NHS Quality Improvement Scotland

NHS Shetland

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 Shetland**. This review visit took place on **8 November 2005**, 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

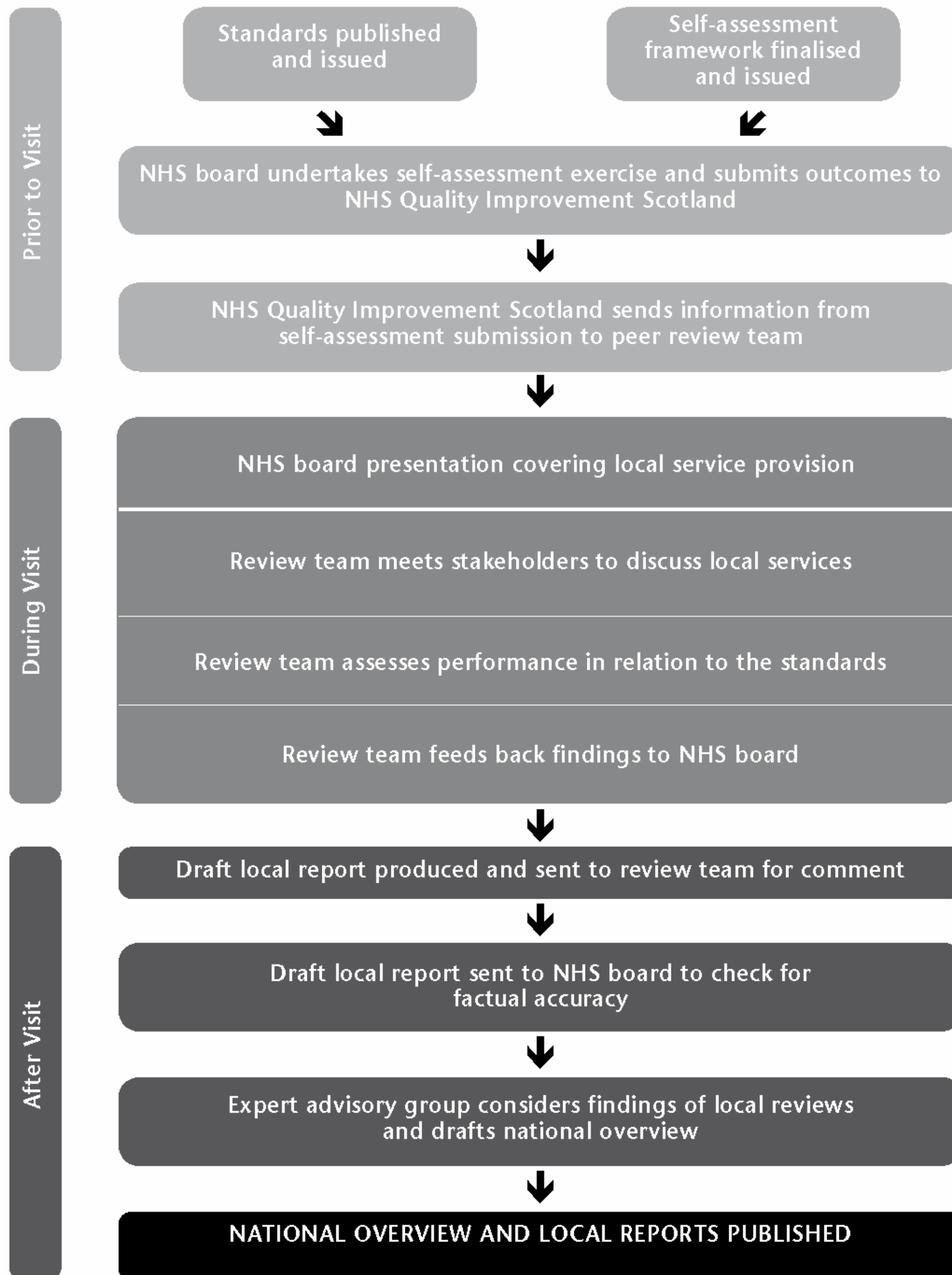
After each review visit, NHS QIS staff, with clinical input as appropriate, draft a local report detailing the findings of the review team. This draft report is sent to the review team for comment, and then to the NHS board to check for factual accuracy. The local report is published only after all the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

Shetland is an island group situated north of mainland Scotland and has a population of around 21,940. Many of the population live in the town of Lerwick, although a significant proportion live in rural areas. The proportion of older people in the population is below the national average, as are levels of illness and deprivation.

### Local NHS system and services

Shetland NHS Board has the same functions as mainland NHS boards. It is responsible for improving the health of the local population and for the delivery of the healthcare required. The NHS board provides strategic leadership and has overall responsibility for the efficient, effective and accountable performance of the NHS in Shetland.

There is one community health partnership (CHP). A 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 Shetland (www.show.scot.nhs.uk/shb).

### 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 Shetland, 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 Grampian.

There is one maternity unit based at Gilbert Bain Hospital, Lerwick, as well as a community midwifery service. This is supported by three GPs with a special interest in obstetrics. The number of births remained relatively static over the last 5 years as illustrated in the following table.

| NHS Shetland | Number of births | | | | |
|---|---|---|---|---|---|
| | 2001 | 2002 | 2003 | 2004 | 2005 |
| Gilbert Bain Hospital | 144 | 131 | 167 | 167 | 127 |
| Births in Aberdeen | 85 | 77 | 79 | 63 | 91 |
| Home births | 5 | 6 | 0 | 1 | 0 |
| Other (eg born before arrival) | 1 | 0 | 0 | 0 | 0 |
| **Total births** | **235** | **214** | **246** | **231** | **218** |

## 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

There are clear lines of responsibility for the planning and delivery of maternity services in NHS Shetland. Shetland's maternity service is midwife-led with support from three obstetric GPs. In addition, the service is supported by the specialist regional service at Aberdeen Maternity Hospital.

The review team noted the Board's efforts to redesign its maternity service provision over the past 2 years and, in particular, noted the good practice of having input from public involvement via the maternity services forum as part of its redesign work. A maternity services strategy has been drafted and forms part of the Board's 'NHS Shetland 2020 Vision of Shetland's Healthcare'. The review team commended both the work undertaken to date as part of the redesign programme and the development of a draft maternity strategy. A maternity services liaison committee has also been set up and meets quarterly to advise the Board on all aspects of maternity services in NHS Shetland.

There is a policy in place for the recording of all critical incidents to ensure these are reported, investigated and analysed, as well as a system to record compliments, comments and any complaints. Women are first informed that they can express their views about their experience during pregnancy and childbirth at parent education classes. There is also a follow-up by midwives at the post-delivery stage prior to discharge from hospital.

There are procedures in place for the safe transfer of women during pregnancy, childbirth and with their newborn baby at the postnatal stage in emergency situations. Due to Shetland's geographical layout, transfer involves the air ambulance service and the national neonatal transport service. The Board complies with the Expert Group in Acute Maternity Services in Scotland (EGAMS) criteria with regard to risk assessment. All women who are considered to be low risk cases are delivered locally, while women with high risk factors identified during their pregnancy are referred for specialist assessment and delivery in the consultant-led service at Aberdeen Maternity Hospital.

There is a named midwife for all women who is responsible for their care plan. Women are provided with a good range of information and support from midwives at the antenatal stage in order to make an informed choice regarding their chosen place of delivery. The review team noted the excellent range of information provided by midwives to support the decision-making process. In situations where it is not always possible to honour a woman's preferred choice because of medical or resource reasons, midwives will explain to women the reason why their preferred choice cannot be provided.

The Board has a system in place known as a 'talk back debrief session' to enable women to reflect on their birth experience. Women are invited to record their comments on a 'talk back form'. Forms are reviewed on completion and any issues noted would be addressed as they arise.

**Example of a local initiative…**

Previously, only women who delivered their babies in the maternity unit at Gilbert Bain Hospital would have an opportunity to complete 'talk back forms'. Women who delivered at Aberdeen Maternity Hospital could only feedback by means of informal discussions with their community midwife once back in Shetland. However, practice regarding 'talk back forms' has changed and these are now completed at discharge by community midwives to allow all women, wherever they deliver, to comment on the care they received. Completing the forms at a later stage also allows women more time to consider the care they received.

The Board provides training for all healthcare professionals on how to communicate information in an effective and sensitive way. Two local midwives have undertaken a counselling skills course. There is a procedure for supporting and informing parents bereaved by miscarriage or soon after birth and the Board reported that it anticipates work in this area will become further developed as part of the Board's commitment to maternity services.

A local handheld maternity record is provided for all women. The review team commended the comprehensiveness of the record. The Board has set up a working group to take forward the implementation of the new national handheld maternity record.

### Pre-conception and Very Early Pregnancy

The Board has a pre-conception service for women with diabetes which is provided and audited as part of the obstetric GP service. Specialist advice is available from the obstetric and diabetic clinic at Aberdeen Maternity Hospital, where all pregnant women with diabetes are referred to have their care planned and co-ordinated. In addition to the diabetes service, the Board has a system in place to provide pre-conception services for women with a personal or family history of significant illness. This would be provided on an individual basis with support from NHS Grampian as appropriate to individual requirements. As well as providing pre-conception support for women with a history of diabetes, personal and family history of significant illnesses, there is also dedicated midwifery support for women and their partners who have undergone a programme of successful assisted reproduction. Midwives provide support from pre-conception through to the delivery stage.

There are formal arrangements in place for referral to the early pregnancy assessment service (EPAS). However, at the time of the review visit, this service was only used by GPs and not other healthcare professionals. The review team would encourage the Board to expand referral procedures to all healthcare professionals as

appropriate. In addition, while there are no documented formal arrangements in place for women to self-refer to an EPAS, the review team was informed that women can contact the maternity unit at Gilbert Bain Hospital at any stage if they have concerns regarding their pregnancy. The review team noted that during their booking appointment, women are encouraged to contact or visit the maternity unit and would encourage the Board to formalise this good practice.

An ultrasound service is provided by one ultrasonographer from 9am–5pm basis, Monday–Friday. This is a general, as well as an obstetric scanning service. Although this service is being provided, the review team highlighted it as both a strength and a challenge to the Board: a strength in terms of one member of staff being able to provide the current level of service locally; and a challenge in terms of its sustainability due to the entire service being dependent on just one member of staff. The review team would encourage the Board to review arrangements to support the continued availability of this service.

### Pregnancy

The Board has a written syllabus of education for childbirth which has been developed by hospital and community midwives. The syllabus outlines the aims, themes and outcomes of the education programme which is provided for all women.

**Example of a local initiative…**

The review team commended midwives for their efforts in encouraging all women to undertake the education programme, especially for their one-to-one approach both during and out-of-hours depending on individual circumstances to attend classes and, in particular, for arranging to meet on an individual basis very late in the evening, if required.

The education programme also includes a postnatal reunion held at Gilbert Bain Hospital. A postnatal support group is also held on the island of Whalsay and is available for all women with babies ranging from 6 weeks to 8 months. This support group covers a wide range of topics, and plans are in place to include additional topics for future classes.

The Board has procedures in place to ensure that all women have a plan for antenatal care which accounts for risk, and acknowledges that women can move between different levels of care and lead professionals. It is local practice that all women are booked-in in accordance with the criteria outlined in the EGAMS report. NHS Shetland has clear criteria and risk management documentation in place for women regarding specialist referrals.

### Childbirth

The Board has undertaken an audit which confirms that all women receive one-to-one care during labour and childbirth by a registered midwife. There are normally two healthcare professionals present for each delivery. This will either be

two midwives or a midwife and an obstetric GP. Additionally, in some instances, a student midwife will also be present.

In cases where a home birth can be resourced, there will be a minimum of two trained midwives present. However, the Board highlighted a challenge in that it is not always possible to provide a home birth service due to midwifery resources and Shetland's geographical layout. The review team noted that this service is not regularly requested and that every effort is made to provide a home birth service where possible.

Information regarding pain management is provided for all women and there is access to a range of pain management techniques which include transcutaneous electrical nerve stimulation (TENS); oral analgesia; intramuscular analgesia; Entonox (known as gas and air); and the use of water for pain relief. All women who have an operative delivery have their pain assessed using a pain assessment tool. The Board does not routinely offer epidural as a form of pain relief, however, it is provided in some instances where considered appropriate. The review team would recommend that the Board undertakes a risk assessment of these cases and also checks that it complies with the guidance provided by the working party of The Royal College of Anaesthetists (RCA), the Royal College of Nursing, the Association of Anaesthetists of Great Britain and Ireland, the British Pain Society, and the European Society of Regional Anaesthesia and Pain Therapy. "Good Practice in the Management of Continuous Epidural Analgesia in the Hospital Setting (RCA, November 2004)".

The Board has an emergency '222 call out system' in place to ensure a rapid response to obstetric emergencies. This service is also available for neonatal emergencies, caesarean sections and cardiac arrests. There is a clear, formal procedure in place to obtain this service.

### Postnatal and Parenthood

There are procedures in place to ensure that women are assessed immediately after giving birth by their midwife and/or sometimes an obstetric GP. Postnatal checks are documented. Women are formally assessed again prior to transfer to the community, normally by the midwife who delivered the baby. Women who deliver at home are assessed by a community midwife within 24 hours of delivery. This is followed up by ongoing assessment for the recognition of complications, eg infection, haemorrhage, thromboembolism and anaesthetic problems.

The Board was awarded UNICEF/WHO Baby Friendly status for the maternity unit at Gilbert Bain Hospital in January 2003. The review team observed the excellent facilities in place for women and their babies and commended Board staff on the achievement of this award.

**Example of a local initiative…**

Women who breastfeed their babies are encouraged to use the facilities in the Gilbert Bain Hospital Maternity Unit anytime they are in Lerwick, eg shopping etc. New mothers are also encouraged to visit the unit's information resource facilities.

Women are provided with information and support in their chosen method of feeding. There is a breastfeeding management workbook for women which the Board has adapted from UNICEF/WHO.

The review team noted the high breastfeeding rates and commended the Board on the achievement of sustaining these rates. Women who choose bottle feeding methods are given support, advice and information on preparing formula feeding safely. Support is normally provided on a one-to-one basis.

The Board has a policy in place for the immediate care of the newborn to ensure that all babies are clinically examined by a midwife within 1 hour of birth. Details of the examination are recorded in the mother's notes. In addition, there is ongoing assessment of babies for the recognition of group B streptococcal infection on a daily basis as part of postnatal care. Babies are also checked for early signs of jaundice. If suspected, phototherapy is administered instantly as treatment at an early stage may prevent the baby having to be transferred to Aberdeen Maternity Hospital at a later stage for additional treatment.

The review team concluded that the Board has an established pathway of care for discharging women and babies from hospital back to the community. Once discharged, women are followed up by the community midwife/health visitor service and are provided with discharge summaries. Women are also provided with an appointment for a postnatal visit the following day. The review team commended the Board for achieving all of the essential criteria in Standard 5.

# 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 Shetland

### Essential Criteria

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

STATUS: **Met**

The director of patient services is the named individual at Board level with responsibility for maternity services.

*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 operates an integrated health system and the director of patient services has overall responsibility for maternity services. The acting medical director is the named clinician with responsibility for maternity services at Board level. The service is supported by three obstetric GPs.

*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**

Maternity services within NHS Shetland have been undergoing a period of redesign over the past 2 years. The maternity services strategy is currently in draft form and is outlined in the Board's 'NHS Shetland 2020 Vision of Shetland's Healthcare'. The review team commended the Board for all the redesign work and efforts to develop a strategy for maternity services, which is expected to be established in the near future.

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

STATUS: **Met**

The Board has a maternity services liaison committee (MSLC) which meets quarterly. The committee functions as a multidisciplinary forum to advise the Board on all aspects of maternity services and has representation from midwifery, surgical, medical, the ambulance service, members of the public, clinical governance, public health and patient services. Although the committee is currently chaired by the Board's nursing director, the Board anticipates having a lay chair in place as soon as possible.

## 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 Shetland

### 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**

The Board has an organisational policy in place for reviewing and dealing with incidents in terms of formal recording, action, sign-off and feedback. Maternity services operate within this policy. The review team was informed that, in the first instance, a critical incident would be reported to the director of patient services, who would then discuss it with the Board's director of public health. Preventative measures would then be put in place to ensure a fast response. Each incident would be formally recorded on a national IR1 incident reporting form.

From a more specific maternity aspect, GPs and midwives meet every 6 weeks to review instrumental deliveries, caesarean sections and women who are considered to be high risk cases. Any issues or patient care concerns relating to mothers or babies would be discussed at these meetings. In addition, the local supervising authority (LSA) representative and supervisor of midwives meet regularly. Any maternity services clinical incidents would be discussed at this meeting as it would have been reported to the LSA representative who would also be involved in investigating and action planning to prevent a similar reoccurrence. The review team was informed that the Board's small team of midwives and GPs promotes good communication and working ethics, and any issues would also be discussed informally within this team.

The Board provided the review team with an example of an incident which led to an action plan being developed and changes to practice implemented. The review team commended the good communication structures in place.

*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 procedures in place to allow women to express views about their experience of pregnancy and childbirth. Women are first informed about this during

parent education classes. This is followed up post-delivery when midwives inform women that there will be an opportunity for women to review their care prior to discharge from hospital.

The Board is proactive in requesting comments by advertising the opportunity to comment in leaflets and posters throughout all the Board's premises. Comments leaflets are also placed in maternity unit bedside lockers to encourage women to feedback on their experience. Feedback forms are maintained by the Board's senior clinical midwife. Information from these forms is used to review and change practice where considered appropriate.

The Board also has a formal complaints procedure and this is also advertised in leaflets and posters. The review team was informed that there has not been any complaints to date in relation to clinical care in the delivery of maternity services and that only general comments in relation to food and general care have been received. The Board reported that any issues are discussed by staff on a regular basis at the GP and midwives meeting. Examples of suggestions which the Board has acted on include improvements to decor and furnishings to improve the appearance and comfort of the maternity unit.

*1b.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: **Met**

The Board reported that the ambulance service responds to an obstetric emergency in the same way as any other medical emergency. The review team was informed that due to Shetland's geographical layout, women in the outer islands are advised by their GPs to book into the maternity unit at the Gilbert Bain Hospital, Lerwick, at the 38–39 week stage of their pregnancy. Women who are considered to be high risk are also transferred to the Aberdeen Maternity Unit at this stage. Should an emergency arise where air ambulance is required, there are procedures in place to utilise this service which would be used in conjunction with the lifeboat service as determined by weather conditions. GPs and midwives escort road and air ambulance emergencies as required and, in some cases, midwives from Aberdeen will provide the escort service. Although the Board is meeting this criterion in terms of having procedures in place, there was some concern regarding the time involved from initially contacting the air ambulance service to the transferral of the patient. The review team acknowledged that this time delay is outwith NHS Shetland's control.

There is a national neonatal transport service which would be initiated in the case of a neonatal emergency. The Board has guidelines in place for the use of this service.

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

STATUS: **Met**

There is a local network of services in place for women and their babies. The Board also has a formal service level agreement with NHS Grampian for provision of specialist maternity services, therefore, if a service is not available locally, it can be accessed at Aberdeen Maternity Hospital for which there are specific referral forms.

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

STATUS: **Met**

The Board has three obstetric GPs; pregnant women will be referred by their own GP to one of these GPs for assessment. High risk women are referred to a consultant obstetrician at Aberdeen Maternity Hospital by an obstetric GP. Women, who are booked to deliver their baby in Aberdeen Maternity Hospital, would continue to receive their antenatal care by midwives in Shetland prior to being transferred to Aberdeen for delivery at approximately 38 weeks gestation.

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

STATUS: **Met**

There is a system in place to audit specific aspects of maternity care, this includes audits of: caesarean sections; breastfeeding rates; parent education; and risk assessment. The clinical governance support team assist clinical staff with audit. While there is ongoing audit of breastfeeding rates, the review team would recommend that a rolling programme of audit is established.

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

STATUS: **Met**

There is a training programme in place for all professionals directly involved in childbirth to update staff regarding basic adult, obstetric and neonatal resuscitation and immediate care. Advanced neonatal resuscitation courses are scheduled regularly. Courses are well attended by obstetric GPs, midwives, nursing auxiliaries, anaesthetists and accident and emergency (A&E) staff as appropriate. Board staff reported that an advanced life support in obstetrics (ALSO) trainer has recently been

appointed and is currently preparing an ongoing training plan for all staff involved in maternity services. Courses include neonatal resuscitation, breastfeeding management, basic life support in maternity services and adult resuscitation.

The review team was also informed that the maternity unit has a variety of mannequins to support training in terms of adult and baby resuscitation, childbirth, perineal suturing and cannulation.

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

STATUS: **Met**

Board staff reported that risk assessment is undertaken for individual women as per the Expert Group in Acute Maternity Services in Scotland (EGAMS) booking criteria and provided the review team with copies of the risk assessment followed. In addition, risk assessment is also carried out for specific situations relating to islands with no resident GP, home deliveries and water births. There is an antenatal care model in place outlining levels of care provided by individual professionals in Shetland and Aberdeen.

*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: **Not met**

Although the Board has established a multi-agency working group to develop a strategy for domestic abuse, progress in this area has been delayed over the past year because of staff leave. Nevertheless, domestic abuse awareness is practiced by midwives as part of antenatal care. Women are provided with information and contact details for local and national support groups should they wish to access these services. The Board has funded a midwife to undertake specialist training in this area and domestic abuse awareness training for all relevant staff has been scheduled. The review team was informed that training courses in general are well attended.

*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 applicable**

The maternity unit at Gilbert Bain Hospital is a level 1c midwife-led unit with obstetric GP support. This criterion is, therefore, not applicable to this maternity unit. However, general adult high dependency unit (HDU) facilities are available

within the hospital and would be utilised prior to transfer if an emergency situation arose. Alternatively, the staffing resource and equipment could be transferred to the maternity department to care for the patient there prior to transfer.

*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: **Not applicable**

The maternity unit in Gilbert Bain Hospital is a level 1c midwife-led unit with obstetric GP support. This criterion is, therefore, not applicable to this maternity unit. However, referral protocols are in place for access to these specialist services within Aberdeen Maternity Hospital, which is part of NHS Grampian services.

*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: **Not applicable**

The maternity unit in Gilbert Bain Hospital is a level 1c midwife-led unit with obstetric GP support. This criterion is, therefore, not applicable to this maternity unit.

*1b.13: Clinical Complications: Where full adult intensive care facilities are not currently available on-site in level llc 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 in Gilbert Bain Hospital is a level 1c midwife-led unit with obstetric GP support. This criterion is, therefore, not applicable to this maternity unit.

*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: **Met**

Although there are no adult intensive care facilities, advanced imaging and cardiology on-site at Gilbert Bain Hospital, EGAMS criteria are used to enable early screening of women who may require specialist services. Procedures are in place to arrange for the care of women with significant medical or obstetric illness in the consultant-led

specialist unit in Aberdeen. In addition, NHS Shetland has procedures in place to stabilise women in emergency situations and there is a protocol in place for all obstetric and neonatal emergencies.

*1b.15: Clinical Complications: Neonatal intensive care unit (NICU) facilities are available on-site in level llc and level lll 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: **Not applicable**

The maternity unit at Gilbert Bain Hospital is a level 1c midwife-led unit with obstetric GP support, therefore, this criterion is not applicable to this maternity unit. Although neonatal intensive care facilities are not on-site at Gilbert Bain Hospital, all women are assessed during pregnancy. Cases considered to be at a risk level, which may require specialist neonatal facilities, are transferred to the specialist unit at Aberdeen Maternity Hospital to ensure the baby is delivered where these facilities are available on-site.

Should a neonatal emergency arise on the island, emergency services would be initiated via the emergency neonatal retrieval air ambulance team.

*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: **Not applicable**

The maternity unit in Gilbert Bain Hospital is a level 1c midwife-led unit with obstetric GP support. This criterion is, therefore, not applicable to this maternity unit.

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

STATUS: **Not applicable**

The maternity unit in Gilbert Bain Hospital is a level 1c midwife-led unit with obstetric GP support. This criterion is, therefore, not applicable to this maternity unit.

## 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 Shetland**

**Essential Criteria**

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

STATUS: **Met**

There is a named midwife for all women who is responsible for the care plan of each woman. The Board reported that, in the maternity unit, named midwives are allocated on a team basis, whilst in the community, named midwives are allocated on a geographical basis.

*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**

Discussions between women and midwives provide the opportunity for midwives to explain details of birth place options. These discussions form part of the antenatal care provided by midwives and assist women and their partners to make an informed choice regarding their preferred place of birth for their baby.

The review team noted the excellent range of information leaflets, books and videos available in the maternity unit which can be loaned out to women to support the information provided by midwives. In NHS Shetland, women can choose to have their baby in the maternity unit at Gilbert Bain Hospital, the specialist unit at Aberdeen Maternity Hospital or alternatively at home. Requests to deliver a baby at home are only accepted where midwifery staffing resources are sufficient to provide this service.

In situations where a woman's preferred choice of birth place cannot be honoured because of medical or, in cases of home birth requests, staff resource or geographical reasons, midwives will explain to women the reason why their preferred choice cannot be provided.

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

STATUS: **Met**

There is a general consent policy in place and one consent form is used for all specialties. Consent is discussed with women at their booking appointment and information leaflets are also provided at this stage. When women return for blood checks, midwives confirm that women have read and understand the information. At this stage, the woman will sign the consent form and bloods will be obtained.

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

STATUS: **Met**

The Board has arrangements in place for women to reflect on their birth experience. This is provided in a 'talk back debrief session'. Women are asked to record their comments on a 'talk back form'. The review team was informed that forms are reviewed on completion and any issues would be addressed as they arise.

*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 communication skills is a major component of all training courses, in particular, breastfeeding courses, train the trainers preparation, mentorship preparation, supervisor of midwives preparation, child protection training and domestic abuse training. The Board also reported that two midwives have undertaken a counselling skills course. A copy of the maternity unit's communication skills training for staff was provided to the review team. It covers the skills of communication, the importance of non-verbal and good verbal communication skills, as well as specific communication styles in relation to communicating with new mothers in terms of being able to empathise and show understanding, building confidence and giving support. The Board reported that all maternity staff have undertaken this training programme.

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

STATUS: **Met**

The Board has a procedure in place for supporting and informing parents bereaved by miscarriage and reported that it anticipates that work in this area will be further developed as part of its ongoing activity around early pregnancy loss. There are currently guidelines in place for still birth or neonatal death as well as a range of information leaflets for local and national support groups. There is an information resource folder in the maternity unit to provide guidance for staff in terms of what information is available for bereaved parents.

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

STATUS: **Met**

The Board monitors and evaluates information provided to women in a number of ways. Midwives use a checklist to record the information provided to women at the antenatal stage. Feedback on information provided to women is monitored. An audit has been conducted on the effectiveness of the antenatal information provided to women and a further audit is planned to review the content of the Board's postnatal information.

## 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 Shetland

### 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**

Maternity unit staff are very proactive in encouraging partner/family involvement from the antenatal stage through to delivery. Board staff reported that partners and family, for example grandparents attendance at antenatal classes and at labour and delivery stages is very good. Staff encourage women and their partners/friend to tour the unit. The information leaflet 'Congratulations! You are having a baby', provided to expectant mothers, invites women and their partners or a friend to visit the maternity unit to meet the midwives and discuss any queries they may have. The telephone number for the unit is provided in the leaflet so that women can organise a mutually convenient time to visit. Partners are also encouraged to participate in parent education classes regarding the intrapartum experience and education in terms of how to care for the baby. The Board reported that specific information sessions for fathers and grandparents are also provided on an informal basis as required.

The Board has also produced an information leaflet for 'Dads' which outlines feelings that are usually experienced by fathers-to-be, things they can do to help support their partner throughout the pregnancy and delivery, what to take to hospital, how to contact the maternity unit at the labour stage and what information they will be required to provide to midwives in terms of frequency of contractions etc. The leaflet also provides information on how to be a good labour partner and how they can get involved with their baby.

The maternity unit's visiting hours are between 3–8pm, while fathers are welcome in the unit at anytime.

## 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 Shetland

### Essential Criteria

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

STATUS: **Met**

A local handheld maternity record is provided for all women. The review team commended the comprehensiveness of the record. The Board reported that a working group has been established to take forward the implementation of the new national Scottish 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**

Midwives take responsibility to ensure that the Scottish birth record and birth notification is completed for all women and newborn babies. The Board reported that there are two dedicated members of staff to ensure correct coding of clinical activity. There are formal guidelines in place to ensure the Scottish birth record is completed and all births are cross checked by the child health department to ensure accuracy.

### 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 Shetland 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 Shetland

### 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: **Met**

There is a pre-conception service available for women with diabetes. This service is provided and audited as part of the GP service and each woman with diabetes, who is planning a pregnancy, receives individual care as appropriate to their requirements. Specialist advice is available from NHS Grampian. When pregnant, women with diabetes have their care planned and co-ordinated at the obstetric and diabetic clinic at Aberdeen Maternity Hospital. Likewise, women who are diagnosed with gestational diabetes are referred to a consultant obstetrician at Aberdeen Maternity Hospital for specialist care. NHS Shetland has guidelines in place for maternity care, which outline the service provided for the management of pre-conception care, and diabetes assessment and advice during pregnancy and delivery. The SIGN guideline for diabetes is used when referring women for specialist care.

### 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: **Met**

The Board reported that the number of women at individual general practice level who have a history of significant illness will be relatively small and, therefore, well known to the practice. As with the pre-conception service for women with diabetes, women with a history of significant illness receive individualised care as appropriate to their individual requirements. Depending on the circumstances, the GP will seek specialist advice from staff in Aberdeen or, alternatively, will refer their patient directly to the consultant obstetric clinic at Aberdeen Maternity Hospital.

The review team was informed that there are currently two dedicated midwives at Gilbert Bain Hospital's maternity department who provide care for women and their

partners who have undergone a successful programme of assisted reproduction. These midwives carry out some investigations from the pre-conceptual phase through to the postnatal stage as well as general health education and referral to other services as necessary. Where possible, depending on geographic location, women who successfully achieve pregnancy through the assisted programme will have the midwife known to them from the assisted reproduction programme as their named midwife for the duration of their pregnancy.

## 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 Shetland

### 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**

Although there are arrangements in place for the referral of women to an early pregnancy assessment service (EPAS), the review team concluded that the Board is currently not meeting this criterion; while formal referral arrangements are in place for GPs, there are no formal arrangements in place for other healthcare professionals to make a referral. This currently happens informally. There is a good documented process for the assessment and management of women who experience an early pregnancy loss, as well as pathways of care for non-viable pregnancies and abdominal pain. The review team noted that current practice allows all patients to be seen as and when necessary, but would recommend that the Board formalises this practice and expands formal referral arrangements to all healthcare professionals.

*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: **Not met**

The Board reported that while there are no documented formal arrangements in place for women to self-refer to an EPAS, women can contact the maternity department at Gilbert Bain Hospital, their GP or NHS 24 if they have any concerns regarding their pregnancy. The review team was informed that, at the initial booking appointment, women are encouraged to contact or drop in to the maternity department at any time. The review team would encourage the Board to formalise this good practice.

*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**

Women who experience early pregnancy complications or loss are cared for in a single room in the hospital's general surgical ward. There are good links between ward staff and midwives to provide support and care for women during this time. Women are given the option to see a midwife whilst in the general surgical ward or alternatively they are given contact details should they wish to contact the maternity department following their discharge from hospital. There are formal care plans in place for women who are experiencing symptoms of threatened miscarriage and miscarriage. These facilitate documentation of the woman's condition, the expected outcome and the nursing intervention required. The care plan forms also record the woman's name, unit number, date and are signed by nursing staff.

The Board also informed the review team that should a woman present with an early pregnancy complication direct to the maternity unit at Gilbert Bain Hospital and requires to be transferred to specialist services at Aberdeen Maternity Hospital, when in Aberdeen, the woman would also be accommodated in single room facilities. If the complication did not involve a pregnancy loss, the woman may be accommodated in a quiet area of the maternity ward away from mothers and babies in the department at that time.

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

STATUS: **Met**

Women who miscarry are offered a choice of management options depending on their condition. There is a 'wait and see' approach and also the option of surgical intervention which is carried out at Gilbert Bain Hospital. Alternatively the woman can be transferred to the Rubislaw Ward at Aberdeen Royal Infirmary.

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

STATUS: **Met**

The Board has one full-time ultrasonographer who provides a general and obstetric scanning service Monday–Friday from 9am–5pm. There is a dedicated scanning slot available at 9am daily for emergencies. While the review team considered that this criterion is generally met, it recognises that it is not always possible for the Board to meet this criterion as there is only one member of staff responsible for this service. The review team recognised that while the ultrasound service provided is a strength

to the service, it highlighted the lack of resource in this area as a challenge, in particular, the absence of cover for annual and professional leave. This is currently provided in Aberdeen when required.

The ultrasonographer spends 1 week per year providing obstetric scanning in Aberdeen.

### Desirable Criterion

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

STATUS: **Met**

Telemedicine facilities are particularly useful to the Board because of Shetland's geographical location and are used for seeking specialist clinical opinions, meetings, etc. It is very cost effective for training purposes as it enables island staff to participate in mainland training sessions without the Board incurring travel and accommodation costs. It also eliminates the inconveniences associated with having to travel between the island and mainland. The review team was informed that the ultrasonographer uses telemedicine facilities to send scan images to Aberdeen when it is necessary to seek specialist opinion regarding the possible transfer of a woman from the maternity unit at Gilbert Bain Hospital to Aberdeen Maternity Hospital. If transferred, the woman would be rescanned in Aberdeen.

The Board has several videoconferencing facilities in the hospital and Board area. In addition, facilities are installed in all GP practices and non-doctor islands to promote good access to communication for training and clinical opinions within Shetland as well as between the island and the mainland. The review team considered the extent of these facilities to be good practice.

## 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 Shetland

### 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 of education for childbirth in place developed by hospital and community midwives. The syllabus is used by all midwives in Shetland to promote a consistent childbirth and parent education programme to all women within NHS Shetland. The syllabus outlines the aims, themes and outcomes of the education programme. The programme is provided for all women. There are dedicated sessions for specific women, eg women who have multiple pregnancies or who will be delivering in Aberdeen Maternity Hospital. The review team commended the midwives for their efforts in encouraging all women to undertake this education programme, in particular, for their one-to-one approach both during and out-of-hours depending on individual circumstances.

*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 senior midwife with recognised training and experience who leads the education programme for the Board. There is also a named lead for the co-ordination of education and training for midwives.

### Desirable Criteria

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

STATUS: **Met**

The Ready, Steady, Baby book is provided to women by their named midwife at the first booking appointment. The book forms part of the information pack used by midwives when undertaking a booking appointment. GPs provide general

information to women on confirmation of pregnancy and use a checklist system to note details of the information provided. This is followed up by midwives with further information and leaflets.

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

STATUS: **Met**

A postnatal reunion is included as part of the Board's parent education programme. The reunion is held at Gilbert Bain Hospital. Health visitors provide a 4–6 week course. Physiotherapists also provide a postnatal exercise programme for women to help prevent pelvic floor problems developing.

In addition to the reunion course at Gilbert Bain Hospital, a postnatal support group is also held on the island of Whalsay. This group is aimed at all women with babies aged from 6 weeks to 8 months and covers a range of topics from baby massage techniques to diet, first aid and child resuscitation. Future courses are planned to include additional topics on child behaviour and sleep problems; child development; postnatal depression; and maternal health.

## Standard 3(b): Standard 3 ~ Pregnancy

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

**NHS Shetland**

**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 hospital-based midwifery unit and community midwives adhere to the national programme for antenatal screening. National standards are followed and standard leaflets and consent forms are used for screening purposes. Women who are screened as rhesus negative are provided with an information leaflet and the woman's care is managed in accordance with NICE Guideline 41 as nationally recommended by NHSScotland. The Board is also developing a local guideline for the administration of Anti-D immunoglobulin for all rhesus negative women in pregnancy and in the postnatal period.

*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: **Met**

The Board reported that past practice has been to provide antenatal care in a schedule of nine visits. Following an audit of notes of women who delivered between May and July 2005, new local guidelines have been developed to conform to the guidance set out in 'A Framework for Maternity Services in Scotland' which includes a fetal anomaly screen at 20 weeks gestation. The Board provided the review team with a copy of the new guidelines for antenatal care in NHS Shetland on the day of the review visit.

## 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 Shetland

### 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: **Met**

There are procedures in place to ensure that all women have a plan for antenatal care which accounts for risk, and acknowledges that women can move between different levels of care and lead professionals. In NHS Shetland, all women are managed in accordance with the criteria outlined in the EGAMS report.

The maternity department at Gilbert Bain Hospital is a level 1c midwife-led unit. All women booked to deliver at Gilbert Bain Hospital are considered low risk deliveries. Decisions regarding levels of risk are made by obstetric GPs in consultation with midwives as a 'fail safe' measure. Women who are identified as high risk are booked to deliver in the specialist consultant obstetric unit at Aberdeen Maternity Hospital and are normally transferred at 38 weeks and 6 days. Women who are initially considered low risk and are identified as high risk as a result of developing complications throughout their pregnancy will also be referred to Aberdeen Maternity Hospital for specialist care.

NHS Shetland has clear criteria and risk assessment documentation in place for women regarding specialist referrals.

*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**

The Board reported that women are encouraged to write their own birth plan during their antenatal care. Women who do not do this are given the opportunity through discussion to develop their plan with their named midwife. Women are also informed that their preferred birth plan may change if their level of risk increases.

Women are offered a choice of place of birth of their baby. The options range from a home birth, to delivery at Gilbert Bain Maternity Hospital or the specialist consultant-led unit at Aberdeen Maternity Hospital. The provision of a home birth

service is limited by the availability of adequate midwifery resource to support a home delivery service. A portable birthing pool is available for women who wish to have a water birth.

*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: **Met**

The Board provided the review team with a copy of its protocol for antenatal care. The routine level of antenatal care is nine visits for primigravida women. Until recently, nine visits was also the routine pattern of care for multigravida women, however, following completion of an audit of women who delivered between May and July 2005, these visits have been reduced to eight to conform to the recommendations in 'A Framework for Maternity Services in Scotland'.

## 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 Shetland**

**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 Board reported that all women who are cared for at Gilbert Bain Hospital Maternity Unit receive one-to-one care during labour and childbirth by a registered midwife. This practice has been audited and results confirmed that 100% of women receive one-to-one care. There are usually two healthcare professionals present for each delivery. This will either be two midwives or a midwife and an obstetric GP. The maternity unit also provides placements for student nurses and midwives, however, student involvement is always supervised.

The review team commended the Board for auditing this practice.

*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 reported that it is difficult for midwives to cover a home birth service mainly because of resources and Shetland's geographical layout. The review team was informed that the home birth service is not regularly requested. Every effort is made by midwives to cover a home birth request and the Board reported that from the woman's 38th week, two midwives will be on-call 24 hours a day to cover the home birth. There are always two midwives scheduled to attend a home birth. The review team noted the excellent team working between midwives to cover and support this service.

*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**

The maternity unit at Gilbert Bain Hospital conforms to the Aberdeen Maternity Hospital labour ward guidelines. There are local guidelines in place for the management of local issues when Aberdeen guidelines are not applicable because of the practical differences between a consultant-led and midwife-led unit. For example, Shetland has local guidelines in place for obstetric emergencies as arrangements for managing such an emergency in Shetland differs significantly from Aberdeen when transfer is involved. Both local and Aberdeen guidelines detail arrangements for the management of: induction of labour; breech presentation; 3rd and 4th degree perineal repair; caesarean section; prophylactic antibiotics for caesarean section; placenta praevia; prostaglandins and oxytocin use; management of thromboembolism and thromboprophylaxis; water birth; epidural analgesia; fetal monitoring; management of multiple pregnancy; diabetes; pre-eclampsia and eclampsia; declination of blood products; haemorrhage; prolapsed cord; rupture of the uterus; shoulder dystocia; neonatal resuscitation; adult resuscitation; retained placenta; and intrauterine death.

The review team was informed that Aberdeen guidelines were reviewed and updated in July 2005 and local guidelines are reviewed in accordance with changes in clinical practice. The Board also reported that maternity audit undertaken and published by Aberdeen is provided to Shetland for information purposes. It is not known if Shetland women who deliver in Aberdeen are included as part of this audit process.

## 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 Shetland

### 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**

Pain management is discussed on a one-to-one basis normally during a home visit. These discussions are supported by leaflets, books, videos and parent education classes. Midwives use a checklist to record the information provided to women to ensure consistent practice. The checklist covers a comprehensive list of topics discussed and leaflets provided, and has a space to record any additional discussion. Women also receive a detailed leaflet for non-epidural pain relief which provides information, and details the advantages and disadvantages of the various pain relief drugs, complementary therapies and choices available. The leaflet also has a useful section for women to note any questions regarding pain relief during labour for when they next see their midwife or GP. The Board reported that women have access to the following range of pain management techniques: transcutaneous electrical nerve stimulation (TENS); oral analgesia; intramuscular analgesia; Entonox; and the use of water for pain relief.

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

STATUS: **Met**

There is a pain assessment tool in place for all women who have an operative delivery.

### Desirable Criterion

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

STATUS: **Not applicable**

The maternity unit at Gilbert Bain Hospital is a midwife-led unit, therefore, epidural analgesia is not routinely offered. The review team considered this criterion to be not applicable to this service, but noted that epidurals are provided when medically necessary. In such circumstances, the administration and management of the epidural would be the responsibility of the consultant anaesthetist. However, the review team would recommend that midwives are also provided with training to support the management of care provided for these cases.

## Standard 4(c): Standard 4 ~ Childbirth

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

**NHS Shetland**

**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: **Not applicable**

This criterion is not applicable to NHS Shetland as the maternity unit is not a consultant-led unit.

*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: **Not applicable**

This criterion is not applicable to NHS Shetland as the maternity unit is not a consultant-led unit.

*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 September 2004. 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**

The Board has an emergency '222 call out system' in place to ensure a rapid response to obstetric emergencies. This service is also in place for neonatal emergencies,

caesarean sections and cardiac arrests. This is co-ordinated through the reception at Gilbert Bain Hospital and there are clear robust instructions on how to report an emergency.

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

STATUS: **Met**

An audit tool is used to monitor arrangements for 'decision to delivery' and perceived urgency.

### 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 (insufficient evidence)**

Following discussions with Board staff, the review team considered the evidence provided in response to this criterion to be insufficient as it included cases which did not require a 30-minute response time from the anaesthetists.

## 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 Shetland

### Essential Criteria

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

STATUS: **Met**

The Board reported that all women are assessed immediately after delivery by the registered midwife present for the delivery. A GP may also be involved in the women's assessment if they have assisted with the delivery or if there are any complications during the delivery which the midwife is concerned about. In such cases, the midwife would ask the GP to examine the woman. Postnatal checks are documented by midwives.

*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 registered midwife prior to discharge from the maternity unit. This is normally carried out by the midwife who delivered the baby. Women who have a home delivery are assessed within 24 hours by a community midwife. The Board undertook a case review of notes and in all cases it was documented that all women were assessed by a midwife within 24 hours.

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

STATUS: **Met**

The Board has a comprehensive guideline in place for postnatal care which is followed by midwives to ensure mother and baby progress well after delivery. Daily checks are carried out to monitor maternal wellbeing, and additional observation and care is carried out on an individual basis to recognise signs of any complications.

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

STATUS: **Met**

All women have contraception discussed prior to discharge from the maternity unit. Condoms and the information leaflet 'After you've had your baby - contraceptive choices' is also provided. Although there is not a family planning service, women can discuss contraception with their GP and are referred to an obstetric GP if necessary.

## 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 Shetland**

**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 Gilbert Bain Hospital Maternity Unit was awarded UNICEF/WHO Baby Friendly status in January 2003. The review team was given a tour of the facilities and noted the good standard and quality of the facilities available for women and their babies. There are two rooms with facilities for breastfeeding and accessing information in the form of leaflets, books, videos, etc.

*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**

The Board has a breastfeeding policy which provides information for parents. There is also a breastfeeding management workbook for women which NHS Shetland has adapted from the UNICEF/WHO.

Midwives provide women with breastfeeding information at approximately 32 weeks of pregnancy. This is recorded on an infant feeding - antenatal checklist and covers the benefits of breastfeeding to the baby and the mother. This is supported by information leaflets: UNICEF 'Feeding your baby', NHS Health Scotland 'Off to a good start' and the Ready, Steady, Baby book. Information cards containing contact telephone and website details for the National Childbirth Trust (NCT) breastfeeding line and the Breastfeeding Network are also provided to women. Additional information is available in parent education classes and from videos. Women can discuss feeding at any time with midwives.

The Board provided the review team with details of a breastfeeding management updating training day course to enable midwives to complete a programme of education which meets with baby friendly requirements.

Women who choose to use bottle feeding methods are given support, advice and information on preparing formula feeding safely. This is normally provided on a one-to-one basis.

### 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: **Not met**

The Board reported that the infant feeding advisor role is the responsibility of the Board's senior clinical midwife; however, this post is currently vacant. Interviews are scheduled with the aim to having this position filled.

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

STATUS: **Met**

The Board reported that, since January 2003, two babies have been admitted to the maternity unit due to inadequate nutrition, linked to neonatal jaundice. In such cases, advice is sought from the neonatal unit at Aberdeen Maternity Hospital. The review team was informed that admissions due to inadequate nutrition are very rare in NHS Shetland.

## 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 Shetland

### 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, since January 2005, one baby required to be re-warmed. Steps taken by midwives to minimise the number of infants who require re-warming include 'skin to skin' contact immediately following birth, the baby is then dried with a warm towel and a dry towel or blanket is placed over the baby. Baby is then dressed. In cases where babies are resuscitated, this takes place under the heater of the resuscitaire.

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

STATUS: **Met**

The Board has a policy for the immediate care of the newborn as part of its NHS Shetland maternity care guidelines, which lists the steps involved in the examination of the baby within 1 hour of birth. The baby is examined by a registered midwife and the guidance also states that the examination is to be recorded in the mother's maternity notes.

*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**

Babies are examined by an obstetric GP in the maternity unit within 72 hours of birth. Should a woman leave the maternity unit prior to this examination, she is advised that a GP will examine the baby.

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

STATUS: **Met**

There is ongoing assessment of babies for the recognition of group B streptococcal infection on a daily basis as part of postnatal care. Babies of women who have had a group B streptococcal positive low vaginal swab during labour are monitored continuously and the neonatal team at Aberdeen Maternity Hospital would be contacted for further advice. In cases where group B streptococcal is picked up antenatally, women would be advised to go to Aberdeen for delivery. If women choose not to go to Aberdeen, they will be automatically swabbed if ruptured membranes occur and antibiotics given during labour/delivery. Babies would also be observed for 48 hours and if they show any symptoms, the baby's GP would be called and antibiotics administered. In cases where a lumber puncture is necessary, the baby would be transferred to Aberdeen to have this undertaken.

The Board follows Aberdeen Maternity Hospital labour ward guidelines for the recognition of group B streptococcal infection and follows the guidance set out in an information leaflet provided by the Group B Strep Support Charity for the care and management of an infant with group B streptococcal infection.

Babies are checked for the recognition of jaundice as part of the routine daily observation process. Staff reported that phototherapy is administered at an early stage if staff have any concerns regarding jaundice, as early treatment may prevent the baby having to be transferred to Aberdeen Maternity Hospital at a later stage. The baby's serum bilirubin level is also taken and advice is sought from the neonatal team at Aberdeen for babies who have early onset jaundice or severely elevated levels of bilirubin.

## 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 Shetland**

**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 Scottish Birth Record is used to enable the efficient transfer of information between hospital and community staff. This includes detailed information regarding labour and delivery, the infant and postnatal stages.

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

STATUS: **Met**

The Board has an established pathway of care for discharging women and babies from hospital to the community. Staff at Gilbert Bain Hospital telephone the relevant community midwife regarding all discharges. If the midwife is not available, a message is left for them to contact the maternity unit to receive information on the women and baby being discharged. In addition, printed discharge summaries are given to each woman to hand to her community midwife. On discharge, the woman is booked for the first postnatal visit the following day. For women who deliver in Aberdeen Maternity Hospital, discharge information is telephoned to the receiving maternity unit at Gilbert Bain Hospital to allow for follow up care in the community in accordance with the same practice as for women who deliver at Gilbert Bain Hospital.

# Appendix 1 – Glossary of abbreviations

| Abbreviation | |
|---|---|
| **A&E** | accident and emergency |
| **ALSO** | advanced life support in obstetrics |
| **CHP** | community health partnership |
| **EGAMS** | Expert Group in Acute Maternity Services in Scotland |
| **EPAS** | early pregnancy assessment service |
| **GP** | general practitioner |
| **GROS** | General Register Office for Scotland |
| **HDU** | high dependency unit |
| **IR1** | incident reporting form |
| **LSA** | local supervisory authority |
| **MSLC** | maternity services liaison committee |
| **NHS QIS** | NHS Quality Improvement Scotland |
| **NICU** | neonatal intensive care unit |
| **NCT** | National Childbirth Trust |
| **RCA** | Royal College of Anaesthetist |
| **SCBU** | special care baby unit |
| **SEHD** | Scottish Executive Health Department |
| **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 Shetland was conducted on 8 November 2005.

**Review team members**

**Dr Fiona Cameron (Team Leader)**
Consultant Anaesthetist, NHS Tayside

**Mrs Catherine Bryce**
Public Partner, Grampian

**Dr Sarah Court**
Associate Specialist, NHS Lothian

**Ms Audrey Thomson**
Midwife, NHS Ayrshire & Arran

**NHS Quality Improvement Scotland Staff**

**Mrs Morag Kasmi**
Senior Project Officer

**Ms Sharon Keane**
Project Officer

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, MHS 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**
Public Partner, 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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