

NHS Lanarkshire

Local Report ~ *January 2007*

Maternity Services

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The maternity services standards apply to specific areas of the service. The clinical standards cover the period of time between confirmation of pregnancy, through until the baby is 6–8 weeks old. The project group developed five standards, covering: core principles; pre-conception and very early pregnancy; pregnancy; childbirth; and postnatal and parenthood. This report presents the findings from the peer review of performance against the standards.

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1 Setting the scene

NHS Quality Improvement Scotland (NHS QIS) was set up by the Scottish Parliament in 2003 to take the lead in improving the quality of care and treatment delivered by NHSScotland. We do this by setting standards and monitoring performance, and by providing NHSScotland with advice, guidance and support on effective clinical practice and service improvements.

About this report

The ‘Clinical standards for maternity services’ were published in March 2005. These standards are being used to assess the quality of services provided by NHSScotland nationwide.

This report presents the findings from the peer review of **NHS Lanarkshire**. This review visit took place on **2 February 2006**, and details of the visit, including membership of the review team, can be found in Appendix 2.

1.1 How the standards were developed

In June 2002, a maternity services project group was established and chaired by Dr Jane Magill, Director, Robert Clark Centre for Technological Education, University of Glasgow. Membership of the maternity services project group includes both healthcare professionals and members of the public (see Appendix 3).

Members of the maternity services project group are involved in the quality assurance process of:

- developing standards
- reviewing performance against the standards throughout Scotland, using self-assessment and external peer review, and
- reporting the findings from the review.

When developing the maternity services standards, a Scotland-wide consultation process was undertaken. The views of health service staff, women (pre and postnatally), and the public were sought, and all the relevant evidence available at the time was taken into account. Draft standards were also piloted in NHS Highland, NHS Lanarkshire and NHS Lothian in June 2004.

1.2 How the review process works

The review process has two key parts: local self-assessment followed by external peer review. First, each NHS board assesses its own performance against the standards. An external peer review team then further assesses performance, both by considering the self-assessment data and visiting the NHS board to validate this information and discuss related issues. The review process is described in more detail below (see also the flow chart on page 9).

Self-assessment by NHS boards

On receiving the standards, each NHS board assesses its own performance using a framework produced by NHS QIS. This framework includes guidance about the type of evidence (eg guidelines and audit reports) required to allow a proper assessment of performance against the standards to be made.

The NHS board submits the data it has collected for this self-assessment exercise to NHS QIS before the on-site visit, and it is this information that constitutes the main source of written evidence considered by the external peer review team.

External peer review

An external peer review team then visits and speaks with local stakeholders (eg staff, patients and carers) about the services provided. Review teams are multidisciplinary, and include both healthcare professionals and members of the public. All reviewers are trained. Each review team is led by an experienced reviewer, who is responsible for guiding the team in its work and ensuring that team members are in agreement about the assessment reached.

The composition of each team varies, and members have no connection with the NHS board they are reviewing. Both of these factors facilitate the sharing of good practice across NHSScotland, and ensure that each review team assesses performance against the standards rather than make comparisons between one NHS board and another.

At the start of the on-site visit, the review team meets key personnel responsible for the service under review. Reviewers then speak with local stakeholders about the services provided. After these meetings, the team assesses performance against the standards, based on the information gathered during both the self-assessment exercise and the on-site visit. The visit concludes with the team providing feedback on its findings to the NHS board. This includes specific examples of local initiatives drawn to the attention of the review team (recognising that other such examples may exist), together with an indication of any particular challenges.

Assessment categories

Each review team assesses performance using the categories ‘met’, ‘not met’ and ‘not met (insufficient evidence)’, as detailed below.

- **‘Met’** applies where the evidence demonstrates the standard and/or criterion is being attained.
- **‘Not met’** applies where the evidence demonstrates the standard and/or criterion is not being attained.
- **‘Not met (insufficient evidence)’** applies where no evidence is available for the review team, or where the evidence available is insufficient to allow an assessment to be made.

A final category **‘not applicable’** is used where a standard and/or criterion does not apply to the NHS board under review.

1.3 Reports

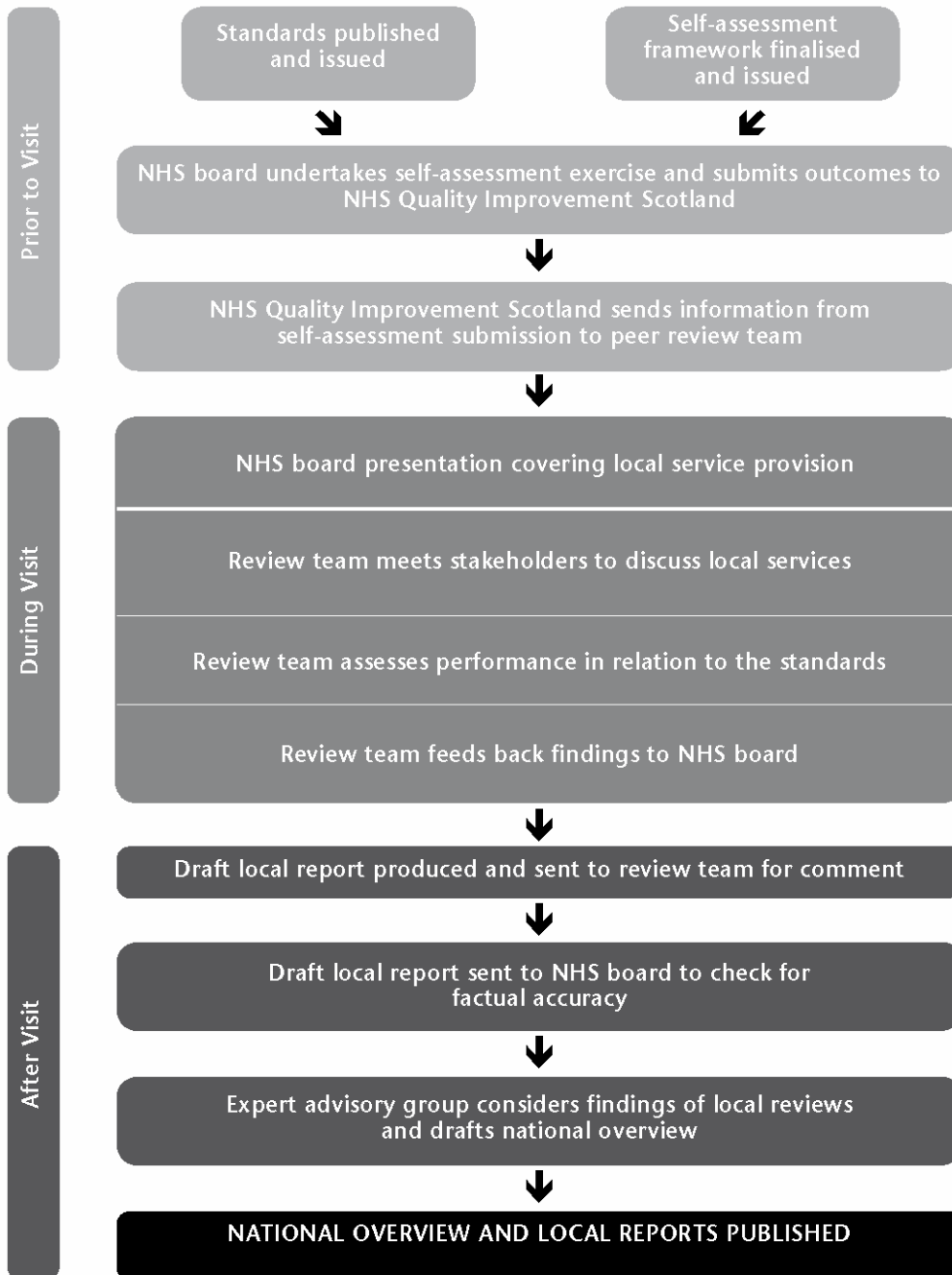
After each review visit, NHS QIS staff, with clinical input as appropriate, draft a local report detailing the findings of the review team. This draft report is sent to the review team for comment, and then to the NHS board to check for factual accuracy. The local report is published only after all the visits for that topic have been undertaken nationwide.

Once a national review cycle is completed, the expert advisory group convenes to examine review findings and make recommendations. The group then oversees the production of a national overview of service provision across Scotland in relation to the standards. This document includes both a summary of the findings (highlighting examples of local initiatives and challenges for the service) and recommendations for improvement.

Part of the remit of NHS QIS is to report whether the services provided by NHSScotland, both nationally and locally, meet the agreed standards. This does not include reviewing the work of individual healthcare professionals. In achieving this aim, variations in practice (and potential quality) within a service will be encountered and subsequently reported.

Please note – all reports published are available in print format and on the NHS QIS website.

The review process



2 Summary of findings

2.1 Overview of local service provision

Lanarkshire is situated in central Scotland and has a population of around 556,114. The majority of the population live in urban areas, of which Cumbernauld, Hamilton and Motherwell are the largest in the region. The proportion of older people in the population is below the national average, whereas levels of illness and deprivation are relatively high.

Local NHS system and services

Lanarkshire NHS Board is responsible for improving the health of the local population and for the delivery of the healthcare required. It provides strategic leadership and has responsibility for the efficient, effective and accountable performance of the NHS in Lanarkshire.

At the time of the review visit, NHS Lanarkshire contained two NHS operating divisions: Lanarkshire Acute Hospitals Division (acute care services); and Lanarkshire Primary Care Division (primary care services). There are two community health partnerships (CHPs). Each CHP covers a geographical area and is a way of organising non-acute care where an NHS board maximises its ability to support integration across health services and between these and other agencies such as social services.

The NHS board is also accountable for both continuously improving the quality of health services, and safeguarding high standards of care, by creating an environment in which excellence in clinical care will flourish (framework of clinical governance).

Further information about the local NHS system can be accessed via the website of NHS Lanarkshire (www.show.scot.nhs.uk/nhslanarkshire).

Service organisation

Information obtained from a scoping study exercise undertaken in 2005 indicated that there are 15 NHS boards within Scotland that provide maternity services.

In NHS Lanarkshire, all maternity services are provided across primary and secondary care settings throughout the NHS board area, with specialist/tertiary services being provided by the regional service within NHS Greater Glasgow.

There is one centralised, specialist maternity unit based at Wishaw General Hospital which is supported by a community midwifery service and three maternity day assessment centres located throughout the NHS board area. The number of births have increased over the last 5 years as illustrated in the following table.

NHS Lanarkshire	Number of births				
	2001	2002	2003	2004	2005
Wishaw General Hospital	4,655	4,665	4,701	4,997	4,923
Home births	5	10	20	26	25
Other (eg born before arrival)	0	0	0	0	11
Total births	4,660	4,675	4,721	5,023	4,959

2.2 Summary of findings against the standards

A summary of the findings from the review, including examples of local initiatives drawn to the attention of the review team, is presented in this section. A detailed description of performance against the standards/criteria is included in Section 3.

Core Principles

NHS Lanarkshire provides a consultant-led maternity service centred at Wishaw General Hospital which is supported by three maternity day assessment centres based in the community. There are defined lines of responsibility for the service. The director of public health has responsibility for the service at Board level and the divisional nurse director is responsible for the service at both acute and primary care levels.

The Board is undertaking work in conjunction with the public, service users and staff to develop a strategy for maternity services which, once finalised, will outline the planned provision of the service up to 2010. The review team would encourage the Board to finalise its strategy for maternity services in compliance with national recommendations.

The Board has made considerable efforts to involve local public participation in the planning of maternity services. There is a maternity services liaison committee (MSLC) and a maternity services strategy group through which members of the public can be formally involved as members of these groups. The review team acknowledged the work undertaken by the Board to sustain public involvement in maternity services and would encourage the Board to continue promoting interest in this area.

There is a well-established system in place to report, investigate and analyse critical incidents. Training has been provided for staff to ensure correct recording and procedures are followed for all reported incidents. There are formal arrangements in place to ensure that all incidents are investigated by specialist review and communicated through the various organisational levels.

Example of a local initiative...

The Board has a mechanism in place to report back to staff regarding critical incidents. A newsletter is distributed to staff detailing the nature and outcome of the incidents. The review team considered this good practice as it allows all staff in the unit an opportunity to be informed of all reported incidents and it can also be used as a learning opportunity.

There is a formal operating procedure between the Board and the Scottish Ambulance Service which outlines an agreed arrangement for maternal and neonatal transfers in accordance with maternity services provision within NHS Lanarkshire. This service is supported by the West of Scotland Neonatal Transport Team which undertakes neonatal transfers to the specialised service provided by the Royal Hospital for Sick Children, Yorkhill, NHS Greater Glasgow. The review team

recommended that the Board produces a local guideline for staff outlining details for contacting the Scottish Ambulance Service to ensure no time is wasted when a specific level of service is required in emergency situations.

Women and babies have access to a range of specialist services at Wishaw General Hospital and also regionalised specialist services at the Royal Hospital for Sick Children. Although the current referral process is normally consultant to consultant, the review team would recommend that formal referral pathways are established for all women and babies who require referral to a specialist service.

The Board has a comprehensive audit system in place and monitors a wide range of maternity care services. In addition, the Board participates in national audits in relation to maternity services.

The Board places a high emphasis on the risk of domestic abuse and has undertaken a multi-agency approach to identifying and supporting women with domestic abuse issues. Many midwives have attended domestic abuse training and have attended regular awareness sessions as part of a local project to support women experiencing domestic abuse in the Lanarkshire area.

Example of a local initiative...

NHS Lanarkshire is participating in a pilot multi-agency risk assessment committee (MARAC) study in conjunction with the Police service. At the time of the review visit, the Board was 6 months into the pilot programme and reported that one midwife in each community area takes responsibility for domestic abuse issues. These midwives are trained to identify risk and provide information on support services to women affected by these issues.

Adult intensive care, special care baby unit (SCBU) and neonatal intensive care unit (NICU) facilities are available on-site at Wishaw General Hospital. Although some high dependency facilities are also available in the obstetric unit, sufficient clinical expertise is not fully in place to provide a complete service and uptake of training in this area has been low. However, should high dependency care be required for an obstetric patient, there is capacity for a high risk area to be set up in the maternity unit where high dependency care can be provided by a multidisciplinary team.

The Board provides an excellent range of information for women to enable them to make informed choices regarding their pregnancy and childbirth. Verbal information is supported by a range of national and local literature. A DVD has recently been produced which outlines the facilities available at the maternity unit at Wishaw General Hospital as well as practical information for bringing the baby home from hospital. The review team commended the Board's maternity services website which complements the range of information available.

There is a robust system in place which provides women with an opportunity to reflect on their birth experience. The review team considered it good practice to

have a specific section on the care plan to discuss and record this as part of routine postnatal care.

Pre-conception and Very Early Pregnancy

There is no specific pre-conception service for women with diabetes or who have a personal or family history of significant illness. In the absence of a dedicated service, women with diabetes are referred to a joint medical obstetric clinic and women with significant illness concerns can be referred to a relevant consultant specialist for specialised care and management.

The Board has an early pregnancy assessment service (EPAS) and has set up an EPAS Group to identify methods of providing a consistent service across NHS Lanarkshire. The review team acknowledged the work undertaken by this group to take the EPAS forward. The shortage of ultrasound equipment and supply of appropriately trained staff was highlighted as a challenge for the service. The review team would encourage the Board to provide prompt access to early pregnancy ultrasound facilities.

Pregnancy

There is a written syllabus for the delivery of a parent education programme, and there is a named midwife who has overall responsibility for co-ordinating the antenatal education programme on a service-wide basis. Midwives provide classes in day and evening sessions throughout NHS Lanarkshire. One-to-one classes are also provided for women who cannot attend scheduled classes and there are additional education sessions provided for special interest areas, eg pool births, twin pregnancies, etc.

The Board is undertaking a pilot education programme for teenage pregnancies in the North Lanarkshire area. The Board plans to roll this out throughout NHS Lanarkshire following an evaluation of the pilot process.

Although the parent education programme includes a postnatal reunion, attendance at this final session in the programme is very low and as a result is no longer provided in many areas. The Board has undertaken a review to promote interest in this area and the review team would encourage the Board in its efforts to re-establish postnatal reunions across NHS Lanarkshire.

An antenatal screening and diagnostic service is provided for all pregnant women in accordance with the national programme for antenatal screening. Women identified with pregnancy complications or potential complications which may affect their baby are managed on an individual basis in accordance with laboratory and clinical findings.

Example of a local initiative...

The Board has established an antibody group which meets on a monthly basis to consider all women who have been identified as having blood group antibodies in their blood. The group comprises of a consultant haematologist, a consultant obstetrician, a senior haematology medical laboratory scientific officer and a senior midwife. The review team considered this group to be a key strength to the service.

Although the Board has arrangements in place for antenatal care for all women, formal plans for antenatal care and risk factors are not in place and the review team would recommend the Board formalises practice in this area. A further recommendation was made for the Board to adapt its current practice to enable a woman to move from consultant to midwifery-led care as risk factors reduce. Current practice involves a woman staying in consultant-led care even if her risk factor has reduced and she no longer requires this level of specialised care.

Childbirth

The review team commended the practice of all women receiving one-to-one midwifery care during advanced stages of labour and childbirth. The service also has guidelines in place to support home births to ensure that two midwives are in attendance for all planned births at home. There is also an established mentoring programme to ensure that student midwives are supervised by a trained midwife at all times.

There are policies in place for the management of all key labour practices. The policies are reviewed by members of the Board's clinical effectiveness maternity subgroup. The subgroup meets on a monthly basis and reviews progress on updating maternity guidelines.

Example of a local initiative...

The Board's clinical effectiveness maternity subgroup has produced a progress table for all maternity services guidelines. The table outlines the title of each guideline, the current status of the guideline, eg whether it is being reviewed, the name(s) of staff responsible for developing and/or updating the policy and the policy's review date. The review team considered this a good practice approach to maintaining up-to-date guidelines.

The maternity unit at Wishaw General Hospital provides a full range of pain management techniques which are discussed as part of antenatal care between midwives and expectant mothers. Midwives encourage pregnant women to complete a birth plan and pain relief is discussed as part of this process.

There is an acting lead consultant anaesthetist with responsibility for the management of the obstetric anaesthetic service at Wishaw General Hospital. The

Board operates a 24-hour on-call rota to ensure a specialist anaesthetic service is available at all times in the maternity unit. There is an audit process in place for all women who have anaesthetic intervention.

The Board reported that there is a process, as part of the clinical IR1 incident reporting system, to monitor delays of more than 30 minutes which results in significant fetal compromise or maternal morbidity for emergency caesarean sections. However, there is not a specific system in place to monitor or classify this process. The review team would recommend that a system is established to specifically audit 'decision to delivery' intervals and perceived procedure urgency.

Postnatal and Parenthood

All women are assessed immediately after giving birth by a midwife. There is ongoing assessment for the recognition of complications as part of postnatal assessment with input from obstetric and anaesthetic staff as required. Details of postnatal assessments are recorded in the woman's maternity care plan.

A transfer summary is completed for every woman prior to discharge from hospital. Midwifery staff discuss and provide contraception to all women prior to leaving the maternity unit.

The maternity unit at Wishaw General Hospital is currently working towards achieving UNICEF/WHO Baby Friendly status and have been awarded a UNICEF/WHO UK Baby Friendly Initiative Certificate of Commitment in March 2005 with an aim to achieving full status by March 2007.

Women are provided with a range of national, local and UNICEF/WHO information to support them in their chosen method of feeding. The information provided contains details for bottle feeding and breastfeeding. Women are also offered practical support with their first breast or formula feed by ward staff. Mothers who choose formula feeding are provided with information on the preparation of formula and sterilisation of equipment.

Example of a local initiative...

The Community Mothers Breastfeeding Support Project was established as an initiative to increase the number of children being breastfed in the North Lanarkshire area. The project provides peer support to breastfeeding mothers in both the community and the hospital. Support is provided on a volunteer basis by local women who have completed a breastfeeding training programme after successfully breastfeeding their own children.

There is an infant feeding advisor to provide education and training for healthcare professionals who support women in their chosen method of feeding. The Board has a system in place to monitor admission rates for babies due to inadequate nutrition.

All babies are examined by a midwife or a neonatal doctor within 72 hours of birth. However, in practice, most babies are examined within 48 hours or earlier if the woman plans to leave hospital within a few hours of giving birth. There is a protocol and guideline in place for the recognition of group B streptococcal infection. All babies have a daily examination undertaken whilst in hospital and assessment for jaundice forms part of this examination. Community midwives continue these observations when the mother and baby return home following discharge from hospital.

The review team commended the Board's efficient system to ensure that information on women and their babies in the postnatal period is collated and transferred between secondary and primary care. There is an established community midwifery service to support women and their babies once they have been transferred from hospital to community care.

3 Detailed findings against the standards

Standard 1(a): Standard 1 ~ Core Principles

Standard Statement

Accountability: There are clear lines of responsibility for the planning and delivery of maternity services, with evidence of public involvement.

NHS Lanarkshire

Essential Criteria

1a.1: There is a named individual at NHS Board director level with responsibility for maternity services.

STATUS: Met

The Board's director of public health has responsibility for maternity services at NHS Lanarkshire Board level.

1a.2: There is a named clinician at both Primary and Acute NHS Operating Division level with responsibility for maternity services.

STATUS: Met

The Board's divisional nurse director has responsibility for maternity services at both acute and primary care levels.

1a.3: There is a current, dated, documented NHS Board strategy, developed by stakeholders, which sets out how maternity services are planned, developed and implemented, in line with Scottish Executive Health Department (SEHD) policies for women-centred care.

STATUS: Not met

There is currently not an up-to-date strategy in place for maternity services. The previous strategy was developed in the early 1990s and the review team was provided with the Board's current draft strategy which is in its fourth version and outlines service provision between 2005 and 2010. The review team noted the considerable work which has been undertaken by the Board in conjunction with the public, service users and staff to draft a new strategy for maternity services throughout NHS Lanarkshire and would encourage the Board to finalise the strategy and make it available as soon as possible.

1a.4: There is evidence of a range of public involvement activities in the planning of all maternity services.

STATUS: Met

Local public participation involvement in the planning of maternity services is undertaken in a variety of formats. There is a maternity services liaison committee (MSLC) as well as a maternity services strategy group which invites public involvement in the form of group membership and participation in decisions regarding the planning of maternity services. The Board informed the review team that the process of establishing lay representative involvement has been challenging; the review team acknowledged the effort by the Board to encourage public interest in this area of the service.

The public are also invited to make comments and suggestions through a 'Picker' survey, at a debrief session prior to discharge and through the maternity care plan. The review team was provided with feedback from 'A Picture of Health' survey which covered the general services provided by NHS Lanarkshire. The Board is also reviewing its maternity services and is inviting women to complete a questionnaire and provide their comments on the service they received from antenatal to post-delivery stage as part of its Women's Services Maternity Charter Review. The review team commended this review as well as the action plan drawn up from the 'Picker' survey and would recommend that the Board continues in its efforts to encourage and promote public involvement.

Standard 1(b): Standard 1 ~ Core Principles

Standard Statement

Risk Management: All healthcare professionals are aware of the importance of risk assessment and management of pregnant women, and take action to minimise avoidable adverse clinical incidents, including during transfer and access to services.

NHS Lanarkshire

Essential Criteria

1b.1: Assessment: There is a system to ensure that all critical incidents are reported, investigated and analysed, resulting in changes in practice, where necessary.

STATUS: Met

There is a well-established comprehensive system in place to ensure that critical incidents are reported, investigated and analysed. Corporate clinical incident forms are in place and training sessions regarding the correct use of these forms have been undertaken by the Board's clinical risk manager for all midwifery staff. It is standard practice for forms to be completed for a range of clinical procedures, eg if a woman requires more than four units of blood or treatment for a third degree tear.

All incidents are investigated, coded and actioned by specialist review undertaken by the clinical risk manager and relevant member of the medical team (anaesthetist, neonatologist or obstetrician). All staff directly involved would also be informed of the incident and the action agreed to be taken. Should the specialist review consider it appropriate, the incident would also be discussed at the Board's monthly directorate risk management meeting and any further action would be agreed at this forum. Supervisors of midwives would also be informed of any risk management issue that would require their input and/or consideration.

The directorate risk management team receives monthly reports of all recorded incidents and quarterly reports are produced for the hospital risk management group.

1b.2: Assessment: A compliments, comments and complaints procedure is in place to enable women to express views about their pregnancy and childbirth experience.

STATUS: Met

There are a number of ways in which women can express their views about their pregnancy and childbirth experience. All women are offered a debriefing discussion prior to going home from hospital after the birth of their baby and a satisfaction audit is completed as part of the maternity care plan prior to the woman's transfer of care to a health visitor. Women are also invited to comment in a range of Board information leaflets.

All formal suggestions and complaints are recorded, analysed and reported annually. Any specific suggestions or trends are discussed at the ward managers' meeting.

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1 b.3: Assessment: There are local guidelines agreed between the NHS Operating Division and the Scottish Ambulance Service, for the safe transfer of women during pregnancy, childbirth and with her newborn baby in the postnatal period.

STATUS: Not met

The Board and the Scottish Ambulance Service have discussed and agreed the most efficient ways to conduct maternal and neonatal transfers in relation to service provision within NHS Lanarkshire. The Board's acute Maternity Service is based at Wishaw General Hospital and arrangements have been agreed with the ambulance service to transfer all maternal cases to this hospital where care is specialised. As a result no such case would be transferred to any of the other hospitals in NHS Lanarkshire Board area even if this means bypassing any of these hospitals on the way to Wishaw General Hospital.

The Scottish Ambulance Service prioritises calls into a scale of 'category of urgency' and the Service audits its response times on a daily basis. The West of Scotland Neonatal Transport Team undertakes all neonatal transfers to the specialised service provided by the Royal Hospital for Sick Children, Yorkhill, NHS Greater Glasgow.

The review team commended the work undertaken between the Board and the Scottish Ambulance Service to establish a transfer procedure for maternity services in NHS Lanarkshire. However to meet the criterion, the review team would recommend that the Board produces a reference list for all maternity service staff outlining how to contact the relevant areas of the Scottish Ambulance Service as appropriate to the service required. This could be held centrally in each ward area for all staff to access quickly and efficiently as and when required and would be particularly useful for new and/or locum staff.

1 b.4: Referral: Formal arrangements exist for women and their babies to access a network of specialist services.

STATUS: Not met

There are arrangements for women and their babies to access a range of specialist services which include access to: allied health professions (AHPs); a dedicated anaesthetic service and adult critical care facilities; imaging; laboratory medicine; medicine; neonatology; obstetrics; perinatal pathology; surgery; and psychiatry. However, while these are mostly consultant to consultant referrals which appear to work well in practice, they are not outlined in formal referral pathways.

Most of these specialised facilities are available on-site at Wishaw General Hospital, where maternity services are centrally based for NHS Lanarkshire and some are provided by the regional specialised service at the Royal Hospital for Sick Children.

The review team commended the Board's specialised neonatal pharmacy service. In terms of imaging, there is currently not the capacity within the radiology department

to report on diagnostic imaging for neonates. These images are currently sent to the Royal Hospital for Sick Children to report via telemedicine. Telemedicine facilities and training have been introduced to the neonatal unit to enable consultation on cardiac problems between NHS Lanarkshire and the Royal Hospital for Sick Children.

1b.5: Referral: All women with risk factors for their pregnancy are offered assessment by a consultant obstetrician.

STATUS: Not met

The Board reported that there is a multi-professional team approach to antenatal care and, while women can be easily referred to a consultant obstetrician if necessary, the review team considered this criterion to be 'not met' as there was not a formal procedure in place for identifying obstetric risk factors.

1b.6: Training and Audit: There is an audit system in place to monitor important aspects of maternity care.

STATUS: Met

There is a comprehensive audit system in place to monitor various aspects of maternity care, including: instrumental, elective and emergency caesarean section rates; anaesthetic interventions during labour and deliveries; infant feeding and breastfeeding rates. In addition, the Board participates in a range of national audits for maternity services.

1b.7: Training and Audit: All healthcare professionals directly involved in childbirth are competent in basic adult obstetric, neonatal resuscitation and immediate care.

STATUS: Not met

Resuscitation training is provided and monitored in terms of attendance. However, there is not a system in place to ensure all professionals directly involved in childbirth are updated with basic adult, obstetric and neonatal resuscitation training.

The Board employs a resuscitation training officer and provided the review team with an outline of the work undertaken in terms of staff attendances at advanced and intermediate life support training courses and midwifery attendance at neonatal advanced life support training. In addition, multidisciplinary seminars are held on a regular basis which cover emergency situations including how to deal with haemorrhage scenarios. The Board has a clinical skills simulator mannequin which is used to facilitate teaching as part of these seminars. Teaching sessions are also undertaken by the Board's practice development midwife.

The review team was informed that a system has been established for all new medical staff to attend mandatory resuscitation training which involves attendees signing to

confirm their attendance. In addition, there are plans to provide resuscitation training for community midwives. There is, however, no system in place to ensure consultant medical staff attend regular resuscitation training. The review team acknowledged the work the Board is undertaking to ensure various staff groups receive training in this area, however, would recommend that there is a mandatory resuscitation training programme for all professionals directly involved in childbirth practice.

1b.8: Clinical Complications: A clinical risk assessment process for individual women, including a communications strategy, is in place, which addresses escalating risk.

STATUS: Not met

The Board reported that clinical risk is assessed as part of routine antenatal care observations, however, there is not a formal system in place to assess how risk factors would be managed between midwifery and consultant-led care.

1b.9: Clinical Complications: A policy is in place for the identification of women who are at risk of domestic abuse, and staff are trained in assessment, communication skills and support of such women.

STATUS: Met

The review team commended the Board's practice for the identification of women who are at risk of domestic abuse. There is a guidance pack for staff which includes: the NHSScotland publication 'Responding to Domestic Abuse'; a policy statement from Strathclyde Police; as well as NHS Lanarkshire guidelines for domestic abuse. An information leaflet for maternity services has also been produced by the Board in conjunction with Scottish Women's Aid. In addition, many midwives have received training in domestic abuse issues and attend regular awareness sessions as part of a local multi-agency project.

1b.10: Clinical Complications: High dependency facilities and clinical expertise are available within the obstetric unit for all women in level II and level III consultant-led units.

STATUS: Not met

High dependency facilities are available, however, sufficient clinical expertise is not fully in place to provide a complete service. There is sufficient medical expertise, but there is not a full capacity of nursing expertise to adequately support this area of the service.

The Board has taken steps to address this by offering specialised training for midwives, however, uptake has been low.

Current practice involves having a high risk area in one of the wards in the maternity unit which is adjacent to obstetric theatres. Women who require high dependency monitoring are cared for in this area by a multidisciplinary team.

1b.11: Clinical Complications: There is a defined rapid access route for women to adult intensive care and expertise in all level II and level III consultant-led units.

STATUS: Met

There is a defined route for women to adult intensive care and expertise. The Board has a guideline which details the arrangements for accessing this level of service.

1b.12: Clinical Complications: Adult intensive care facilities and specialist medical back-up are available on-site in all level IIc and level III consultant-led units.

STATUS: Met

Adult intensive care facilities and medical back-up are available on-site at Wishaw General Hospital which has a centralised maternity service for NHS Lanarkshire.

1b.13: Clinical Complications: Where full adult intensive care facilities are not currently available on-site in level IIc and level III consultant-led units, a strategy is in place outlining the process and timescale to achieve this.

STATUS: Not applicable

The maternity unit at Wishaw General Hospital is a level IIc unit and has adult intensive care facilities and specialist medical back-up available on-site. This criterion is, therefore, not applicable to NHS Lanarkshire.

1b.14: Clinical Complications: Units that do not have adult intensive care facilities, advanced imaging and cardiology on-site, must have protocols in place for the care of women with significant medical or obstetric illness to ensure that they are delivered in a unit that can provide these resources on-site.

STATUS: Not applicable

The maternity unit at Wishaw General Hospital is a level IIc unit and has adult intensive care facilities, advanced imaging and cardiology available on-site. This criterion is, therefore, not applicable to NHS Lanarkshire.

1b.15: Clinical Complications: Neonatal intensive care unit (NICU) facilities are available on-site in level IIc and level III consultant-led units. Where NICU facilities are not available on-site, a strategy is in place outlining the process and timescale to achieve this.

STATUS: Met

Neonatal intensive care facilities (NICU) are available on-site at Wishaw General Hospital. The neonatal unit is located close to the maternity unit and provides neonatal intensive care, high dependency care and special care facilities. The unit has eight neonatal intensive care cots. There is a dedicated team of neonatal consultants, neonatal midwives, AHPs and support workers providing specialised care for all babies in the unit.

1b.16: Clinical Complications: Special care baby unit (SCBU) facilities are available on-site in all level II and level III consultant-led units and there is a defined rapid access route to NICU in all level II and level III consultant-led units.

STATUS: Met

Special care baby unit (SCBU) facilities are available in the neonatal unit at Wishaw General Hospital. There are 14 special care cots supported by a dedicated specialised team of multi-professional staff.

There is a criterion for admitting babies to the neonatal unit as well as 24-hour access to neonatal medical staff who can be contacted to review any baby suspected of requiring transfer to the unit.

1b.17: Clinical Complications: Where there is provision of NICU and SCBU facilities, these conform to agreed national guidelines.

STATUS: Not met

The Board aims to conform to national guidelines regarding the provision of NICU and SCBU facilities, however, at the time of the review visit, this area of the service was unable to be supported by radiologists other than through the links with paediatric radiology at the Royal Hospital for Sick Children. The Board reported that it planned to have an additional radiologist in post to allow support to be provided to the neonatal and special care facility.

Standard 1(c): Standard 1 ~ Core Principles

Standard Statement

Information, Communication and Support: All women are fully informed of the different options available to enable them to take an informed and active role in planning their care, and in the decision-making involved in providing this care. Healthcare professionals are skilled in supporting women in the decision-making process.

NHS Lanarkshire

Essential Criteria

1c.1: There is a named healthcare professional identified for each woman, who leads and plans her contact with maternity services.

STATUS: Not met (insufficient evidence)

The review team was unable to confirm from the maternity care plan how the Board can ensure that all women have an identified healthcare professional who leads and plans her contact with maternity services. The Board reported that each woman is allocated a consultant and a midwife or a team of midwives depending on the size of the geographical area. The review team would recommend a more formal arrangement to identify a midwife and/or consultant on the care plan as there is currently no dedicated space on the plan for this contact name to appear.

1c.2: Women are provided with information in order to make an informed decision about the chosen place of birth for their baby.

STATUS: Met

Women are provided with a range of both written and verbal information regarding the services offered by the maternity unit to enable them to make an informed decision regarding their preferred place of birth. Information provided includes the national Ready, Steady, Baby book and a local maternity services guide which outlines the services offered at the maternity unit at Wishaw General Hospital. This information is also available on the hospital website. In addition, community midwives discuss options regarding choices available to women as part of antenatal care. Should a situation arise where there are concerns regarding the safety of a woman or her baby in terms of the woman's preferred place of birth, this would be explained to the woman and documented in her casenotes.

The Board has recently developed a DVD which highlights the facilities available at the maternity unit at Wishaw General Hospital.

1c.3: There is evidence that professionals obtain informed consent for interventions and investigations, and this is documented.

STATUS: Met

The Board has a system in place for professionals to obtain informed consent for interventions and investigations. Informed consent is sought at various stages throughout pregnancy, delivery and the postnatal period. Some of these situations, eg pregnancy and newborn screening, require written consent to be obtained while for other procedures, such as physical examinations, verbal consent is sought. Consent is documented in the woman's casenotes and also in her maternity care plan.

1c.4: All women are given the opportunity to reflect on their birth experience.

STATUS: Met

Women are given the opportunity to reflect on their birth experience as part of routine postnatal care and there is a specific debriefing section on the maternity care plan to record details of this discussion. Care plans are evaluated and monitored to check that this section has been completed as a means of ensuring this process has been undertaken.

1c.5: Training on how to communicate information in an effective and sensitive manner, is provided to all healthcare professionals.

STATUS: Met

The Board reported that communications skills training is included in a variety of courses, in particular, the Board's customer care training. In addition, awareness sessions are included as part of the education programme for midwifery staff. Staff who have attended the Advanced Life Support in Obstetrics (ALSO) course have also received a lecture and information on communication issues. All new medical staff have communication skills included as part of their induction process. While evidence provided in response to this criterion did not include details of training undertaken by senior medical staff, the review team acknowledged that specialist medical accreditation incorporates such training and competence.

1c.6: There is a policy for supporting and informing parents bereaved during pregnancy, or soon after giving birth.

STATUS: Met

There are a variety of information leaflets and services for supporting parents bereaved in this way. The Board has an education pack for staff regarding pregnancy

loss which enables staff to provide comprehensive information and support. Midwives organise a monthly meeting for parents who have experienced an early pregnancy loss. This is supported by the local Stillbirth and Neonatal Death Society (SANDS). The review team commended the Board's approach in supporting and informing parents who are bereaved during pregnancy or soon after giving birth, however, would recommend that the Board has a bereavement counsellor in post to provide specialist support in this area.

1c.7: Information giving (verbal, written and other media) is monitored and evaluated.

STATUS: Met

The Board has a checklist which allows information provided to parents to be monitored and evaluated. The review team was informed that information is reviewed on a regular basis.

Standard 1(d): Standard 1 ~ Core Principles

Standard Statement

Partner and Family Involvement: All maternity services and healthcare professionals recognise the important role of the partner/family, and ensure that they are encouraged and supported to be involved in pregnancy and childbirth.

NHS Lanarkshire

Essential Criterion

1d.1: There is evidence that partner/family/friend involvement occurs, (including information provision for partners and families and open/flexible visiting times for partners and children).

STATUS: Met

The Board encourages partners to be actively involved during antenatal, labour and postnatal stages. At antenatal stage, this involves attending parent education classes. The Board also has a specific website for fathers where additional information regarding parent education sessions can be accessed. Partners are encouraged and welcome during the labour and delivery stages, and also postnatally where visiting for partners is on an all day basis (9am–9pm).

Standard 1(e): Standard 1 ~ Core Principles

Standard Statement

Record-keeping: A structured and accurate record of all events during the antenatal, childbirth and postnatal periods is maintained for every woman and child (known as a 'unified record').

NHS Lanarkshire

Essential Criteria

1e.1: All women have a unified handheld record.

STATUS: Not met

The review team was informed that women have a handheld midwifery care plan, however, the full record of information is maintained in the women's casenotes. At the time of the review visit, the Board was working towards implementing the new national handheld maternity record.

1e.2: The SMR02, Scottish birth record and birth notification General Register Office for Scotland (GROS), is completed for all women and newborn babies in line with current standards.

STATUS: Met

The SMR02, Scottish birth record and birth notification General Register Office for Scotland (GROS) are completed for all women and newborn babies. The review team was informed that all maternity casenotes are coded by the medical records department. In addition, a manual check is undertaken by staff in each ward at midnight to ensure a birth notification has been completed for all babies.

Desirable Criterion

1e.3: The national unified handheld record and national electronic record are completed for all women and newborn babies.

STATUS: Not applicable

The review visit to NHS Lanarkshire took place shortly after the official launch of the national unified handheld maternity record. As the review team considered the time between the launch of the national record and this review visit to be insufficient to measure progress in this area, it concluded this criterion was not applicable at this stage of the review process.

Standard 2(a): Standard 2 ~ Pre-conception and Very Early Pregnancy

Standard Statement

Pre-conception Services: All women with a poor obstetric/medical history, a previous poor fetal/maternal outcome, or where there is a family history of significant illness, have access to specific pre-conception services.

NHS Lanarkshire

Essential Criterion

2a.1: There is a specific pre-conception service for women with diabetes which is based on the SIGN guideline for diabetes.

STATUS: Not met

There is not a specific, pre-conception service for women with diabetes; such cases, when referred, are currently seen at a joint medical obstetric antenatal clinic. The review team would recommend a specific pre-conception service where women considering pregnancy can attend for advice and care management.

Desirable Criterion

2a.2: There are specific pre-conception services for women with a personal or family history of significant illness (eg epilepsy, neural tube defect, chromosomal abnormality).

STATUS: Not met

The Board reported that there is not a specific pre-conception service for women with a personal or family history of significant illness. In the absence of a dedicated service a woman would be referred to a relevant consultant specialist for specialised care and management.

Standard 2(b): Standard 2 ~ Pre-conception and Very Early Pregnancy

Standard Statement

Early Pregnancy Complications: All women who experience complications in early pregnancy have access to an early pregnancy assessment service.

NHS Lanarkshire

Essential Criteria

2b.1: There are formal arrangements in place for referral to the early pregnancy assessment service, which allows any healthcare professional to access the service directly.

STATUS: Not met

There is an early pregnancy assessment service (EPAS) which accepts direct referrals from healthcare professionals, however, there are variances in this service throughout the NHS board area. The Board identified these variances and set up a NHS Lanarkshire EPAS Group in 2003 to establish a service across Lanarkshire. The review team acknowledged this initiative, however, highlighted the shortage of formal referral protocols, ultrasound equipment and staff as a challenge for the Board. At the time of the review visit, the Board reported that plans were in place to appoint a consultant to take the service forward and the review team would encourage the Board in its efforts to establish this role.

2b.2: There are formal arrangements in place for referral to the early pregnancy assessment service, which allows women with previous early pregnancy problems to self-refer.

STATUS: Met

There are arrangements in place to allow women with early pregnancy problems to self-refer to the EPAS. Contact details for the EPAS units are given to women and they are encouraged by maternity services staff to refer themselves to this service should they experience any problems.

2b.3: Women who experience early pregnancy complications are cared for in a dedicated area distinct from the general gynaecology or antenatal ward.

STATUS: Met

The Board reported that women who experience early pregnancy complications are cared for in single rooms in Wishaw General Hospital.

2b.4: Women who miscarry have access to a choice of management options (surgical/medical/expectant).

STATUS: Met

Women who miscarry have a choice of surgical, medical and expectant management options. All three options are available at Hairmyres Hospital, East Kilbride, and Wishaw General Hospital. Both expectant and surgical options are available at Monklands Hospital, Airdrie, however, should a woman attending Monklands Hospital choose a medical management option, a referral would be made to either of the other two hospitals which provide this service.

2b.5: There is prompt access (within 24 hours) to ultrasound facilities with trained staff in secondary and tertiary services.

STATUS: Not met

The Board provides 24-hour access to ultrasound facilities on a Monday–Friday basis. In addition, Hairmyres Hospital provides a Saturday morning EPAS ultrasound service, however, there is not 24-hour access to ultrasound facilities in NHS Lanarkshire at weekends.

Desirable Criterion

2b.6: Telemedicine is used to promote regional networking, and to expedite the reporting of results.

STATUS: Not met

The Board reported that telemedicine is not currently used in the provision of maternity services. However, plans are in place to establish these facilities between Wishaw General Hospital and the Royal Hospital for Sick Children.

Standard 3(a): Standard 3 ~ Pregnancy

Standard Statement

Education Programme: All maternity services provide comprehensive programmes of education for childbirth and parenthood to women and their partners and families.

NHS Lanarkshire

Essential Criteria

3a.1: There is a written syllabus of education that targets specific groups, and is in a user-friendly format. The syllabus outlines the aims, themes and outcomes of the education programme.

STATUS: Met

There is a written syllabus for the delivery of a parent education programme for childbirth which outlines the aims, themes and outcomes of the education programme. Classes are provided in either day or evening sessions. One-to-one classes are provided for women who cannot attend the scheduled sessions. In addition, education sessions are also provided for: early pregnancy; twin pregnancies; pool birth; and baby resuscitation techniques. At the time of the review visit, the Board was piloting a specific parent education programme at Airdrie Health Centre for teenage pregnancies. The Board plans to roll this out to other areas within NHS Lanarkshire following an evaluation of the pilot process. The review team commended the content of the parent education programme and would encourage the Board in its plans for the expansion of the teenage pregnancy group to other areas within NHS Lanarkshire.

3a.2: There is a lead named co-ordinator, with recognised training and development to undertake the role, who takes responsibility for the programme on a service-wide basis.

STATUS: Met

There is a named midwife who has overall responsibility for co-ordinating the antenatal education programme on a service-wide basis.

Desirable Criteria

3a.3: The Ready, Steady, Baby book is provided to all women on confirmation of pregnancy.

STATUS: Met

The Board reported that GP surgeries are provided with copies of the Ready, Steady, Baby book in order for it to be provided to women on confirmation of pregnancy.

3a.4: Parent education programmes include a postnatal reunion.

STATUS: Met

The parent education programme currently includes a postnatal reunion, however, the Board reported that attendance is very low and as a result there is just one postnatal reunion for NHS Lanarkshire. An audit has been undertaken to ascertain what can be done to improve attendance rates. The review team would encourage the Board in its efforts to promote and re-establish the postnatal reunion session as part of the parent education programme.

Standard 3(b): Standard 3 ~ Pregnancy

Standard Statement

Screening Services: All women have access to screening services and antenatal diagnostic testing.

NHS Lanarkshire

Essential Criteria

3b.1: All women who are identified in the screening programme as at risk of rhesus disease are managed and treated according to an agreed protocol.

STATUS: Met

The Board provides a full range of screening and diagnostic options for all pregnant women in accordance with the national programme for antenatal screening. Women identified at risk of rhesus disease will be provided with information to enable informed consent to be given and have their care managed in accordance with laboratory and clinical findings.

At the time of the review visit, antenatal Anti-D prophylaxis was due to commence once an electronic system is established in community locations to enable staff to gain remote access to screening and blood results. The review team would recommend that all women had a handheld maternity record where all results could be recorded and viewed by all healthcare professionals involved in the woman's care. Currently this information is contained in the women's casenotes which are not readily accessible to community staff.

3b.2: The antenatal care and investigation of women conforms to the guidance set out in Table 14, page 40 of A Framework for Maternity Services in Scotland.

STATUS: Not met

The review team considered the antenatal care and investigation of women to be slightly out with the guidance set out in 'A Framework for Maternity Services in Scotland' as the Board reported that one additional appointment has been included in the programme of visits to assess women for pre-eclampsia. Also, pregnant women are only offered one ultrasound scan, rather than the two recommended in 'A Framework for Maternity Services in Scotland'.

Standard 3(c): Standard 3 ~ Pregnancy

Standard Statement

Antenatal Care: All maternity services provide antenatal care delivered by a network of professionals, such that each woman is managed by a midwife, GP or obstetrician according to her level of risk, and as locally as possible.

NHS Lanarkshire

Essential Criteria

3c.1: Each maternity service has an explicit plan for antenatal care for all women, taking account of risk, which acknowledges that women can move in either direction between different levels of care and lead professionals.

STATUS: Not met

There are arrangements in place for antenatal care for all women which take account of risk, however, it is not a formal plan and it does not currently enable women to move in either direction between different levels of care. Following risk assessment women are seen by a consultant obstetrician, it is then current practice for women to remain with the consultant-led service even if they no longer require this level of care. The review team would recommend that current practice is adapted to enable women to move between consultant and midwifery-led care as appropriate to the woman's risk level and also to establish formal guidelines for antenatal care and risk assessment.

3c.2: Women are offered the opportunity to be involved in the development of their birth plan, including the chosen place of birth of their baby.

STATUS: Met

Women are provided with comprehensive information and midwifery support during their pregnancy to enable them to be involved in the development of their birth plan. There is a section on their care plan to record their preferred choices regarding arrangements for the birth of their baby. The information in the care plan is followed up by midwives at the woman's 34-week stage of gestation.

3c.3: The routine pattern of antenatal care for pregnant women is no more than nine visits for a primigravida and eight visits for a multigravida.

STATUS: Not met

The routine pattern of antenatal care is slightly outwith the recommended number of visits. There are currently 10 visits for primigravida and eight for multigravida. The review team was informed that an extra visit has been built in to the antenatal care plan for primigravida to identify pre-eclampsia.

Standard 4(a): Standard 4 ~ Childbirth

Standard Statement

Care Planning and Birth: All women receive an agreed plan of care throughout labour in line with current professional standards consistent with their risk assessment and their chosen place for childbirth.

NHS Lanarkshire

Essential Criteria

4a.1: Each woman receives one-to-one midwifery care during established labour and childbirth by a trained midwife, or trainee midwife under supervision.

STATUS: Met

The review team was informed that all women receive one-to-one midwifery care during established stages of labour and childbirth and that maternity provision is planned to ensure this is achieved.

The Board also operates a mentoring programme to ensure that student midwives are supervised by a trained midwife at all times.

4a.2: For planned home births there is a minimum of two trained professionals present, one of whom is a midwife.

STATUS: Met

The Board has comprehensive guidelines in place for home births and there is an established system to ensure that there are two midwives in attendance for planned home deliveries. The guidelines contain a checklist of drugs and equipment required for home births. All equipment is double checked by midwives prior to being transferred to the woman's home. Midwives operate an on-call rota from the woman's 39-week gestation stage to ensure sufficient staffing levels are maintained.

4a.3: There are agreed multidisciplinary, evidence-based policies for the management of all key labour practices, when care deviates from the norm.

STATUS: Met

Policies are in place for the management of: induction of labour; breech presentation; perineal repair; caesarean section; prophylactic antibiotics for caesarean section; antepartum haemorrhage (including placenta praevia); Oxytocin; thromboprophylaxis; thromboembolic disease in pregnancy; water birth; epidural analgesia; fetal heart rate monitoring; twin pregnancy; diabetes; eclampsia; women who decline blood products; antepartum and postpartum haemorrhage; prolapsed

cord; rupture of the uterus; shoulder dystocia; neonatal resuscitation; adult resuscitation; retained placenta; and intrauterine death.

The review team was informed that members of the clinical effectiveness maternity subgroup are involved in writing these policies. The subgroup meets on a monthly basis and reviews progress on updating maternity guidelines. At the time of the review visit, the subgroup was in the process of reviewing the fetal monitoring guideline as well as updating the policy for the management of retained placenta. The review team noted that there was not a review date on the policy for epidural analgesia and that the policy for shoulder dystocia is due for review and would recommend that all policies are produced in a corporate format detailing members of staff involved in producing the policy as well as issue and review dates.

Standard 4(b): Standard 4 ~ Childbirth

Standard Statement

Pain Management: All women, regardless of their specific location, are informed about, and offered the range of pain management techniques during childbirth, and are supported in their choice of pain control.

NHS Lanarkshire

Essential Criteria

4b.1: All women receive information about, and have access to, a range of pain management techniques which include: transcutaneous electrical nerve stimulation (TENS); oral and intramuscular analgesia; inhalational analgesia; and the use of water for pain relief. Epidural analgesia is available in consultant-led units.

STATUS: Met

The maternity unit at Wishaw General Hospital provides a full range of pain management techniques which are discussed as part of antenatal care between midwives and expectant mothers. These include: transcutaneous electrical nerve stimulation (TENS); oral analgesia; intramuscular analgesia; Entonox; the use of water for pain relief; and epidural analgesia.

Midwives encourage pregnant women to complete a birth plan, and pain relief is discussed as part of this process to enable women to make informed choices regarding their pain management options during labour and childbirth. In addition, a comprehensive information leaflet regarding pain management has been prepared by the obstetric anaesthetic staff to further facilitate this process. The review team commended the detail of this leaflet. The Board reported that women can also discuss epidural analgesia with a consultant anaesthetist either in the antenatal period or when admitted to the maternity unit at the labour stage.

4b.2: All women, who have epidural analgesia or an operative delivery, have their pain assessed using a pain assessment tool.

STATUS: Met

The review team was informed that most women who have an operative delivery choose to have patient controlled analgesia. Observations are recorded on a chart which includes a visual analogue score for pain assessment. In addition, all women who have epidural analgesia have their sensory and motor block assessed, and the epidural infusion and maternal position altered accordingly. There is an audit process in place for all women who have an anaesthetic intervention.

Desirable Criterion

4b.3: Epidural analgesia is available at all times in consultant-led units.

STATUS: Met

Epidural analgesia is available at all times in the Wishaw General Hospital Maternity Unit.

Standard 4(c): Standard 4 ~ Childbirth

Standard Statement

Anaesthesia: During childbirth all women have access to anaesthesia that conforms to current professional standards.

NHS Lanarkshire

Essential Criteria

4c.1: There is a lead consultant obstetric anaesthetist with responsibility for the organisation and management of the specialist anaesthetics service within consultant-led units.

STATUS: Met

There is a lead consultant obstetric anaesthetist with responsibility for the management of the obstetric anaesthetic service at Wishaw General Hospital. At the time of the review visit, this consultant was on maternity leave and there was an acting lead consultant obstetric anaesthetist providing this level of service during the maternity leave period.

4c.2: Arrangements are in place in consultant-led units, to ensure that a specialist anaesthetic service is available at all times during childbirth.

STATUS: Met

A specialist anaesthetic service is available at all times at Wishaw General Hospital. The Board has a 24-hour on-call rota for this service.

4c.3: All specialist anaesthetic services comply with NHS QIS anaesthesia standards and Royal College of Anaesthetists (RCA) guidelines.

STATUS: Met

The review team acknowledged the Board's commitment to comply with the NHS QIS anaesthesia standards and the guidelines issued by the Royal College of Anaesthetists (RCA). The Board has an action plan to follow-up on the NHS QIS anaesthesia review visit in February 2005. The review team confirmed from observation of this plan that the Board is meeting this criterion.

4c.4: There is a system in place to ensure that anaesthetic and theatre services respond rapidly to obstetric emergencies and expedite delivery in the event of maternal or fetal compromise.

STATUS: Met

There is a system in place to ensure that anaesthetic and theatre staff are able to respond rapidly to obstetric emergencies. There is a paging system to call staff to emergencies and there is sufficient staff on-call to provide this level of response. Additionally, a second theatre can be opened for simultaneous emergencies.

4c.5: There is a system in place to ensure that 'decision to delivery' intervals and perceived urgency are monitored.

STATUS: Not met

The Board reported that there is a process, as part of the clinical IR1 incident reporting system, to monitor delays of more than 30 minutes for emergency caesarean sections for significant fetal compromise or maternal morbidity. However, there is not a specific system in place to monitor 'decision to delivery' intervals.

Desirable Criterion

4c.6: The time from informing the anaesthetist to the start of an emergency operative delivery should not normally exceed 30 minutes except if there is a risk to maternal health.

STATUS: Not met

The Board reported that, at the time of the review visit, it did not record 'the time from informing the anaesthetist' to 'the start of an operative delivery'. The review team noted that this information is initially included in the woman's casenotes and would encourage the Board to have a system in place to audit practice in this area.

Standard 5(a): Standard 5 ~ Postnatal and Parenthood

Standard Statement

Care of Women: All women receive appropriate care and assessment from giving birth to the 6-week postnatal check.

NHS Lanarkshire

Essential Criteria

5a.1: All women are assessed immediately after giving birth by a suitably qualified member of the birth team.

STATUS: Met

All women have post-delivery observations undertaken by a midwife with input from consultant obstetric and anaesthetic staff as required. This assessment is documented in the woman's maternity care plan.

5a.2: All women are assessed prior to transfer to community care and/or within 24 hours of giving birth, by a midwife.

STATUS: Met

All women are assessed by a midwife within 24 hours of giving birth and prior to being transferred to community care. Details of postnatal assessments are recorded in the woman's maternity care plan. A transfer summary is undertaken for every woman prior to discharge from hospital.

5a.3: There is ongoing assessment for the recognition of complications, eg infection, haemorrhage, thromboembolism and anaesthetic problems.

STATUS: Met

There is ongoing assessment for the recognition of complications as part of the postnatal assessment. Assessment indicators for infection, haemorrhage and thromboembolism form part of these checks, and a risk assessment form is completed for all deliveries in accordance with SIGN Guideline 55: Management of Diabetes. Assessment for any potential anaesthetic problems are also included as part of the postnatal check.

5a.4: Women receive information on contraception within 2 weeks of childbirth.

STATUS: Met

Midwifery staff discuss and provide contraception to all women prior to leaving the maternity unit. A national information leaflet regarding contraception is also provided to the woman to take home. Details of the information provided are also documented in the woman's casenotes.

Standard 5(b): Standard 5 ~ Postnatal and Parenthood

Standard Statement

Infant Feeding: Maternity services promote, support and sustain breastfeeding. Women are informed of its benefits, while being supported in their chosen mode of feeding.

NHS Lanarkshire

Essential Criteria

5b.1: There is evidence that the maternity service adheres to the principles of, or is working towards, the UNICEF/WHO Baby Friendly status.

STATUS: Met

The maternity unit at Wishaw General Hospital is currently working towards achieving UNICEF/WHO Baby Friendly status. A UNICEF/WHO UK Baby Friendly Initiative Certificate of Commitment was achieved in March 2005 with an aim to achieving full status in March 2007. The Board provided the review team with a copy of its action plan highlighting the unit's progress to achieving full status.

5b.2: Women are provided with readily accessible information and support in their chosen method of feeding, including access to peer support groups.

STATUS: Met

Women are provided with a range of national, local and UNICEF/WHO information to support them in their chosen method of feeding. The information provided contains details for bottle feeding and breastfeeding. Information is first provided at the antenatal stage as part of parent education sessions. Women are invited to a breastfeeding workshop and are shown videos recommended by UNICEF/WHO. Information is also provided on breastfeeding support groups and there is a Lanarkshire breastfeeding website for women to obtain further information.

Women are also offered practical support with their first breast or formula feed by ward staff. Mothers who choose bottle feeding are provided with information on the preparation of formula and sterilisation of equipment. Breastfeeding mothers are observed and further assistance offered within 6 hours of the first feed to ensure that feeding is established. A record of progress is maintained in the postnatal checklist. Women who are experiencing any difficulties with breast or bottle feeding are provided with help and support from both maternity staff and the community mothers breastfeeding support group. Community midwives and the community mothers breastfeeding project continue to support women with feeding following discharge from hospital.

Desirable Criteria

5b.3: Each NHS Board area has an infant feeding advisor to provide education and training to healthcare professionals who support women in their chosen method of feeding.

STATUS: Met

There is an infant feeding advisor to provide education and training for healthcare professionals who support women in their chosen method of feeding. The review team was provided with a comprehensive list of training provided for staff to enable them to support women with feeding their babies. The training includes UNICEF/WHO Baby Friendly training and in-house education. Training is provided for all staff groups, eg support, clinical and medical staff.

5b.4: Admission rates for babies due to inadequate nutrition are monitored.

STATUS: Met

The Board has a system in place to monitor admission rates for babies due to inadequate nutrition. The neonatal unit records reasons why all babies are admitted to the unit in its admission record book.

Standard 5(c): Standard 5 ~ Postnatal and Parenthood

Standard Statement

Care of Babies: All babies receive appropriate care and assessment from birth until 6 weeks post birth.

NHS Lanarkshire

Essential Criteria

5c.1: Steps are taken to minimise the number of infants who require re-warming or avoidable admission to SCBU.

STATUS: Met

The Board reported that national recommended precautions are taken to minimise the number of infants who require re-warming or avoidable admission to the SCBU. Steps taken to maintain a baby's temperature include: room temperature control; 'skin to skin' contact; appropriate drying of the baby; and covering the baby with dry clothing. The review team would recommend the Board undertakes an audit of all babies who require re-warming.

5c.2: All babies are clinically examined immediately following birth by a suitably qualified member of the birth team.

STATUS: Met

All babies are clinically examined immediately following birth by a midwife and details of the examination are recorded in the mother's notes. Vitamin K is also administered at this stage with parental consent, which is also recorded in the notes. Babies will be referred to the neonatal team if any anomalies are observed during this initial examination.

5c.3: All babies are clinically examined prior to discharge from hospital and/or within 72 hours of birth, by a suitably qualified healthcare professional.

STATUS: Met

All babies are examined by a neonatal doctor or a midwife who has been trained to undertake this level of examination. The Board reported that this examination is normally undertaken within 48 hours of birth or earlier if the woman plans to leave hospital at an earlier stage. If the woman decides to leave hospital within a few hours of giving birth, the option is provided for the woman to return to the unit with her baby the following day to receive this examination.

The review team was informed that 12 midwives have successfully completed the 'examination of the newborn' course.

5c.4: There is ongoing assessment, including recognition of group B streptococcal infection and jaundice.

STATUS: Met

The Board has a protocol and guideline in place for the recognition of group B streptococcal infection. All babies have a daily examination whilst in hospital and assessment for jaundice forms part of this examination. Community midwives continue these observations when the mother and baby return home following discharge from hospital. The review team would recommend that a protocol is developed for the recognition and management of neonatal jaundice.

Standard 5(d): Standard 5 ~ Postnatal and Parenthood

Standard Statement

Transfer Standard: The transfer of women and their newborn babies into the community is planned to facilitate continuing effective care.

NHS Lanarkshire

Essential Criteria

5d.1: A system is established to ensure that information on women and their babies in the postnatal period is collated and transferred between secondary and primary care in a reliable, timely and secure manner.

STATUS: Met

The review team commended the Board's efficient system to ensure that information on women and their babies in the postnatal period is collated and transferred between secondary and primary care. A discharge summary is completed as part of the woman's care plan. This is a 3-part copy form, one copy remains in the case record, the second copy goes to the woman's GP and the third copy is given to the mother to give to her community midwife. On discharge from midwifery care, the midwife will provide an updated summary to the health visitor.

5d.2: Guidelines for transfer and post transfer care are in place.

STATUS: Not met

There is an established community midwifery team to care for women and their babies once they have been transferred from hospital to community care. Whilst a discharge summary is in place for all women and their babies who transfer from secondary to primary care, there is not a formal guideline for the transfer and post-transfer care of a woman and baby between secondary and primary care. The review team would recommend that existing arrangements are formalised into a guideline.

Appendix 1 – Glossary of abbreviations

Abbreviation

AHP	allied health profession
ALSO	advanced life support in obstetrics
CHP	community health partnership
EPAS	early pregnancy assessment service
GP	general practitioner
GROS	General Register Office for Scotland
IR1	incident reporting form
MARAC	multi-agency risk assessment committee
MSLC	maternity services liaison committee
NHS QIS	NHS Quality Improvement Scotland
NICU	neonatal intensive care unit
RCA	Royal College of Anaesthetists
SANDS	Stillbirth and Neonatal Death Society
SCBU	special care baby unit
SEHD	Scottish Executive Health Department
SIGN	Scottish Intercollegiate Guidelines Network
SMR02	Scottish Morbidity Record 2
TENS	transcutaneous electrical nerve stimulation
UNICEF/WHO	United Nations Children’s Fund/World Health Organisation

Appendix 2 – Details of review visit

The review visit to NHS Lanarkshire was conducted on 2 February 2006.

Review team members

Dr Drew Smith (Team Leader)

Consultant Anaesthetist, NHS Greater Glasgow

Mrs Elspeth Fleming

Public Partners, Tayside

Dr Corinne Love

Consultant Obstetrician, NHS Lothian

Dr Una MacFadyen

Consultant Paediatrician, NHS Forth Valley

Ms Anne McGinley

Health Visitor, NHS Greater Glasgow

Ms Elizabeth McGovern

Public Partners, Tayside

Ms Shirley Seabury

Midwife Counsellor, NHS Lothian

Dr Linda de Caestecker (Observer)

Acting Director of Public Health, NHS Greater Glasgow

NHS Quality Improvement Scotland Staff

Ms Sharon Keane

Project Officer, Performance Assessment Unit

Mr Steven Wilson

Team Manager, Performance Assessment Unit

During the visit, members of the review team met with local health service personnel including anaesthetists, health visitors, midwives, neonatologists, obstetricians, paediatricians, paramedics, AHPs and GPs.

Appendix 3 – Maternity services project group members

Chair

Dr Jane Magill

Director, Robert Clark Centre for Technological Education, University of Glasgow

Project group members

Ms Gill Allan

Sister Midwife, NHS Tayside

Mrs Frances Arnott

Health Visitor, NHS Forth Valley

Ms Irene Barkby

LSA Midwifery Officer/Divisional Nurse Director – Acute, NHS Lanarkshire

Dr Ian Bashford

Senior Medical Officer, Scottish Executive Health Department

Dr Jennifer Bennison

Deputy Chair (Policy), Royal College of General Practitioners (Scotland)

Professor Andrew Calder

Consultant Obstetrician, NHS Lothian

Ms Cynthia Clarkson

Lay Representative, National Childbirth Trust

Dr Corinne Love

Consultant Obstetrician, NHS Lothian

Dr John McClure

Consultant Anaesthetist, Royal College of Anaesthetists, NHS Lothian

Ms Dahrlene McMahon

Paramedic, Scottish Ambulance Service

Mrs Mathilde Peace

Lay Representative, Lothian Health Council

Dr Gillian Penney

Clinical Senior Lecturer & Programme Director, Scottish Programme for Clinical Effectiveness in Reproductive Health, NHS Grampian

Ms Nancy Robson

Lay Representative, Grampian

Ms Joanne Thorpe

Midwifery Team Leader, NHS Argyll & Clyde

Dr Tom L Turner

Consultant Paediatrician, NHS Greater Glasgow

Support from NHS QIS was provided by **Ms Jan Warner** (Director of Performance Assessment and Practice Development), **Mr Steven Wilson** (Team Manager), **Mrs Morag Kasmi** (Senior Project Officer), **Ms Sharon Keane** (Project Officer), **Dr Avril MacLennan** (Project Officer) and **Mrs Lorraine Inglis** (Project Administrator).

Appendix 4 – Timetable of review visits

Organisation reviewed	Visit date(s)
NHS Argyll & Clyde	20 June 2006
NHS Ayrshire & Arran	7 June 2006
NHS Borders	19 April 2006
NHS Dumfries & Galloway	29 March 2006
NHS Fife	10 May 2006
NHS Forth Valley	17 January 2006
NHS Grampian	27 April 2006
NHS Greater Glasgow	25 May 2006
NHS Highland	16 March 2006
NHS Lanarkshire	2 February 2006
NHS Lothian	1 March 2006
NHS Tayside	16 February 2006
NHS Orkney	22 November 2005
NHS Shetland	8 November 2005
NHS Western Isles	6 December 2005

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NHS Quality Improvement Scotland

Edinburgh Office
Elliott House
8-10 Hillside Crescent
Edinburgh EH7 5EA

Phone: 0131 623 4300
Textphone: 0131 623 4383

Glasgow Office
Delta House
50 West Nile Street
Glasgow G1 2NP

Phone: 0141 225 6999
Textphone: 0141 241 6316

Email: comments@nhshealthquality.org
Website: www.nhshealthquality.org

