

NHS Western Isles

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 Western Isles**. This review visit took place on **6 December 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

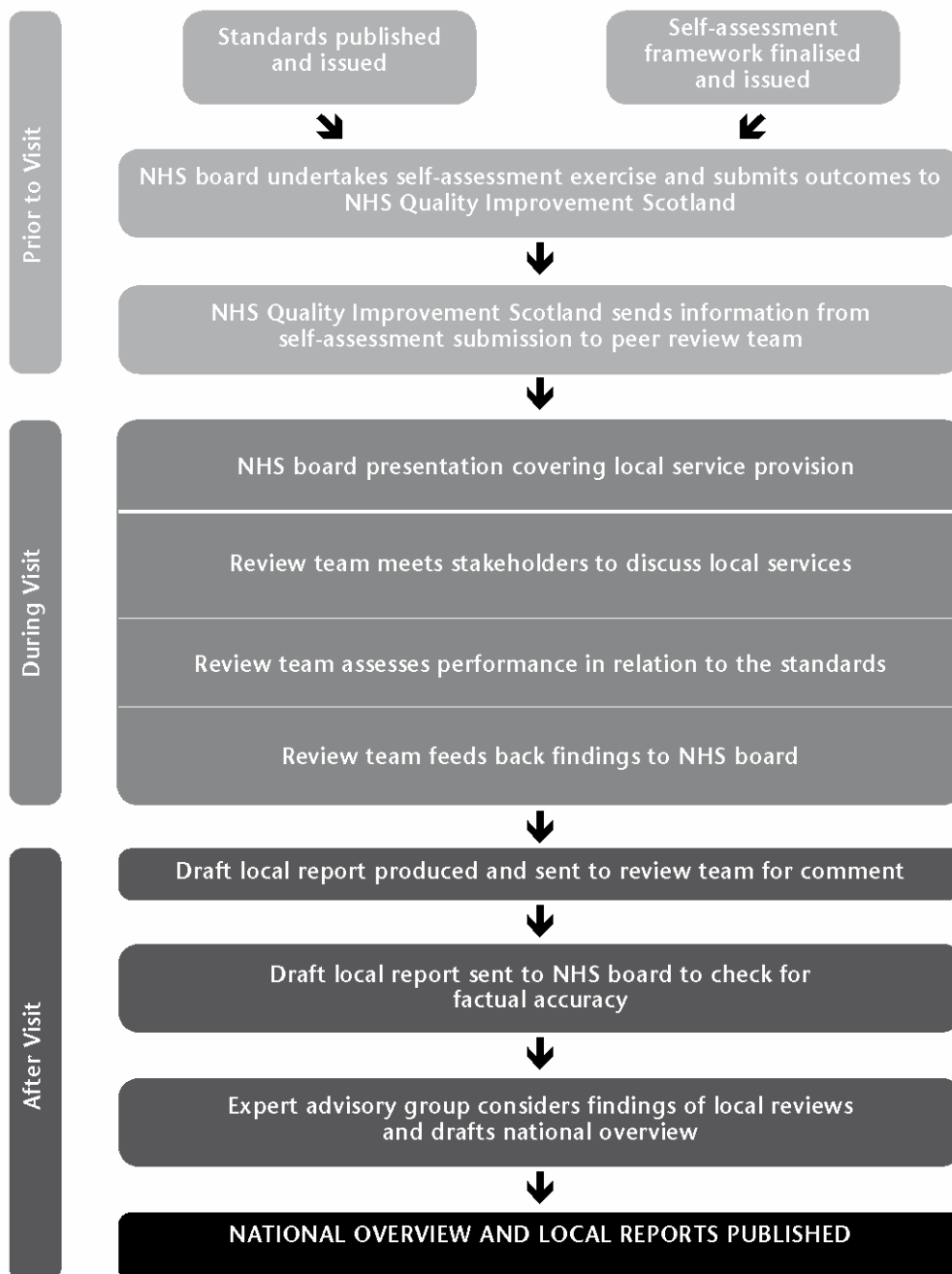
After each review visit, NHS QIS staff, with clinical input as appropriate, draft a local report detailing the findings of the review team. This draft report is sent to the review team for comment, and then to the NHS board to check for factual accuracy. The local report is published only after all the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

The Western Isles is a name covering the Outer Hebrides, an island group situated north-west of mainland Scotland. The population of around 26,260 live on 10 islands, the largest and most populous of which is the Isle of Lewis where the town of Stornoway is located. The proportion of older people in the population is above the national average, as are levels of illness and deprivation.

Local NHS system and services

Western Isles 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 the Western Isles.

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 Western Isles (www.wihb.org.uk).

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 Western Isles, 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 Highland and NHS Greater Glasgow.

There are two maternity units in NHS Western Isles, one is consultant-led: Western Isles Hospital, Stornoway; and one midwifery-led: Uist & Barra Hospital, Benbecula which are supported by a community midwifery service. The number of births have remained relatively static over the last 5 years as illustrated in the following table.

NHS Western Isles	Number of births				
	2001	2002	2003	2004	2005
Western Isles Hospital	188	196	211	173	179
Uist & Barra Hospital	4	6	2	4	7
Home births	1	2	0	0	3
Other (eg born before arrival)	0	0	0	0	33
Total births	193	204	213	177	222

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 Western Isles has a consultant-led maternity service. There are defined lines of responsibility for the planning and delivery of the service. The director of nursing, midwifery and allied health professional services has responsibility for the service at NHS Board level and the senior midwife has responsibility for maternity services at both primary and acute operating levels. The review team would encourage the Board in its efforts to provide senior midwifery manager deputisation to support the senior midwife in the wide remit of this post.

The Board has undertaken work in redesigning maternity services and is currently in the process of developing a maternity services strategy. The review team commended the Board for the excellent maternity facilities complemented by committed, enthusiastic staff and highlighted midwifery one-to-one care during labour as well as continuity of care in the post partum period as a major strength of the service. The review team would however encourage the Board to agree and publish a maternity services strategy.

The Board has set up a maternity services liaison committee (MSLC), which is currently chaired by the Board's senior midwife; while the committee has representation from Uist, there is currently no representation from Barra. The review team would recommend links are established with Barra and that the group is chaired/co-chaired by one of the lay committee members.

The review team commended the Board's policy for healthcare professionals to obtain informed consent for interventions and investigations. There are also comprehensive procedures in place to ensure all critical incidents, comments, compliments and complaints can be reported, investigated and analysed. In addition, there is a feedback system for women to express their views about their pregnancy and childbirth experience known as the 'postnatal review'. This is recorded on a postnatal review debriefing form.

Example of a local initiative...

The Board undertook a patient satisfaction survey between May 2004 and May 2005. The survey highlighted a high level of satisfaction with the service and reflected similar results from a survey undertaken the previous year. The review team commended staff for auditing this area of practice.

Maternity unit staff encourage partner/family involvement at parent education classes and antenatal clinics as well as during labour and childbirth.

Although there is currently no formal policy in place for the identification of women with domestic abuse, Board staff have undertaken a considerable amount of work in this area and plan to have a policy in place in the near future.

In practice, the Board has arrangements in place for women and their babies to access a range of specialist services as well as referring women with significant medical or obstetric illness; however, the review team highlighted the lack of formal protocols in this area as a challenge for the service and would encourage the Board to formalise its existing arrangements into protocols. The review team also supports the Board in its efforts to recruit an audit facilitator to ensure continuity of audit practice while the current postholder is on secondment.

There are arrangements in place between the Board and the Scottish Ambulance Service in terms of providing a general ambulance service throughout the Western Isles, and also for providing an air ambulance service to transfer patients from the Western Isles to a mainland hospital for specialised emergency treatment. The review team noted the logistics involved and time delays incurred in relation to neonatal retrieval. While this is outwith the Board's control, the review team would encourage the Board to address the current arrangements with the Scottish Ambulance Service and explore possibilities of establishing a more efficient retrieval time.

Communication skills training for all staff working in maternity services is undertaken through a variety of means and the review team commended the Board's approach to providing communications skills training for all groups of staff. In particular, the course for senior medical staff was commended by the review team, which the Board plans to roll out to other staff groups. In the maternity unit, the Board's senior midwife maintains a record of all midwifery training.

At the time of the review visit, not all pregnant women in the Western Isles used a handheld maternity record, however, the Board has plans in place to implement the new, national record for all women.

Overall, the review team acknowledged the challenges involved in the geographical distance between Barra and Stornoway in terms of service provision. There are more established links between Barra and NHS Greater Glasgow than between Barra and Stornoway. Although these arrangements appear to work well, the review team would encourage the Board to explore ways of developing closer links with Barra for future service provision.

Pre-conception and Very Early Pregnancy

The Board has a policy for the management of diabetes in pregnancy which outlines practice for the management of women with diabetes from pre-pregnancy through to the postnatal period. There is a mechanism for a diabetic nurse specialist to refer women with diabetes who are planning a pregnancy to the consultant obstetrician for advice and specialist care. The Board does not have any specific pre-conception services for women with a personal or family history of significant illness. However, any woman in this situation would be referred by their GP to the consultant

obstetrician who would assess their case and make an appropriate referral for the woman to see a specialist on the mainland.

There is a mechanism for any health professional to make a referral to the early pregnancy service. There are also arrangements to allow women with early pregnancy problems to self-refer to the early pregnancy service. There are clinical guidelines regarding early pregnancy assessment, and diagnosis and management of an early pregnancy loss. However, the review team noted that there is not a dedicated area for the early pregnancy assessment service (EPAS); this is currently held in an outpatient area of the hospital. The review team would recommend that the Board provides a dedicated area for the EPAS. The Board reported that there is just one ultrasound scanner in the Western Isles Hospital and that only the consultant obstetrician undertakes obstetric scanning for all pregnant women at the Western Isles Hospital. In addition, one GP on the Isle of Uist provides a scanning service locally. In situations where an obstetric scan is required out-of-hours/weekends, this will be treated as an emergency for which the consultant obstetrician provides an on-call service. The review team commended the good level of care provided given the constraints on the service; however, recommended that ultrasonography training is provided for midwives and/or radiography staff to ensure continuity of service provision during leave and long-term sustainability.

On Uist and Lewis, women who require admission to the Western Isles Hospital following an early pregnancy complication are given a choice of ward area. These choices range from a side room in the day surgery unit, a bed in the 'mixed specials ward' or a quiet room in the maternity department. On Barra, women experiencing early pregnancy problems would normally attend services at NHS Greater Glasgow. Women who miscarry have a choice of management options in accordance with the Board's clinical guidelines for the management of an early pregnancy loss.

Pregnancy

There is a written syllabus for the delivery of a parent education programme. On Lewis, midwives provide one-to-one classes for anyone who cannot attend a scheduled class and one-to-one care is also provided for specific groups, eg teenage pregnancy. In the other islands, classes also tend to be offered on a one-to-one basis as appropriate to the number of pregnant women at any one time. The Board's parent education programme also includes postnatal classes. The postnatal reunion class is the first in this series of classes. Women are sent an invitation to attend these classes at 8–12 week post-delivery. The Board evaluates postnatal education by asking women to complete a questionnaire at the end of the series of classes.

Example of a local initiative...

In addition to parent education classes, midwives also provide aquanatal classes at the hydrotherapy pool at Grianan Day Centre, Stornoway. The class provides exercise and relaxation specifically designed for pregnant women from 16 weeks onwards and can be continued from 6 weeks to 18 months following birth.

The Board has an antenatal care plan for all women which takes account of risk factors, and all women with identified risk factors have their care managed by the Board's consultant obstetrician. The review team would recommend a system where women can move in either direction between different levels of care and lead professionals, in line with national guidance on midwifery-led care and risk assessment. The review team commended the high level of midwifery care provided in both the acute and community setting and would encourage the Board to further utilise this resource in terms of midwifery-led care.

The review team commended the Board's protocol for routine Anti-D prophylaxis for rhesus negative women which conforms to the national guidance for antenatal screening. Women are provided with a comprehensive information leaflet to facilitate informed choice regarding Anti-D prophylaxis. All rhesus negative women are asked to complete a consent form to receive Anti-D immunoglobulin at 28 and 34 weeks of pregnancy and again at the post-delivery stage.

The Board reported that amniocentesis is carried out at the Western Isles Hospital and there are approximately five women per year who request this service. The review team noted that carrying out approximately five amniocentesis per year is considerably less than the required national guidance on maintaining skills. Whilst recognising this figure is low in accordance with the number of births per year, the issue of maintaining clinical skills should be addressed.

Childbirth

The review team commended the practice of all women receiving one-to-one midwifery care during labour and childbirth. It is Board policy to have two trained midwives in attendance for planned home births. The review team was informed that there are very few requests for the home birth service.

Example of a local initiative...

The maternity unit at Western Isles Hospital provides two placements each year for trainee midwives based in Inverness. These placements are for a 10-week period during which trainee midwives work under supervision to gain experience of remote and rural midwifery practice.

The Board has set up a multidisciplinary protocol group to monitor, update and review its policies for the management of all key labour practices. There are a range of policies in place for some of these areas of care and the group are currently working on developing policies for the other areas of practice.

All women are provided with information regarding pain management and there is access to a range of pain management techniques including: transcutaneous electrical nerve stimulation (TENS); oral analgesia; intramuscular analgesia; Entonox; the use of water for pain relief; and epidural analgesia.

The Board does not currently have a birthing pool and while there are few requests from women to have a water birth, the review team would encourage the Board to develop practice in this area.

Anaesthesia services are available for all pregnant women. The number of births in Western Isles per year does not sustain a specialist obstetric anaesthetic service and, therefore, anaesthetic services are provided by a team of anaesthetists who provide a full anaesthesia service throughout the hospital. There is a system in place to ensure that anaesthetic and theatre services respond rapidly to obstetric emergencies.

The review team highlighted the commitment of the consultant obstetric and anaesthetic services as a strength which complements the Western Isles maternity service.

Postnatal and Parenthood

The Board has procedures to ensure that all women are assessed immediately by a midwife after giving birth. This assessment is documented by midwives in the woman's notes. The review team was informed that women will be checked daily for up to 10 days postnatally, and beyond if required. A system is in place to ensure ongoing assessment for the recognition of complications. Staff use a postnatal daily check chart and a postoperative anaesthetic chart to monitor maternal wellbeing and observe any signs of additional complications. All women are provided with information on contraception prior to leaving the maternity unit. In addition, GPs also provide a family planning service and there is a family planning clinic at the Western Isles Hospital.

The Board is working towards achieving UNICEF/WHO baby friendly status and the review team acknowledged the considerable work in this area led by the unit's senior midwife. The Board has also been visited by a UNICEF/WHO baby friendly co-ordinator to advise on what is required to achieve this status.

Women are provided with a good range of information on their chosen method of feeding. Information is provided during parent education classes in the form of posters, videos and information leaflets. Midwives use an infant feeding antenatal checklist to ensure that the benefits of breastfeeding are discussed with all pregnant women by 32 weeks of pregnancy to assist them to make an informed choice.

Example of a local initiative...

The Board reported that there is a midwife-led breastfeeding support group held at the Western Isles Hospital and that an additional support group is currently being established by health visitors.

The review team commended the excellent breastfeeding rates achieved in NHS Western Isles.

At the time of the review visit, there was not an infant feeding advisor in the Western Isles NHS board area. However, breastfeeding management courses are provided for

midwives to support women who choose to breastfeed their babies. The Board reported that there have been no admissions due to inadequate nutrition in the past 3 years. The review team commended the team for this success and noted that it is probably due to a combination of good care provided by midwives and the length of time mothers and babies stay in hospital as this allows feeding to be well established prior to mother and baby going home.

The Board adheres to standard practice to minimise the number of infants who require re-warming. In addition, midwifery staff follow a bathing policy for all newborn babies which involves ensuring the baby, the room and the bath water are at appropriate temperatures. Bathing is undertaken quickly and efficiently to minimise temperature loss.

All babies are examined by a GP, midwife or paediatrician within 72 hours following birth. The review team commended the protocol in place for the recognition of group B streptococcal infection and all babies are checked on a daily basis for the recognition of jaundice.

The review team acknowledged the efficient transfer of information on women and their babies between secondary and primary care, and again commended midwifery staff for their professionalism and approach throughout all areas of the service.

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 Western Isles

Essential Criteria

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

STATUS: Met

The director of nursing, midwifery and allied health professional services is the named individual at NHS Board level with responsibility for maternity services throughout the Western Isles.

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 senior midwifery manager has overall responsibility for maternity services at both primary care and acute operating levels. The review team noted that this is a broad remit for one individual, particularly as this post is unsupported by a deputy. The Board has explored the possibility of supporting this post at local level and the review team would encourage the Board in its efforts to achieve this.

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 in the Western Isles are currently undergoing a period of redesign and, while there is no formal strategy, considerable work has been undertaken to establish a strategy for nursing, midwifery and allied health professional (AHP) levels. The review team acknowledged the work that has been undertaken to date in these areas, however, would recommend that Western Isles NHS Board develops a Board-wide strategy to outline how maternity services are planned, developed and

implemented throughout the Western Isles, in line with Scottish Executive Health Department (SEHD) policies for women-centred care.

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

STATUS: Not met

The Board involves local public participation in its maternity service through its well established maternity services liaison committee (MSLC). The committee acts as a multidisciplinary forum to ensure the various professions involved in the provision of maternity services and the public work together in the planning and co-ordination of the local service. The committee membership includes; anaesthetists; GPs; an NHS board non-executive director; a health council representative; a health promotion representative; a health visitor; three lay representatives; midwives; the midwifery services manager; an obstetrician; and paediatrician. Lay members were sought through health promotion work and in association with health visitors. The review team noted, however, that while the committee included representation from Uist, there was currently no representation from Barra and would recommend that the Board establishes links with Barra.

The review team also noted that the committee is currently chaired by the senior midwifery manager and would recommend the committee is chaired/co-chaired by a lay member of the group.

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 Western Isles

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 a comprehensive system to ensure all critical incidents can be reported, investigated and analysed. Any maternity incidents would be reported to the Board's senior midwife on an IR1 incident reporting form. The Board's consultant obstetrician would then be responsible for investigating and analysing the incident. The review team recommended a more multidisciplinary approach and was informed that the Board's risk management committee has developed a formal pathway which covers all aspects of risk management in both the primary and acute setting. The Board also has a risk assessment and scoring process in place to promptly identify, evaluate and address potential or actual risk in order to protect all parties (patients, staff and the public) from any potential incident.

In addition to recording incidents on IR1 forms, the Board's department of women's health has a clinical IR1 form to record an obstetric clinical incident. The purpose of this form is to record details of the incident at the time it is reported and concentrates on the collection of facts rather than opinion. It outlines a five level grading chart to classify the severity of the risk, and how and when it should be reported. In addition, it categorises incidents into three groups: maternal/delivery incidents; fetal/neonatal incidents; and organisational incidents. It is designed to improve practice and patient care as well as address any problems in the clinical setting.

The review team was provided with an example of how an incident would be recorded on these forms and was informed that maternity incidents would be reviewed at the unit's labour ward forum and ward meetings where any appropriate change to practice would be discussed.

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 is a procedure that enables women to express their views about their pregnancy and childbirth experience, known as a post-delivery review. This involves a one-to-one discussion between a midwife and the woman prior to being discharged from hospital, or if the woman delivered at home, this would be undertaken by a community midwife. The discussion is noted on a 28-day postnatal debriefing form and covers the following areas: during pregnancy; during labour; postnatal stay in hospital (if applicable); and community midwifery care at home. In addition, the Board undertook a patient satisfaction survey between May 2004 and May 2005. The survey highlighted a high level of satisfaction with the services and reflected similar results from a survey undertaken the previous year. The review team commended staff for auditing this area of practice.

The review team considered the Board to have a proactive approach to invite comments on the service it provides. In addition to the post-delivery review, women are given a comment card with their hospital discharge pack to invite their comments on the service they received during their stay in hospital.

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: Not met

The Board reported that, at the time of the review visit, there were no locally agreed guidelines in place between the Board and the Scottish Ambulance Service. However, the review team was informed that guidelines are currently being developed. The review team noted that while this criterion is not met, there are good links between the Board and the Scottish Ambulance Service. The review team also acknowledged that while existing staff are aware of how to contact the most appropriate parts of the ambulance service (eg local ambulance, air ambulance or the 'Glasgow retrieval team' for neonatal emergencies), it would recommend that clear instructions are written down and available in a central, obvious area for all staff, in particular for new/locum staff to access this information in emergency situations.

The review team also noted that should a baby require transfer to a special care baby unit (SCBU), the Board would contact the Glasgow retrieval team. The retrieval aircraft is based in Aberdeen which then goes to Glasgow to collect the team prior to going to the Western Isles to collect the baby for transfer. Staff reported that this can take between 2–4 hours. The review team noted that while the logistics involved in initiating this type of a response are outwith the Board's control, it would recommend that the Board discusses this with the ambulance service to establish a

more efficient neonatal retrieval system. The system currently in place is very time consuming given the urgency of some situations which require this level of service.

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

STATUS: Not met

Arrangements exist for women and their babies to access a network of specialist services ranging from: AHPs; anaesthesia and intensive care; imaging; laboratory medicine; medicine; neonatology; obstetrics; perinatal pathology; surgery; and psychiatry. However, most of these arrangements are informal consultant to consultant (verbal) referrals. From discussions with Board staff, the review team considered there to be generally good informal links in place for women and their babies to access these services. However, the absence of formal protocols and referral pathways led the review team to conclude that the Board is currently not meeting this criterion.

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

STATUS: Met

The Board reported that all pregnant women are assessed by a consultant obstetrician. The review team would recommend that risk assessment is initially undertaken by midwives and a referral made by midwife to consultant depending on the woman's risk factors. The Board informed the review team that it plans to move towards this practice of midwifery-led care.

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

STATUS: Not met

The review team was informed that there is a vacancy for an audit facilitator as the person who undertook this role has moved into a new secondment role. The post has not been back filled due to difficulties in recruiting which has had an impact on audit activity.

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

The Board provided the review team with a list of members of midwifery staff who have attended neonatal resuscitation training during 2005. However, a full programme of training had not been undertaken and this is currently being addressed by the Board. The review team would recommend regular updates of adult and neonatal resuscitation training for all medical staff as well as midwifery staff.

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 (insufficient evidence)

The Board uses an antenatal care risk assessment form to identify individual women's levels of risk and to ascertain the level of care required, eg midwife-led/consultant-led/joint care between midwife and consultant or midwife and GP. However, it was unclear from the evidence provided if this method of assessment addressed and facilitated escalating risks and how this would be managed between different levels of healthcare professionals.

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

While there is currently no formal policy in place for the identification of women who are at risk of domestic abuse, the review team acknowledged that the Board has undertaken a considerable amount of work in this area. A training day for midwives and health visitors had been arranged as well as further information sessions in conjunction with the police. The review team was informed that the Board plans to undertake further work to ensure a domestic abuse policy is in place as soon as possible.

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: Met

High dependency facilities and clinical expertise are available on-site at the Western Isles Hospital. The high dependency facilities are available on the general medical ward which is situated beside the maternity unit.

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 met

From discussion with Board staff the review team considered the Board to have good access facilities for women who require adult intensive care and expertise. However, these arrangements are not formalised or documented into a defined rapid access route. The review team would recommend that the Board formalises practice in this area.

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

This criterion is not applicable to NHS Western Isles as it is a level 11b consultant-led service. The Board reported that all cases requiring adult intensive care facilities and specialist medical back-up are stabilised prior to transfer to a mainland unit.

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

This criterion is not applicable to NHS Western Isles as it is a level 11b consultant-led service. The Board reported that all cases requiring adult intensive care facilities and specialist medical back-up are stabilised prior to transfer to a mainland 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: Not met

The review team was informed that while there are no written protocols in place for the care of women with significant medical or obstetric illness to ensure they are delivered in a unit that can provide adult intensive care, advanced imaging and cardiology on-site, all potential cases are identified in advance. Plans are made for all women with high risk factors to deliver in a mainland unit equipped to provide the level of facilities that may be required. From discussions with staff the review team considered this works well in practice however, would recommend the Board formalises these arrangements into a protocol.

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: Not applicable

This criterion is not applicable to NHS Western Isles as it is a level 11b consultant-led service.

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 met

The Board reported that SCBU facilities are not available on-site. However, can be provided for babies requiring stabilisation prior to being transferred to these facilities in a mainland unit.

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

STATUS: Not applicable

The review team did not consider this criterion applicable to Western Isles Hospital as it does not have a neonatal intensive care unit (NICU) or SCBU facilities on-site.

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 Western Isles

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 professional identified for each woman, who leads and plans her contact with maternity services. At present, each woman is allocated to a consultant, however, the Board reported that it is currently in the process of adapting its practice to conform to national recommendations by implementing a risk assessment for all women to identify whether their care should be midwifery or consultant-led.

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 verbal information to enable them to make an informed decision regarding their preferred place of birth. On Lewis, women have a choice to deliver at the maternity unit in the Western Isles Hospital or alternatively they can choose to have their baby at home. The review team was informed that most women choose to have their baby in the local maternity unit. On Uist and Barra, women can choose: to deliver their baby at the community midwife-led maternity unit on Uist; the consultant-led unit on Lewis; a mainland unit or at home. The review team was informed that an information leaflet is currently being developed by the MSLC regarding the options available for women on Uist as part of a Western Isles information pack. The review team would recommend that one Board-wide information leaflet is developed outlining the options available and the level of service provided by each one.

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

STATUS: Met

The Board has a comprehensive policy in place for professionals to obtain informed consent for interventions and investigations. Written consent is obtained for amniocentesis and all other pregnancy investigations. Details on the information provided to women to facilitate informed choice regarding consent is recorded in the casenotes.

The review team commended the Board's policy on informed consent for examination or treatment.

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 through a post-delivery review process. This involves a one-to-one discussion between a midwife and the woman prior to being discharged from hospital, or if the woman delivered at home, this would be undertaken by a community midwife. The discussion is noted on a 28-day postnatal debriefing form.

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

STATUS: Met

Communication skills training is undertaken through a variety of means and is prominent through various training courses. In addition, the Board has provided communication skills training for senior clinicians which will be rolled out to other groups of medical and clinical staff. Training attendance is recorded on the Human Resource department's training database. In addition, the Board's senior midwife keeps a record of all midwifery staff training.

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

STATUS: Met

There is a system in place to support and inform bereaved parents. An information resource pack is used to provide guidance to staff on how to support bereaved parents during this time. Maternity staff provide all bereaved parents with a

telephone number for the local branch of the Stillbirth and Neonatal Death Society (SANDS).

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

STATUS: Met

The Board reviews information provided to women on an ongoing basis. Its patient information leaflet was under review during the review visit. There is a comment card system which is used to evaluate general written and verbal communications.

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 Western Isles

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 encourage partner/family/friend involvement during pregnancy and childbirth. The Board provides 'couples classes' during the antenatal period and partners/family and/or friends are welcome to accompany women to clinic appointments. There is also a waiting area provided in the labour ward for family or friends. The maternity unit operates an open visiting policy (outwith a 12.30–2.30pm rest time) for family and friends. Fathers are welcome in the unit at all times. Women are provided with an information leaflet on the Western Isles Maternity Unit which provides details on: parent education classes; investigations; ultrasonic scanning; blood tests for screening purposes; what is involved on admission to the unit; care in the ward and postnatal care; how to register a birth; and information about going home; postnatal examination; family planning; and support at home. The leaflet also contains a section on general information. In addition, the Board provides grandparents with an information leaflet produced by the National Childbirth Trust (NCT) to advise them on how they can provide help and support when the baby arrives.

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 Western Isles

Essential Criteria

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

STATUS: Not met

The Board reported that it is currently working towards all women having a handheld maternity record. However, women in Uist & Barra have been provided with handheld maternity records since 2001.

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 is a dedicated member of staff who has responsibility to ensure that records are completed appropriately.

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 Western Isles 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. The Board is working towards implementing the new record.

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 Western Isles

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

The Board has a management of diabetes in pregnancy policy which outlines practice for the management of women with diabetes from pre-pregnancy through to the postnatal period. A diabetic nurse specialist, based on Lewis, provides care for the islands diabetic men and women. There is a mechanism in place for this nurse to refer women with diabetes who wish to conceive to the consultant obstetrician for specialist advice and care. The review team was informed that the number of women with Type 1 diabetes in the Western Isles is very low; there has been one case in the past 3 years. The Board also has a management of gestational diabetes protocol which includes a section to record blood sugar levels, insulin administered and the initials of the healthcare professional providing 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: Not met

The Board reported that while there are no specific pre-conception services for women with a personal or family history of significant illness, any woman in this situation would be referred by their GP to the consultant obstetrician who would assess their case and make an appropriate referral for the woman to see a specialist on the mainland.

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 Western Isles

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: Met

An early pregnancy service has recently been established and there is a mechanism in place for any health professional to make a referral to this service. There are clinical guidelines regarding early pregnancy assessment, and diagnosis and management of an early pregnancy loss. The guidelines clearly state: who can refer; indications for referrals; information required at referral; information given at the time of referral; the early pregnancy assessment clinic timetable; and documentation required. However, the review team noted that the provision of this service is in its infancy and that currently there is not a dedicated space for the early pregnancy assessment service (EPAS); at the time of the review visit, this service was set up in an outpatient area of the hospital. The review team would recommend that the Board accommodates this part of the service in a specific, dedicated area and highlighted this as a challenge of the Board.

The Board reported that there is only one scanner in the Western Isles Hospital and provided the review team with a copy of its antenatal scanning guideline. One consultant obstetrician currently undertakes scanning for all pregnancies at the Western Isles Hospital. In addition, one GP on Uist provides a scanning service locally and a midwife is currently undertaking training to be able to provide this service in future. In situations where an obstetric scan is required out-of-hours/weekends, this is treated as an emergency for which the consultant obstetrician provides an on-call service. The review team commended the good level of care provided given the constraints on the service and recommended that midwifery/radiology staff are trained in obstetric scanning to support the consultant obstetrician with this part of the service.

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. An information leaflet has been developed, 'bleeding in early pregnancy: questions and answers', which provides information regarding early pregnancy problems as well as contact details for the early pregnancy service.

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

On Lewis and Uist, women who require admission to the Western Isles Hospital following an early pregnancy complication are given a choice of ward area. These choices range from a side room in the day surgery unit, a bed in the 'mixed specials ward' or a quiet room in the maternity department. The review team was informed that in such cases women tend to request the quiet room in the maternity unit. Board staff also reported that should a woman request to be admitted to a ward outwith the maternity ward, a midwife would be available to see the woman in that ward. From January 2006, there will be two midwives dedicated to providing care for all women experiencing early pregnancy complications in non-maternity wards. On Barra, women experiencing early pregnancy problems would normally attend services within NHS Greater Glasgow for treatment.

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 management options in accordance with the Board's clinical guidelines for the management of an early pregnancy loss.

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

STATUS: Met

The Board provides a Monday–Friday service to ensure prompt access to ultrasound facilities. The consultant obstetrician also provides an emergency out-of-hours service. While this criterion is met in terms of service provision, there

was concern that the entire ultrasound service is provided by just one member of staff and this was highlighted as a challenge for the Board. The review team recommended that ultrasonography training is provided for midwives and/or radiography staff to ensure continuity of service provision during leave and long-term sustainability.

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 facilities are not currently used. The review team highlighted the potential for development in this area, particularly in relation to ultrasound scanning.

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 Western Isles

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 which outlines the aims, themes and outcomes of the education programme. The programme ranges from the early pregnancy stage through to the 12 week postnatal stage. On Lewis, one-to-one classes are provided for pregnant teenagers and also for anyone who is unable to attend the scheduled group sessions. On the other islands, these classes are arranged on a one-to-one basis. In all areas, revision classes are provided for women who do not require the full programme.

Fathers/birthing partners are invited to attend some of the classes as appropriate. The review team commended the one-to-one approach provided by midwives to deliver a parent education programme.

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: Not met

A staff midwife is the lead named co-ordinator responsible for the education programme in the Lewis and Harris area. This midwife has attended recognised parent education and teaching skills training to undertake this role. Due to the geographical layout of the Western Isles, other trained midwives are responsible for providing parent education classes on Uist and Barra.

Desirable Criteria

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

STATUS: Met

The Board reported that the Ready, Steady, Baby book is provided to GP surgeries to ensure it is given to women at initial point of contact regarding their pregnancy.

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

STATUS: Met

The Board's parent education programme includes a series of postnatal classes. The postnatal reunion class is the first of these classes. Invitations are sent out to women at the 8–12 week post-delivery stage. The Board evaluates these classes by asking mothers to complete a feedback questionnaire at the end of the series of postnatal classes.

Standard 3(b): Standard 3 ~ Pregnancy

Standard Statement

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

NHS Western Isles

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 adheres to the national programme for antenatal screening and provided the review team with a copy a letter sent to all Western Isles GPs in January 2005 regarding the update of practice in this area. The review team was provided with a copy of the Board's protocol for routine antenatal Anti-D prophylaxis for rhesus negative women. The review team also received a copy of the information booklet provided to women to enable them to make an informed choice regarding antenatal Anti-D prophylaxis. Rhesus negative women are asked to complete a consent form to receive Anti-D immunoglobulin at 28 and 34 weeks of pregnancy and again at the post-delivery stage.

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 has comprehensive protocols for the antenatal care and investigation of women which conform to national guidance, including a fetal anomaly ultrasound scan at 20 weeks gestation. The Board provided the review team with a copy of its guidelines for pregnancy and newborn screening.

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 Western Isles

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

The Board does not meet this criterion as currently the consultant obstetrician sees all pregnant women regardless of their risk level rather than having a system where the woman could move between different levels of care, eg midwifery and obstetrics. Board staff reported that plans are in place to enable different healthcare professionals to plan antenatal care as appropriate.

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 one-to-one care during the antenatal stage to assist with completing a birth plan. The review team was informed that some women are very proactive in preparing their birth plan while other women require encouragement. Board staff reported that women are offered a choice of place of birth for their baby and reported that women can choose between: hospitals in the Western Isles, Glasgow, Inverness, and Aberdeen; a midwifery-led unit on Uist; or a home birth depending on their requirements and risk assessment. The review team was informed that women generally choose to deliver where relatives and friends are based rather than the facilities provided. An information leaflet is currently being developed to provide information on the maternity service provision at the mainland sites.

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 routine pattern of antenatal care is within the recommended number of visits.

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 Western Isles

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 receive one-to-one care during labour and childbirth by a registered midwife. The review team was also informed that the maternity unit provides two placements each year for trainee midwives based in Inverness to experience rural midwifery practice. These placements are for a 10-week period during which trainee midwives work under supervision. The Board had not undertaken any audit to formally verify that one-to-one care is provided, however, from verbal discussions on working practice and the number of deliveries each year, the review team concluded that the Board is currently meeting this criterion.

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

STATUS: Met

It is Board policy to have two midwives in attendance for planned home births. The review team was provided with a copy of the information leaflets provided to women regarding home births. In the leaflet, women are informed that two midwives will attend a home birth and will be on-call for one month from 38 weeks gestation. The review team was also provided with a copy of the Board's midwifery on-call rotas and home birth guidelines. While the review team found these comprehensive, it would recommend that they are reviewed and updated during 2006. The review team commended the detail of the information provided to women regarding home births.

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

STATUS: Not met

There are policies for the management of: induction of labour; breech presentation; perineal repair; prophylactic antibiotics for caesarean section; prostaglandin and oxytocin use; management of thromboembolism and thromboprophylaxis; epidural analgesia; fetal monitoring; diabetes; pre-eclampsia and eclampsia; women who decline blood products; haemorrhage; prolapsed cord; rupture of the uterus; shoulder dystocia; neonatal resuscitation; adult resuscitation; retained placenta; and intrauterine death. The review team commended the policies for induction of labour and prophylactic antibiotics for caesarean section, however, would recommend that the Board change the title of the policy for induction of labour to encompass pre- and post-term deliveries. There are currently no policies for: caesarean section; placenta praevia; or the management of multiple pregnancies. The review team was informed that policies are being developed for caesarean section and placenta praevia, and that a multidisciplinary protocol group has been set up to regularly review and monitor policies, and to establish those currently in development.

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 Western Isles

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 as part of parent education classes as well as on a one-to-one basis. These discussions are supported by a comprehensive information leaflet, 'Pain Relief For Labour', which outlines relaxation and breathing techniques, pain relief drugs including details on how these drugs work and their advantages and disadvantages. The Board reported that women have access to the following range of pain management techniques: TENS; oral analgesia; intramuscular analgesia; Entonox; the use of water for pain relief; and epidural analgesia. During labour, women's pain levels are closely monitored by midwives, and options and choices of pain relief are discussed and recorded in the 'labour progress notes'.

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

STATUS: Met

A pain assessment tool has recently been introduced for women who have epidural analgesia or an operative delivery. The review team was informed that continuous infusion epidural analgesia is practised.

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 Western Isles Hospital.

Standard 4(c): Standard 4 ~ Childbirth

Standard Statement

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

NHS Western Isles

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 met

There is a lead consultant anaesthetist with responsibility for the organisation and management of the obstetric anaesthetic service. However, there is not a dedicated consultant obstetric anaesthetist as the number of births each year do not warrant this level of sub-specialist service. The review team noted the high level of commitment to the obstetric service by the consultant anaesthetists.

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 met

The review team was informed that obstetric anaesthetic services are provided by a team of anaesthetists who are responsible for all general anaesthetic services throughout the Western Isles Hospital. All consultant anaesthetists cover the obstetric anaesthetic 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 August 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 review team verified from discussions with Board representatives on the day of the review visit that there is a system to ensure that anaesthetic and theatre services respond rapidly to obstetric emergencies and expedite delivery in the event of maternal or fetal compromise.

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

STATUS: Not met (insufficient evidence)

The review team considered the evidence insufficient in response to this criterion and would encourage the Board to ensure that 'decision to delivery' intervals and perceived urgency are formally monitored.

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)

The review team considered the evidence insufficient in response to this criterion and would encourage the Board to ensure that 'decision to delivery' intervals and perceived urgency are formally monitored.

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 Western Isles

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 are assessed immediately after giving birth by a midwife. This assessment is documented by midwives in the woman's notes.

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 prior to discharge from the maternity unit or within 24 hours of giving birth if still in hospital. The review team was informed that women will be checked daily for up to 10 days postnatally, and beyond if required.

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

STATUS: Met

The Board has a system to ensure ongoing assessment for the recognition of complications. Staff use a postnatal daily check chart and a post-operative anaesthetic chart to monitor maternal wellbeing and observe any signs of additional complications.

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

STATUS: Met

Information on contraception is provided for all women prior to leaving the maternity unit. This is also discussed with women prior to discharge and recorded in the unit's 'discharge planner' and also in the 'puerperal record'.

GPs provide a family planning service and there is also a family planning clinic held at the Western Isles Hospital every Monday afternoon.

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 Western Isles

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

Staff at the Western Isles Hospital Maternity Unit have undertaken considerable work, led by the unit's senior midwife, to progress towards achieving UNICEF/WHO baby friendly status. The review team was informed that all midwives, health visitors and auxiliaries have attended the baby friendly course. The Board has also received a visit from the UNICEF/WHO baby friendly co-ordinator to advise on what is required to achieve baby friendly 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

There is a good range of information provided for women on their chosen method of feeding. This is first provided during parent education classes in the form of posters, videos and information leaflets. Women who choose to bottle feed their babies are provided with an information leaflet 'Bottlefeeding & Sterilisation of Equipment'. Women who prefer to breastfeed their babies are provided with UNICEF/WHO leaflets 'Feeding Your Baby' and 'Breastfeeding Your Baby'. They are also provided with the NHS Health Scotland leaflets 'Off to a good start' as well as a leaflet produced by the National Childbirth Trust, 'Breastfeeding: the first seven days'.

Midwives use an infant feeding antenatal checklist to ensure that the benefits of breastfeeding are discussed with all pregnant women by 32 weeks of pregnancy to assist them to make an informed choice. The review team commended this practice as well as the Board's excellent breastfeeding rates.

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, at the time of the review visit, there was not an infant feeding advisor in the Western Isles NHS board area. However, breastfeeding management courses are provided for midwives to support women who choose to breastfeed their babies.

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

STATUS: Met

The Board reported that there have been no admissions due to inadequate nutrition in the past 3 years. The review team commended the team for this success and noted that it is probably due to a combination of good care provided by midwives and the length of time mothers and babies stay in hospital as this allows feeding to be well established prior to mother and baby going home.

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 Western Isles

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 review team was informed that standard practice is followed to minimise the number of infants who require re-warming. This includes 'skin to skin' contact immediately following birth and the baby is then wrapped in a towel. If there is any concern, the baby's temperature would be taken and recorded, and the baby placed in an incubator. A paediatrician would also be called to examine the baby.

The review team commended the Board's policy for bathing newborn babies which was highlighted as a local initiative.

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

STATUS: Met

The review team was informed that all babies are clinically examined by a suitably trained midwife immediately following birth. A checklist 'Initial baby assessment following delivery' chart is used to ensure the examination follows a standard procedure. This form is then signed by the midwife undertaking the 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

Babies are examined by either a paediatrician or a midwife (who has successfully completed the examination of the newborn training course) in the maternity unit within 72 hours of birth. The review team was informed that mothers and babies would not normally go home earlier than 72 hours following birth. However, if an early discharge is requested, a paediatrician would examine the baby prior to discharge.

For home births, a midwife trained in examination of the newborn would visit the baby at home to undertake the examination within 72 hours of birth. On Uist, this examination would normally be undertaken by a GP.

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

STATUS: Met

The Board has guidelines for the prevention of early onset neonatal group B streptococcal disease. There is also 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 previously had a group B streptococcal positive vaginal swab during labour are monitored continuously and the baby's care is managed in accordance with the Board's guidelines. The review team commended the Board on its policy for the management of group B streptococcal infection.

Babies are also checked daily for the recognition of jaundice as part of the routine care.

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 Western Isles

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

Community staff reported that there is an established system to ensure that information on women and their babies is collated and transferred between secondary and primary care in a reliable and timely manner. The review team was informed that on discharge the woman's GP surgery is telephoned by the hospital's midwifery staff to notify the discharge. The woman's health visitor is also informed and the hospital's ward clerk sends letters to GPs to follow up phone calls the day after the woman and baby have been discharged from hospital.

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

STATUS: Not met

The Board reported that while it did not currently have formal guidelines in place for transfer and post-transfer care for women and their newborn babies, there is a system should this situation arise: a maternity ward neonatal transfer form is completed together with a letter from the woman's consultant and a photocopy of her medical notes.

Appendix 1 – Glossary of abbreviations

Abbreviation

AHP	allied health profession
EPAS	early pregnancy assessment service
GP	general practitioner
GROS	General Register Office for Scotland
IR1	incident reporting form
MSLC	maternity services liaison committee
NCT	National Childbirth Trust
NICU	neonatal intensive care unit
NHS QIS	NHS Quality Improvement Scotland
RCA	Royal College of Anaesthetists
SANDS	Stillbirth and Neonatal Death Society
SCBU	special care baby unit
SEHD	Scottish Executive Health Department
TENS	transcutaneous electrical nerve stimulation
UNICEF/WHO	United Nations Children’s Fund/World Health Organisations

Appendix 2 – Details of review visit

The review visit to NHS Western Isles was conducted on 6 December 2005.

Review team members

Dr John McClure (Team Leader)

Consultant Anaesthetist, NHS Lothian

Sister Marjorie Andres

Senior Midwife, NHS Ayrshire & Arran

Dr David Farquharson

Clinical Director, Women's Services, NHS Lothian

Mrs Joanna McGregor

Public Partner, Highland

NHS Quality Improvement Scotland Staff

Ms Sharon Keane

Project Officer

Mr Steven Wilson

Team Manager

Mrs Fiona Dagge-Bell (Observer)

Professional Practice Development 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, 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

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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