



# **Maternity Services**

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a short guide to our findings

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# Context

Over 50,000 babies are born in Scotland each year, making maternity one of the most commonly used services in the NHS.

Each maternity services has to be able to respond to the needs of every woman before, during and after pregnancy and birth, and to provide safe and effective care.

In February 2001, the Scottish Executive Health Department (SEHD) published, A Framework for Maternity Services in Scotland. It set out a vision for maternity services and provides a template for best practice. Following this, NHS Quality Improvement Scotland (NHS QIS) published clinical standards for maternity services in March 2005.

A Scotland-wide review of performance against these standards has now been carried out and this booklet is a summary of our findings.



# The standards

At the time we conducted our reviews, NHSScotland had 15 NHS board areas (this has since been reduced to 14) and we visited them all to assess their performance against the national standards.

There are five standards, each with a number of criterion:

- **Standard 1** covers: planning and provision of services; risk assessment and management; information, communication and support; partner and family involvement; and record-keeping.
- **Standard 2** covers pre-conception and very early pregnancy.
- **Standard 3** covers pregnancy.
- **Standard 4** covers childbirth, including pain management.
- **Standard 5** covers postnatal and parenthood.

The standards were developed in wide consultation with healthcare professionals, and most importantly, with women and mothers.

Full details of the standards and how your NHS board is performing are available on request or by visiting our website at [www.nhshealthquality.org](http://www.nhshealthquality.org)

# Standard 1

## core principles

This standard sets out the fundamental elements of maternity services that apply at every stage of pregnancy and childbirth:

- accountability for planning and providing services,
- risk assessment and management that aims to make sure all healthcare professionals understand the concept of risk management in improving the quality of care and safety for mothers and babies, and take action to minimise any potential harm,
- information, communication and support,
- partner and family involvement, and
- accurate record-keeping.

**The standard requires that there are clear lines of responsibility for the planning and delivery of services, with evidence of public involvement. We found:**

- all NHS boards have named clinicians with responsibility for maternity services,
- only one board was able to present a coherent, board-wide, strategy for maternity services, and
- 11 boards were able to provide evidence of public involvement in the planning of all maternity services.

**The standard requires that staff are aware of risk management, and act to minimise adverse clinical incidents. We found:**

- all boards have a system to report, investigate and analyse critical incidents, resulting in changes in practice where necessary,
- 8 boards have formal access to specialist services arrangements, and
- 14 boards offer all women with risk factors an assessment by a consultant obstetrician.

**The standard requires that all women are fully informed of the different options available and that the important role of the partner/family is recognised. We found:**

- 13 boards have a named professional identified for each woman, who leads and plans her contact with maternity services,
- 14 boards provide information to make an informed decision about the place of birth, and
- all boards provide evidence that partner/family/ friend involvement occurs.

**The standard requires that a structured and accurate record is maintained for every woman and child (the 'unified record'). We found:**

- 9 boards have a unified hand-held record.





# Standard 2

## pre-conception and early pregnancy

This standard is aimed particularly at women with a poor obstetric or medical history, those who experience problems in early pregnancy and those who miscarry.

**The standard requires that all women with a poor obstetric/medical history have access to specific pre-conception services. We found:**

- 13 boards have a pre-conception service for women with diabetes, based on the SIGN guideline for diabetes, and
- 11 boards have a pre-conception service for women with a personal or family history of significant illness.

**The standard requires that all women who experience complications in early pregnancy have access to an early pregnancy assessment service. We found:**

- 12 boards have formal arrangements for referral to the early pregnancy assessment service,
- 10 boards provide a dedicated area for women who experience early pregnancy complications,
- 13 boards offer women who miscarry access to a choice of management options, and
- 9 boards have prompt access to ultrasound facilities.



# Standard 3

## pregnancy

This standard covers: antenatal education; screening and diagnostic testing; antenatal care and investigation; and a risk-based approach to antenatal care.

**The standard requires that there is comprehensive education for childbirth and parenthood. We found:**

- 7 boards have a written syllabus that targets specific groups, and
- 5 boards have a properly trained, named, lead co-ordinator.

**The standard requires that women have access to screening and antenatal diagnostic testing. We found:**

- 14 boards manage and treat all women who are identified in the screening programme as at risk of rhesus disease according to an agreed protocol, and
- 5 boards conform to the appropriate guidance for antenatal care and investigation.

**The standard requires that antenatal care is delivered by a network of professionals, as locally as possible. We found:**

- 11 boards have an explicit plan for antenatal care for all women, and
- 14 boards involve women in the development of their birth plan.

# Standard 4

## childbirth

This standard covers all aspects of childbirth including midwifery care, policies for the management of labour when deliveries do not go as anticipated, the availability of pain management and anaesthesia, and the response to obstetric emergencies.

**The standard requires that all women have an agreed plan of care throughout labour. We found:**

- 14 boards deliver one-to-one midwifery care, and
- all boards provide a minimum of two professionals, one a midwife, for planned home births.

**The standard requires that all women are informed about and offered a range of pain management techniques. We found:**

- 12 boards provide information and access to a range of pain management techniques, and epidural analgesia is available in consultant-led units, and
- 11 boards assess women who have epidural analgesia or an operative delivery using a pain assessment tool.

**The standard requires that during childbirth all women have access to anaesthesia that conforms to current professional standards. We found:**

- 8 boards have a lead consultant obstetric anaesthetist with responsibility for the organisation and management of the specialist anaesthetics service within consultant-led units,
- 8 boards have arrangements in consultant-led units to ensure that a specialist anaesthetic service is available at all times during childbirth
- 14 boards comply with NHS QIS anaesthesia standards and Royal College of Anaesthetists (RCA) guidelines for all specialist anaesthetic services, and
- 14 boards have a system to ensure that anaesthetic and theatre services respond rapidly when required.



# Standard 5

## postnatal and parenthood

This standard covers the care women and babies receive from giving birth until the 6-week postnatal check.

This includes information and support on infant feeding, minimising avoidable admission to special care baby units, examination of the newborn, and transfer and discharge home.

**The standard requires that all women receive appropriate care and assessment from giving birth to the 6-week postnatal check. We found:**

- all boards assess women immediately after giving birth,
- all boards assess women prior to transfer to community care and/or within 24 hours of giving birth,
- all boards assess for the recognition of complications, and
- all boards give women information on contraception within 2 weeks of childbirth.

**The standard requires that maternity services promote, support and sustain breastfeeding and that women are supported in their chosen mode of feeding. We found:**

- 14 boards adhere to the principles of, or are working towards, the UNICEF/WHO Baby Friendly status, and

- all boards provide women with information and support in their chosen method of feeding.

**The standard requires that all babies receive appropriate care and assessment from birth until 6 weeks post birth. We found:**

- 13 boards take steps to minimise the number of babies who need re-warming or avoidable admission to special care baby units,
- all boards examine babies immediately following birth,
- all boards examine babies prior to discharge and clinical examination within 72 hours is routine in 13 boards, and
- 14 boards provide ongoing assessment.

**The standard requires that the transfer into the community is properly planned. We found:**

- all boards have a system established to ensure that information is collated and transferred between secondary and primary care in a reliable, timely and secure manner, and
- 13 boards have guidelines for transfer and post transfer care in place.





# Summary

## progress and challenges:

A number of key strengths were identified that are core to providing care that is safe and clinically effective:

- there are excellent levels of public involvement in all maternity services,
- maternity services are at the forefront of assessing and managing risk,
- maternity care involves a multi-professional approach,
- high quality information, in a range of media and languages, is provided, and
- pre-conception services for women are generally of a high standard; as are dedicated early pregnancy assessment services.

The challenges for maternity services include:

- all boards should formalise the status of and future vision for their maternity services in the form of a coherent board-wide strategy,
- ensuring that use of high dependency cots is maximised,
- ensuring non-obstetric anaesthetists receive an annual training update,
- ensuring out-of-hours access to ultrasound,
- each woman's maternity care should be documented within a unified record, and
- the majority of boards do not have formal, robust systems in place to ensure that all relevant staff receive regular resuscitation training and that attendance is logged.

**Notes:**

# About NHS QIS

The role of NHS QIS is to improve the quality of care and treatment delivered by the health service.

Our purpose is to help the health service deliver:

- consistently high standards of care and equity of access,
- improved outcomes for patients,
- better experiences for patients and carers, and
- support for NHS staff in the provision of effective clinical practice and service improvements, and in making best use of resources.

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.

More information about our work is available on request or by visiting our website at [www.nhshealthquality.org](http://www.nhshealthquality.org)





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- by email
- in large print
- on audio tape or CD
- in Braille, and
- in community languages.

## **NHS Quality Improvement Scotland**

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

Phone: 0131 623 4300  
Textphone: 0131 623 4383

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

Phone: 0141 225 6999  
Textphone: 0141 241 6316

**Email: [comments@nhshealthquality.org](mailto:comments@nhshealthquality.org)**  
**Website: [www.nhshealthquality.org](http://www.nhshealthquality.org)**