post-delivery causing avoidable harm to the newborn.

#### References:


## Standard 5 - Criterion 5: Newborn Feeding

The maternity service has an approved system for improving care and learning lessons relating to ensuring that all mothers are supported in feeding their newborn, whatever their chosen method, in all care settings that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5.5</td>
<td>The maternity service has <strong>approved documentation</strong> which describes the process for ensuring that all mothers are supported in feeding their <strong>newborn</strong>, whatever their chosen method, in <strong>all care settings</strong>, which as a minimum must include:</td>
</tr>
<tr>
<td></td>
<td>a. process for supporting mothers who are breastfeeding</td>
</tr>
<tr>
<td></td>
<td>b. process for supporting mothers who are artificially feeding</td>
</tr>
<tr>
<td></td>
<td>c. process to be followed if a problem with feeding is identified</td>
</tr>
<tr>
<td></td>
<td>d. process for weighing <strong>newborns</strong>*</td>
</tr>
<tr>
<td></td>
<td>e. <strong>maternity service’s expectations in relation to staff training, as identified in the training needs analysis</strong>, regarding breast and artificial feeding methods</td>
</tr>
<tr>
<td></td>
<td>f. <strong>system for reporting newborns re-admitted to hospital with feeding problems during the first 28 days of life</strong></td>
</tr>
<tr>
<td></td>
<td>g. process for <strong>monitoring</strong> compliance with all of the above requirements, review of results and subsequent <strong>monitoring</strong> of action plans.</td>
</tr>
<tr>
<td></td>
<td>* As a minimum the maternity service is expected to follow NICE guidance for this minimum requirement.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 1:**
Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.5.5</td>
<td>The maternity service can demonstrate implementation of the <strong>approved documentation</strong> for ensuring that all mothers are supported in feeding their <strong>newborn</strong>, whatever their chosen method, in <strong>all care settings</strong>, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• maternity service’s expectations in relation to staff training, as identified in the <strong>training needs analysis</strong>, regarding breast and artificial feeding methods</td>
</tr>
<tr>
<td></td>
<td>• <strong>system for reporting newborns re-admitted to hospital with feeding problems during the first 28 days of life</strong></td>
</tr>
</tbody>
</table>

**Method of assessment at Level 2:**
Evidence provided by the maternity service demonstrating implementation of training, with attendance levels at a minimum of 75%.

Additional evidence provided by the maternity service demonstrating implementation of the second minimum requirement.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.5.5</td>
<td>The maternity service can demonstrate that it is <strong>monitoring</strong> compliance with the <strong>approved documentation</strong> for ensuring that all mothers are supported in feeding their <strong>newborn</strong>, whatever their chosen method, in <strong>all care settings</strong>, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• maternity service’s expectations in relation to staff training, as identified in the <strong>training needs analysis</strong>, regarding breast and artificial feeding methods</td>
</tr>
</tbody>
</table>
Standard 5 - Criterion 5: Newborn Feeding

- system for reporting newborns re-admitted to hospital with feeding problems during the first 28 days of life.
Where the monitoring has identified deficiencies there must be evidence that recommendations and action plans have been developed and changes implemented.

Method of assessment at Level 3:
Evidence provided by the maternity service demonstrating monitoring compliance with training, with attendance levels at a minimum of 75%.
Additional evidence provided by the maternity service demonstrating monitoring compliance of the second minimum requirement.

Rationale: There have been a number of clinical negligence claims arising relating to problems with newborn feeding. Feeding is a crucial part of the development of the newborn. If the mothers are adequately supported in their chosen method of feeding this will help to prevent future problems and re-admission to hospital.

Template document:
A template document has been created to assist maternity services in complying with the criterion, but its use is entirely optional. It is available for downloading from the NHSLA website at www.nhsla.com/publications, under Risk Management Publications followed by Document Templates.

References:
Standard 5 - Criterion 6: Examination of the Newborn

The maternity service has an approved system for improving care and learning lessons relating to the full physical examination of the newborn that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5.6</td>
<td>The maternity service has approved documentation for the full physical examination of the newborn, which as a minimum must include:</td>
</tr>
<tr>
<td></td>
<td>a. process for the first full physical examination, which as a minimum must include standards for the examination, the timeframe for the examination and a description of who can perform the examination*</td>
</tr>
<tr>
<td></td>
<td>b. process for referral for further medical investigation, treatment or care, if a deviation from the norm is identified*</td>
</tr>
<tr>
<td></td>
<td>c. process for communicating the outcome of the full physical examination with the parent(s)*</td>
</tr>
<tr>
<td></td>
<td>d. documentation of all of the above</td>
</tr>
<tr>
<td></td>
<td>e. maternity service’s expectations in relation to staff training, as identified in the training needs analysis, for all staff who perform examinations of newborns</td>
</tr>
<tr>
<td></td>
<td>f. process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans.</td>
</tr>
<tr>
<td></td>
<td>* As a minimum the maternity service is expected to follow UK National Screening Committee guidance for these minimum requirements.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 1:**

Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.5.6</td>
<td>The maternity service can demonstrate implementation of the approved documentation for the full physical examination of the newborn, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• documentation of the prompt referral for further medical investigation, treatment or care, if a deviation from the norm is identified.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 2:**

8 sets of health records of newborns for whom a referral has been made.

Minimum implementation of 75% compliance required.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.5.6</td>
<td>The maternity service can demonstrate that it is monitoring compliance with the approved documentation for the full physical examination of the newborn, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• documentation of the prompt referral for further medical investigation, treatment or care, if a deviation from the norm is identified.</td>
</tr>
<tr>
<td></td>
<td>Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.</td>
</tr>
</tbody>
</table>
### Standard 5 - Criterion 6: Examination of the Newborn

**Method of assessment at Level 3:**

1% or 10 sets, whichever is the greater, of all health records of newborns for whom a referral has been made. Minimum implementation of 75% compliance required.

**Rationale:** The NHS Litigation Authority claims data suggests that there are clinical negligence claims which occur as a result of failure to detect abnormalities in the newborn, both immediately following the birth and in the postnatal period. The NICE clinical guideline *Routine Postnatal Care of Women and Babies* (NICE 2006) and the UK National Screening Committee both advocate a complete physical examination of the newborn after birth.

**References:**

- UK National Screening Committee. (2010). *Change To Guidance On Ultrasound Examination Of The Hips In Screening For Developmental Dysplasia Of The Hips (DDH)*. Available at: [http://newbornphysical.screening.nhs.uk](http://newbornphysical.screening.nhs.uk)
## Standard 5 - Criterion 7: Bladder Care

The maternity service has approved documentation for the management of post-delivery bladder care that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5.7</td>
<td>The maternity service has approved documentation for the management of post-delivery bladder care, which as a minimum must include:</td>
</tr>
<tr>
<td></td>
<td>a. recording in the health records the time of the first void</td>
</tr>
<tr>
<td></td>
<td>b. recording in the health records the volume of the first void</td>
</tr>
<tr>
<td></td>
<td>c. when indwelling urinary catheters should be used</td>
</tr>
<tr>
<td></td>
<td>d. commencement of a fluid balance chart</td>
</tr>
<tr>
<td></td>
<td>e. when to refer to an appropriate clinician for evaluation</td>
</tr>
<tr>
<td></td>
<td>f. when to instigate a management plan</td>
</tr>
<tr>
<td></td>
<td>g. documentation of all of the above</td>
</tr>
<tr>
<td></td>
<td>h. process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 1:**
Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.5.7</td>
<td>The maternity service can demonstrate implementation of the approved documentation for the management of post-delivery bladder care, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• recording in the health records the time of the first void.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 2:**
0.5% of all health records of women who have delivered.
Minimum implementation of 75% compliance required.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.5.7</td>
<td>The maternity service can demonstrate that it is monitoring compliance with the approved documentation for the management of post-delivery bladder care, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• recording in the health records the time of the first void.</td>
</tr>
<tr>
<td></td>
<td>Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 3:**
1% or 10 sets, whichever is the greater, of all health records of women who have delivered.
Minimum implementation of 75% compliance required.

**Rationale:** The practice of intrapartum and postpartum bladder care appears variable and there does not appear to be a consensus of opinion about the diagnostic criteria for postpartum urinary retention. The management for voiding dysfunction remains controversial, in spite of the increasing awareness of the risk management issues involved.
## Standard 5 - Criterion 7: Bladder Care

Although further research is needed to develop evidence based guidelines, all maternity services should have approved documentation in place to help reduce the risk of urine retention going unrecognised and thus untreated.

### References:


## Standard 5 - Criterion 8: Support for Parent(s)

The maternity service has an approved process for ensuring that parent(s) have postnatal support in cases of actual and suspected poor outcome for the newborn at term that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5.8</td>
<td><strong>The maternity service has approved documentation for ensuring that parent(s) have postnatal support in cases of actual and suspected poor outcome for the newborn, which as a minimum must include:</strong></td>
</tr>
<tr>
<td></td>
<td>a. <em>process for providing postnatal support for parent(s) in cases of actual poor outcome for the term newborn</em></td>
</tr>
<tr>
<td></td>
<td>b. <em>process for providing postnatal support for parent(s) in cases of suspected poor outcome for the term newborn</em></td>
</tr>
<tr>
<td></td>
<td>c. process for providing support to parent(s) who have communication or language support needs</td>
</tr>
<tr>
<td></td>
<td>d. <em>requirement to document all discussions with parent(s)</em></td>
</tr>
<tr>
<td></td>
<td>e. process for ensuring parent(s) have information about the relevant support groups</td>
</tr>
<tr>
<td></td>
<td>f. process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 1:**
Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.5.8</td>
<td><strong>The maternity service can demonstrate implementation of the approved documentation for ensuring that parent(s) have postnatal support in cases of actual and suspected poor outcome for the newborn, as described at Level 1, in relation to the:</strong></td>
</tr>
<tr>
<td></td>
<td>• documentation of all support, information and discussions with parent(s).</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 2:**
8 sets of health records where support for parents has been required for term newborns.
Minimum implementation of 75% compliance required.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.5.8</td>
<td><strong>The maternity service can demonstrate that it is monitoring compliance with the approved documentation for ensuring that parent(s) have postnatal support in cases of actual and suspected poor outcome for the newborn, as described at Level 1, in relation to the:</strong></td>
</tr>
<tr>
<td></td>
<td>• documentation of all support and discussions with parent(s).</td>
</tr>
<tr>
<td></td>
<td>Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 3:**
1% or 10 sets, whichever is the greater, of all health records where support for parents for term newborns.
Minimum implementation of 75% compliance required.
<table>
<thead>
<tr>
<th>Standard 5 - Criterion 8: Support for Parent(s)</th>
</tr>
</thead>
</table>

**Rationale:** When there is either a poor or uncertain outcome of the pregnancy, or a concern that the newborn may suffer from developmental delay, the whole family may be distressed and therefore maintaining a positive and supportive relationship with parent(s) is important. There are a number of support groups who can help at this difficult time and it is important that the maternity service informs the parent(s) of help and support that may be available to them.

**References:**


## Standard 5 - Criterion 9: Postnatal Care

The maternity service has an approved system for ensuring that there is a documented, individualised postnatal care plan, with access for parents to information about signs of illness in the newborn that is implemented and monitored.

### Level 1 Minimum Requirements

1.5.9 The maternity service has approved documentation for ensuring that there is a documented, individualised postnatal care plan, with access for parent(s) to information about signs of illness in their newborn, which as a minimum must include:
   
   a. process for developing an individualised postnatal care plan
   
   b. **process for giving information to enable parent(s) to assess their newborn’s general condition and identify any signs and symptoms of common health problems to enable parent(s) to respond to problems**
   
   c. **process for ensuring that parent(s) have contact details for the relevant healthcare professionals regardless of the place of birth**
   
   d. **process for ensuring that there is a coordinating healthcare professional for women with multiagency or multidisciplinary needs**
   
   e. system for postnatal visiting once the woman has been discharged from the hospital/midwifery led unit
   
   f. **documentation in the health records of all of the above**
   
   g. process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans.

### Method of assessment at Level 1:

Approved documentation.

### Level 2 Minimum Requirements

2.5.9 The maternity service can demonstrate implementation of the approved documentation, for ensuring that there is a documented, individualised postnatal care plan, with access for parent(s) to information about signs of illness in their newborn, as described at Level 1, in relation to the:

- documentation of information given to enable parent(s) to assess their newborn’s general condition and identify any signs and symptoms of common health problems to enable parent(s) to respond to problems
- documentation that parent(s) have been given contact details for the relevant healthcare professionals regardless of the place of birth
- documentation of the coordinating healthcare professional for women with multiagency or multidisciplinary needs.

### Method of assessment at Level 2:

0.5% of all health records of women who have delivered.

Minimum implementation of 75% compliance required.

### Level 3 Minimum Requirements

3.5.9 The maternity service can demonstrate that it is monitoring compliance with the approved documentation for ensuring that there is a documented, individualised postnatal care plan, with access for parent(s) to information about signs of illness in their newborn, as described at Level 1, in relation to the:
### Standard 5 - Criterion 9: Postnatal Care

- documentation of information given to enable parent(s) to assess their newborn’s general condition and identify any signs and symptoms of common health problems to enable parent(s) to respond to problems
- documentation that parent(s) have been given contact details for the relevant healthcare professionals regardless of the place of birth
- documentation of the coordinating healthcare professional for women with multiagency or multidisciplinary needs.

Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

### Method of assessment at Level 3:

1% or 10 sets, whichever is the greater, of all health records of women who have delivered.
Minimum implementation of 75% compliance required.

### Rationale:

Postnatal care should be planned through a process of education, discussion and assessment of clinical need. Postnatal care should be structured to meet the requirements of each individual mother and baby in order to promote long term physical and emotional wellbeing for both. In addition, as communication is considered to be a cornerstone of good clinical practice, it is expected that there are effective systems of communication between all team members and all disciplines, as well as with parent(s) and their families.

### References:


NHS Screening Programmes. ‘Newborn Bloodspot Screening’. *Website Resources*. Available at: [http://newbornbloodspot.screening.nhs.uk](http://newbornbloodspot.screening.nhs.uk)


UK National Screening Committee. ‘Newborn Hearing Screening’. *UK Screening Portal*. Available at: [http://www.screening.nhs.uk](http://www.screening.nhs.uk)
The maternity service has an approved system for improving care and learning lessons relating to the care of all women who have received a general or regional anaesthetic in theatre for an operative intervention that is implemented and monitored.

### Level 1 - Minimum Requirements

1.5.10 The maternity service has approved documentation which describes the care of women following general or regional anaesthetic for an operative intervention, which as a minimum must include:
   a. equipment that should be available, as defined in the AAGBI guidelines
   b. criteria for transfer to the recovery area
   c. minimum requirements for observations whilst in recovery
   d. agreed discharge and transfer criteria from recovery
   e. documentation of observations whilst in recovery and agreed discharge and transfer criteria
   f. guidelines for care for the following 24 hours, including frequency of the observations
   g. maternity service’s expectations in relation to staff training*, as identified in the training needs analysis
   h. process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans.

* It is not expected that this training includes staff who are employed in a recovery role.

**Method of assessment at Level 1:**
Approved documentation.

### Level 2 - Minimum Requirements

2.5.10 The maternity service can demonstrate implementation of the approved documentation which describes the care of women following general or regional anaesthetic for an operative intervention, as described at Level 1, in relation to the:
   - documentation of the minimum requirements for observations whilst in recovery
   - documentation of agreed discharge and transfer criteria from recovery.

**Method of assessment at Level 2:**
8 sets of health records of women who have delivered and who required recovery care.
Minimum implementation of 75% compliance required.
## Standard 5 - Criterion 10: Recovery

### Level 3 Minimum Requirements

3.5.10 The maternity service can demonstrate that it is monitoring compliance with the approved documentation which describes the care of women following general or regional anaesthetic for an operative intervention, as described at Level 1, in relation to the:

- documentation of the minimum requirements for observations whilst in recovery
- documentation of agreed discharge and transfer criteria from recovery.

Where monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

### Method of assessment at Level 3:

1% or 10 sets, whichever is the greater, of all health records of women who have delivered and who required recovery care.

Minimum implementation of 75% compliance required.

### Rationale:

All pregnant women and women who have recently delivered require the same high standard of anaesthetic care. Staff providing care to women recovering from an anaesthetic should be appropriately trained and able to receive immediate effective assistance from the anaesthetist if required.

### References:


Appendix A: Standard 1 - Staffing Levels

Flow chart of requirements - Criteria 1.3, 1.4, 1.5

The maternity service has approved safe staffing levels for all midwifery, nursing and support staff, consultant obstetrician presence on the labour ward, obstetric anaesthetists and their assistants, which are in line with *Safer Childbirth* (RCOG 2007) recommendations and are implemented and monitored.

Yes

All staffing levels are in line with the recommendations in *Safer Childbirth* (RCOG 2007)

No

All staffing levels are not in line with the recommendations in *Safer Childbirth* (RCOG 2007)

- Develop a business plan(s) which reflects the result of the annual review to address staffing shortfalls

- Develop a contingency plan(s) to address ongoing staffing shortfalls

- Those maternity services with staffing levels in line with the recommendations from the annual review will not be required to produce a business plan or contingency plan to address ongoing staffing shortfalls

- All maternity services will need to provide contingency plans to address short term staffing shortfalls, e.g. due to increased workload or sickness
Appendix B: Training Needs Analysis - Minimum Data Set

Within the CNST Maternity Clinical Risk Management Standards there are key subject areas in relation to risk which incorporate aspects of training. The maternity service must therefore ensure that the following areas of risk management training are included within the training needs analysis at 1.1.9.

As a minimum the following must be included:

**Standard 1**

1.10 Skills & Drills Training:
- Cord Prolapse
- Shoulder Dystocia
- Vaginal Breech
- Antepartum & Postpartum Haemorrhage
- Eclampsia

**Standard 2**

2.3 Continuous Electronic Fetal Monitoring
2.8 Early Recognition of Severely Ill Pregnant Women
2.8 Maternal Resuscitation

**Standard 3**

3.5 Assessment & Management of all Types of Perineal Trauma
3.6 Shoulder Dystocia
3.7 Postpartum Haemorrhage

**Standard 4**

4.5 Maternal Antenatal Screening Tests
4.6 Mental Health Training - to include as a minimum: maternal mental health disorders, risk assessment methods and referral routes

**Standard 5**

5.2 Newborn Life Support
5.5 Newborn Feeding
5.6 Full Physical Examination of the Newborn
5.10 Care of Women Following Operative Interventions*

* It is not expected that this training includes staff who are employed in a recovery role
Appendix C: Maternal Antenatal Screening Tests - Minimum Data Set

The CNST Maternity Clinical Risk Management Standards focus on the maternal antenatal screening tests which follow the UK National Screening Committee guidance. The maternity service must therefore ensure that it includes the following tests as a minimum, within approved documentation at 1.4.5.

As a minimum the following tests must be included:

Fetal Anomaly Screening
- Fetal anomalies
- Down’s syndrome

Infectious Diseases in Pregnancy Screening
- Hepatitis B
- Human immunodeficiency virus
- Rubella susceptibility
- Syphilis

Sickle Cell & Thalassaemia Screening
- Sickle Cell & Thalassaemia
### Appendix D: Method of Assessment - Summary

#### Maternity Level 2 – Summary of methods of assessment

<table>
<thead>
<tr>
<th>Service evidence</th>
<th>1.1</th>
<th>1.2</th>
<th>1.3</th>
<th>1.4</th>
<th>1.5</th>
<th>1.6</th>
<th>1.8</th>
<th>1.9 *</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5.2 *</td>
<td>5.3 *</td>
<td>5.5 *</td>
<td></td>
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</table>

<table>
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<th>Training</th>
<th>1.9 *</th>
<th>1.10</th>
<th>2.3 **</th>
<th>2.8 *</th>
<th>3.5 **</th>
<th>5.2 *</th>
<th>5.5 *</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Health record sets (2, 4 or 8)</th>
<th>2.2</th>
<th>2.3 **</th>
<th>2.4 (2)</th>
<th>2.5 (2)</th>
<th>2.6</th>
<th>2.7</th>
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<th>2.9</th>
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<td>3.1</td>
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<td>3.3 (3)</td>
<td>3.4</td>
<td>3.5 **</td>
<td>3.6 (2)</td>
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<td>3.10 (3) *</td>
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<thead>
<tr>
<th>0.5% of health records</th>
<th>1.7</th>
<th>2.1</th>
<th>2.3 **</th>
<th>3.5 **</th>
<th>3.10 *</th>
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<td>4.6 *</td>
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</table>

**KEY:** ( ) the number of multiple sets required  
* another requirement elsewhere in grid  
** another two requirements in grid
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<tr>
<th>Service evidence</th>
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<th>1.3</th>
<th>1.4</th>
<th>1.5</th>
<th>1.6</th>
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<th>1.9 *</th>
<th>5.2 *</th>
<th>5.3 *</th>
<th>5.5 *</th>
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<tbody>
<tr>
<td>Training</td>
<td>1.9 *</td>
<td>1.10</td>
<td>2.3 **</td>
<td>2.8 *</td>
<td>3.5 **</td>
<td>5.2 *</td>
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<tr>
<td>All health records with specific risk</td>
<td>2.6</td>
<td>3.2</td>
<td>3.5 **</td>
<td>3.6 (2)</td>
<td>3.7 (2)</td>
<td>4.9 *</td>
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</tr>
<tr>
<td>1% or 10 sets of all health records of women who have delivered</td>
<td>1.7</td>
<td>2.1</td>
<td>2.3 **</td>
<td>3.5 **</td>
<td>3.10 *</td>
<td>4.1 *</td>
<td>4.3 *</td>
<td>4.4</td>
<td>4.5 *</td>
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<td>4.7 *</td>
<td>4.8</td>
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<tr>
<td>1% or 10 sets of all health records with a specific risk</td>
<td>2.2</td>
<td>2.3 **</td>
<td>2.4 (2)</td>
<td>2.5 (2)</td>
<td>2.7</td>
<td>2.8 *</td>
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<td>3.3 (3)</td>
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<td></td>
<td>3.4</td>
<td>3.8 (2)</td>
<td>3.9</td>
<td>3.10 (3) *</td>
<td>4.1 *</td>
<td>4.2</td>
<td>4.3 *</td>
<td>4.5 *</td>
<td>4.6 *</td>
<td>4.7 *</td>
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<td>4.9 *</td>
<td>4.10 (2)</td>
<td>5.1</td>
<td>5.3 *</td>
<td>5.4 (2)</td>
<td>5.6</td>
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</tbody>
</table>

KEY: ( ) the number of multiple sets required  * another requirement elsewhere in grid  ** another two requirements in grid
Appendix E: Maternity Stakeholders

Below is listed all the organisations who have been stakeholders in the development and review of the CNST Maternity Standards.

- Baby Friendly Initiative
- Baby Lifeline
- Birth Trauma Association
- BLISS
- British Association of Perinatal Medicine
- Care Quality Commission
- Centre for Maternal and Child Enquiries
- Department of Health
- Independent Midwives
- Kings Fund
- Local Supervising Authority Officers
- Monitor
- National Audit Office
- National Childbirth Trust
- National Commissioning Board, Patient Safety Sub-committee
- National Institute for Health and Clinical Excellence
- National Institute of Innovation
- National Patient Safety Agency
- NHS Blood and Transplant Authority
- NHSLA Panel Solicitors
- Obstetric Anaesthetists Association
- Resuscitation Council (UK)
- Royal College of Anaesthetists
- Royal College of Midwives
- Royal College of Nursing
- Royal College of Obstetricians and Gynaecologists
- Royal College of Paediatrics and Child Health
CNST MATERNITY CLINICAL RISK MANAGEMENT STANDARDS

- Royal College of Psychiatrists
- Stillbirth & Neonatal Death Charity
- UK National Screening Committee
- UK Obstetric Surveillance System
### Appendix F: Criteria Removed from the Standards

#### Standard 1 – Criterion 6: Guideline Development

The maternity service has approved documentation which describes the process for developing and reviewing clinical guidelines and is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 1.1.6   | The maternity service has approved documentation for developing and reviewing clinical guidelines, which as a minimum must include:  
|         | a. style and format to be adopted  
|         | b. consultation process  
|         | c. ratification process  
|         | d. review arrangements (which must be at least every three years) to include reference to the process of changing guidelines as a result of learning from experience  
|         | e. associated documentation and references (which must make reference to NICE guidance where applicable)  
|         | f. control of clinical guidelines, including dating and archiving arrangements  
|         | g. process for monitoring compliance with all of the above requirements, review of results and subsequent monitoring of action plans.  

**Method of assessment at Level 1:**

Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 2.1.6   | The maternity service can demonstrate implementation of the approved documentation for developing and reviewing clinical guidelines, as described at Level 1, in relation to the:  
|         | • ratification process  
|         | • control of clinical guidelines, including dating and archiving arrangements.  

**Method of assessment at Level 2:**

Evidence provided by maternity service demonstrating implementation.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| 3.1.6   | The maternity service can demonstrate that it is monitoring compliance with the approved documentation for developing and reviewing clinical guidelines, as described at Level 1, in relation to the:  
|         | • ratification process  
|         | • control of clinical guidelines, including dating and archiving arrangements.  
|         | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.  

**Method of assessment at Level 3:**

Evidence provided by maternity service demonstrating monitoring compliance.
**Standard 1 – Criterion 6: Guideline Development**

**Rationale:** There should be guidance on producing referenced evidence based multidisciplinary guidelines/pathways of care, for the management of all key conditions or situations in the antenatal, intrapartum and postnatal periods. The documentation which describes the process for developing organisation-wide procedural documents will influence and complement the maternity service’s guidance.

**Date of removal:** January 2012 (CNST Standards 2012/13)

**Reason for removal:** It was necessary to remove a criterion from Standard 1 to allow Labour Ward Staffing to be moved from being a pilot criterion to a fully assessed criterion. Analysis of assessment data from 2010/11 shows a high compliance rate with Guideline Development so this was selected for removal.
**Standard 3 – Criterion 7: Postpartum Haemorrhage (Midwifery Led Units)**

The midwifery led unit has approved documentation for the management of postpartum haemorrhage that is implemented and monitored.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3.7</td>
<td>The midwifery led unit has approved documentation for the management of <strong>postpartum haemorrhage</strong>, which as a minimum must include:</td>
</tr>
<tr>
<td></td>
<td>a. agreed local definition of <strong>postpartum haemorrhage</strong></td>
</tr>
<tr>
<td></td>
<td>b. <strong>description of observations to be carried out</strong></td>
</tr>
<tr>
<td></td>
<td>c. <strong>clear and well understood trigger phrase to activate the massive haemorrhage protocol</strong></td>
</tr>
<tr>
<td></td>
<td>d. <strong>documented clear lines of communication with the receiving hospital or labour ward</strong></td>
</tr>
<tr>
<td></td>
<td>e. description of the management of women with a <strong>postpartum haemorrhage</strong></td>
</tr>
<tr>
<td></td>
<td>f. requirement to document fluid balance</td>
</tr>
<tr>
<td></td>
<td>g. <strong>description of access to transport arrangements</strong></td>
</tr>
<tr>
<td></td>
<td>h. <strong>standards for record-keeping in relation to observations performed and transfer arrangements</strong></td>
</tr>
<tr>
<td></td>
<td>i. maternity service’s expectations for staff training, as identified in the <strong>training needs analysis</strong></td>
</tr>
<tr>
<td></td>
<td>j. process for <strong>continuous audit</strong>, multidisciplinary review of <strong>audit</strong> results and subsequent <strong>monitoring</strong> of action plans.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 1:**
Approved documentation.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.3.7</td>
<td>The midwifery led unit can demonstrate implementation of the approved documentation for the management of <strong>postpartum haemorrhage</strong>, as described at Level 1, in relation to the:</td>
</tr>
<tr>
<td></td>
<td>• description of observations to be carried out</td>
</tr>
<tr>
<td></td>
<td>• clear and well understood trigger phrase to activate the <strong>massive haemorrhage protocol</strong></td>
</tr>
<tr>
<td></td>
<td>• documented clear lines of communication with the receiving hospital or labour ward</td>
</tr>
<tr>
<td></td>
<td>• description of access to transport arrangements</td>
</tr>
<tr>
<td></td>
<td>• standards for record-keeping in relation to observations performed and transfer arrangements.</td>
</tr>
</tbody>
</table>

**Method of assessment at Level 2:**
8 sets of health records of women who have had a postpartum haemorrhage in midwifery led unit. 3 sets of health records of women who have triggered the massive haemorrhage protocol. Minimum implementation of 75% compliance required.

| Level 3 | Minimum Requirements |
### Standard 3 – Criterion 7: Postpartum Haemorrhage (Midwifery Led Units)

**3.3.7** The **midwifery led unit** can demonstrate that it is **monitoring** compliance with the **approved documentation** for the management of **postpartum haemorrhage**, as described at Level 1, in relation to the:

- description of observations to be carried out
- clear and well understood trigger phrase to active the **massive haemorrhage protocol**
- documented clear lines of communication with the receiving hospital or labour ward
- description of access to transport arrangements
- standards for record-keeping in relation to observations performed and transfer arrangements.

Where the **monitoring** has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

#### Method of assessment at Level 3:

All health records of women who have had a postpartum haemorrhage in a midwifery led unit.  
All health records of women who have triggered the massive haemorrhage protocol.

Minimum implementation of 75% compliance required.

**Rationale:** There has been a decline in deaths from postpartum haemorrhage in the United Kingdom over the last 50 years. Midwifery led units must ensure they have robust processes to manage the risks associated with postpartum haemorrhage, and when appropriate safely transfer women to a receiving hospital or labour ward for multidisciplinary care. Midwifery led units should learn from and improve the management of postpartum haemorrhage when it does occur.

**Date of removal:** January 2012 (CNST Standards 2012/13)  
**Reason for removal:** Due to reduced numbers of maternity services which solely provide midwifery led care it was decided not to include specific criteria or requirements for this type of organisation. Where a midwifery led unit is assessed, the criteria that are relevant will be agreed between the assessor and the maternity service in advance of the assessment and prior to an assessment date being booked.
Appendix G: Clarification of Terms Used in the Standards

- **Actual poor outcome**

  Actual poor outcome for the newborn is when there is a case of a neonatal death, stillbirth or a confirmed postnatal diagnosis which may have a severe detrimental effect on the newborn’s wellbeing. This may due to a number of conditions but could include congenital abnormality or neonatal encephalopathy.

- **All care settings**

  Any setting in which the maternity service provides care to women and the newborn, including home births.

- **Approved guideline/documentation**

  A clinical guideline or other documentation such as care pathway, standard operating procedure or protocol that has been approved by the agreed method as per the organisation-wide and/or maternity service procedure that covers the relevant clinical area(s).

- **Audit**

  Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team or service level and further monitoring is used to confirm improvement in healthcare delivery.

- **Basic clinical note keeping standards audit**

  As a minimum the audit must include: antenatal assessment; labour ward management plan; cardiotocograph recording; operation details; anaesthetic details; discharge arrangements.

- **Basic record-keeping standards audit**

  As a minimum the audit must include: date and time; printed name and signature; legibility; use of abbreviations prescription sheets.

- **Continuous audit**

  At Level 3 maternity services will be expected to demonstrate through monitoring that the processes to manage risk have been implemented. Three of the criteria at Level 3 require the service to demonstrate that they have a process in place that enables ongoing timely review and action:

  - 3.2.6: Caesarean Section
  - 3.3.6: Shoulder Dystocia
  - 3.3.7: Postpartum Haemorrhage

  The service must document the process for continuous/ongoing review of events in a timely manner to make certain that each event is discussed and considered to ensure that any omissions or deviations to documented clinical processes are identified, controlled and that learning is implemented within the service where required.
The service will collate the findings from these ongoing reviews to produce an audit report to a timeframe specified by the service – this can be weekly, monthly or quarterly, **but not annually.** Over a 12 month period **each individual audit** must meet the required 75% compliance rate. Please note that an audit which has been completed annually will not be acceptable on its own since the aim of continuous audit is to demonstrate an ongoing process.

- **Electronic patient information system**

If a maternity service uses an electronic patient information system that has an appropriate field for recording the BMI, then it is expected that it is completed. If however a maternity service does not use an electronic patient information system then they will be assessed against the minimum requirement for the documentation of the BMI in the health records and will not be penalised for not having an electronic patient information system. If a maternity service uses both methods, meaning that the service records the BMI in the health record and on the electronic patient information system, they will be assessed against both minimum requirements.

- **Emergency drills**

An exercise intended to train the multidisciplinary team in duties and procedures to be followed in cases of Cord Prolapse, Shoulder Dystocia, Vaginal Breech, Antepartum & Postpartum Haemorrhage and Eclampsia.

- **Fresh eyes**

A study in 2006 noted that what often prevents an adverse outcome in maternity practice is the incidental intervention by another practitioner. The implementation of a ‘fresh eyes’ approach involves the interpretation or review of the CTG trace by more than one person (i.e. someone other than the midwife giving ongoing care to the woman and undertaking an hourly assessment of the CTG). This will make the interpretation of CTG traces more robust, and offer both a second opinion and a learning opportunity.

- **Full physical examination**

A complete examination of the newborn that takes place within 72 hours of birth.

- **Individualised postnatal care plan**

This plan should be developed with the woman ideally in the antenatal period or as soon as possible after birth and documented in the health records. It should include 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 and plans for the postnatal period.

- **Massive haemorrhage protocol**

The maternity service should agree a definition of when the massive haemorrhage protocol should be activated.

- **Maternity team based care**

Every woman has care provided by a midwife. For women with complex pregnancies, care is provided by a maternity team comprising midwives, obstetricians, anaesthetists, neonatologists and other specialists working in partnership.
• **Measurable objectives**

The maternity service should have in place, measurable objectives which are:

• Specific - the objective (aim) should state exactly what is to be achieved

• Measurable - an objective should be capable of measurement, so that it is possible to determine whether (or how far) it has been achieved

• Achievable - the objective should be realistic given the circumstances in which it is set and the resources available to the business

• Relevant - objectives should be relevant to the people responsible for achieving them

• Timely - objectives should have achievable and realistic timescales set

• **Midwifery Led Units (MLU)**

This is part of a maternity service where care is normally provided exclusively by midwives to women with low risk pregnancies and labours. The MLU may be attached to or integrated within the obstetric unit or it may be a stand alone unit in a separate building or site from the obstetric unit.

• **Migrant women**

All pregnant mothers from countries where women may experience poorer overall general health.

• **Monitor/monitoring**

Maternity services should measure, monitor and evaluate compliance with the minimum requirements within the CNST Maternity Clinical Risk Management Standards. This should include the use of audits (or continuous audit where specified) and data relating to the minimum requirements. The maternity service should define the frequency and detail of the measurement, monitoring and evaluation process.

Monitoring demonstrates whether or not the process for managing risk, as described in the approved documentation, is working across the entire service. Where deficiencies have been identified actions plans must have been drawn up and changes made to reduce the risks. Monitoring is normally proactive - designed to highlight issues before an incident occurs - and should consider both positive and negative aspects of a process.

• **Newborn**

The newborn in this context is the sick or well baby from birth until 28 days of life.

• **Newborn life support skills**

The Newborn Life Support (NLS) guidelines are specifically intended for resuscitation at birth. They deal with warming and drying and assessment of the newborn followed, if necessary, by resuscitation, which is mainly concerned with the initial inflation of the lungs and establishing stable respiration. This is different to resuscitation at any other time of life. In addition, the questions of oxygen administration, airway blockage, meconium aspiration and umbilical venous catheterisation are considered which are also usually only applicable to babies in the first hours of life. *UK Resuscitation Council. (2010). Clarifications on Newborn Life Support Guidelines.*
• **Ongoing review**

The review is performed on an ongoing basis whereby cases are not left for a number of weeks before being reviewed. Review should be prompt.

• **Postpartum haemorrhage**

The maternity service should agree their local definition for obstetric haemorrhage. An example may be “blood loss from uterus or genital tract >1500ml, a decrease in haemoglobin of >4 g/dl or acute transfusion of >4 units blood”.

• **Professional leads**

The maternity service should identify the professional lead(s) with managerial accountability for clinical risk management throughout the maternity service. Depending on the organisational structure this may be a midwife for example the Head of Midwifery or an obstetrician for example the Clinical Director or both.

• **Presence**

The consultant obstetrician is physically present on the labour ward as described in *Safer Childbirth* (RCOG 2007).

• **Postnatal Support**

Postnatal support for parents should as a minimum consist of emotional support and information giving. The maternity service should describe how and when this support will take place and which healthcare professionals will be involved. This support may be offered by the maternity service, the neonatal service or both.

• **Prospective**

Prospective consultant obstetrician presence on each labour ward is the requirement to provide cover for leave, i.e. sick leave, study leave and annual leave.

• **RSVP**

RSVP stands for Reason, Story, Vital Signs, Plan. RSVP: a system for communication of deterioration in hospital patients.

• **Specialist training**

In relation to the CNST Clinical Maternity Risk Management Standards, this covers all areas where staff training is specified within the criteria at 1.9 or in the TNA Minimum Data Set. Please note that these specialist training requirements currently only apply to permanent staff. However, it would be good practice for the maternity service to ensure that temporary staff are trained to a similar standard. Permanent staff are all staff directly employed under a contract of employment with the maternity service and medical staff in training.

• **Suspected poor outcome**

Suspected poor outcome for the newborn is when a problem has been identified, either antenatally or postnatally, which could have a severe detrimental effect on the newborn’s wellbeing but at present there is not a long term prognosis.
• **SBAR/ACCEPT**

SBAR stands for Situation Background Assessment and Recommendation. Available at: [www.nodelaysachiever.nhs.uk](http://www.nodelaysachiever.nhs.uk)

ACCEPT stands for Assessment, Control, Communication, Evaluation, Preparation & Packaging and Transportation.

• **Systematic assessment**

The regular review (i.e. hourly) of the electronic fetal monitoring trace using a step by step procedure to review, interpret and document the features of the fetal heart rate which must include an assessment of:

- The baseline rate
- The baseline rate variability
- Accelerations
- Decelerations

• **Term newborn**

The word term means 37 to 42 weeks of pregnancy, meaning from 37 completed weeks of pregnancy exactly (36 weeks + 6 days) onwards to 42 weeks gestation.

• **Training needs analysis (TNA)**

A breakdown, usually presented in the form of a spreadsheet or table, which contains as a minimum: all staff groups; all training required by each group; and the frequency of the training required by each group. The TNA may also include further details such as who will provide the training, specific training packages to be used, etc.

• **Unbiased external input**

An impartial, without prejudice contribution from outside of the maternity service. This could include but not exclusively: a contribution from another service within the organisation or external organisations, for example the National Patient Safety Agency (NPSA), the Strategic Health Authority and/or another maternity service/organisation.

• **Women in labour**

NICE guidance defines established labour as women who are giving birth at 37-42 weeks (known as 'term'). This applies to all care settings.