Clinical Standards ~ March 2005

Maternity Services
# Contents

1 Background on NHS Quality Improvement Scotland  
2 Development of Clinical Standards  
3 An Introduction to Maternity Services  
4 Development of the Clinical Standards for Maternity Services  

5 Clinical Standards for Maternity Services  
   Standard 1 – Core Principles  
   Standard 2 – Pre-conception and Very Early Pregnancy  
   Standard 3 – Pregnancy  
   Standard 4 – Childbirth  
   Standard 5 – Postnatal and Parenthood  

6 Appendices  
   Appendix 1  Membership of the Maternity Services Standards Project Group  
   Appendix 2  Evidence Base  
   Appendix 3  Glossary of Terms
1 Background on NHS Quality Improvement Scotland

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 achieve our objectives through four key functions that link together:

- setting standards
- reviewing and monitoring performance
- providing advice and guidance on effective practice
- supporting staff to improve services.

We deliver our commitments to the public and to NHSScotland by following an approach that is:

- **independent** - we reach our own conclusions and report on what we find
- **open and transparent** - we explain what we do, how and why we do it, and what we find, using language and formats that are easy to understand and to access
- **sensitive and professional** - we recognise needs, beliefs and opinions and respect and encourage diversity.

Our work is:

- **partnership-focused** - we work with patients and the public, NHSScotland and many organisations to improve the quality of care and avoid duplication
- **evidence-based** - we base our conclusions and recommendations on the best evidence available
- **quality-driven** - we make sure our own work is monitored and evaluated, internally and externally.
2 Development of Clinical Standards

Basic principles

A major part of the remit of NHS Quality Improvement Scotland (NHS QIS) is to develop and run a national system of quality assurance of clinical services. Working in partnership with healthcare professionals and members of the public, NHS QIS sets standards for clinical services, assesses performance throughout NHSScotland against these standards, and publishes the findings. The standards are based on the patient's journey as he or she moves through different parts of the health service. A wide range of diseases and services have already been addressed including diabetes, breast screening and stroke services.

The standards set by NHS QIS are clear and measurable, based on appropriate evidence, and written to take into account other recognised standards and clinical guidelines. The standards are:

- written in simple language and available in a variety of formats
- focused on clinical issues and include non-clinical factors that impact on the quality of care
- developed by healthcare professionals and members of the public, and consulted on widely
- regularly reviewed and revised to make sure they remain relevant and up to date
- achievable but stretching.

Healthcare governance standards

In addition to standards for specific services or conditions, healthcare governance standards are currently being developed. These are based on the integration of the generic clinical governance standards which were first published in January 2001, and the healthcare risk management standards developed by the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS). Once finalised, these standards will apply to all clinical and non-clinical areas. They should, therefore, be read alongside all topic-specific standards.

Copies of the draft healthcare governance standards are available on request from NHS QIS or can be downloaded from the website (www.nhshealthquality.org).
Process

For each project in the work programme, NHS QIS appoints a group comprising appropriate healthcare professionals and members of the public to:

- oversee the development of, and consultation on, the standards and self-assessment framework
- recommend an external peer review process.

The way in which standards are developed is a key element of the quality assurance process. Project groups working on behalf of NHS QIS are expected to:

- adopt an open and inclusive process involving members of the public, voluntary organisations and healthcare professionals
- work within NHS QIS policies and procedures
- test the measurability of draft standards by undertaking pilot reviews.

Assessment of performance against the standards

The framework for the NHS QIS review process is as follows.

- Once the standards have been finalised, each relevant NHS Board/service is asked to undertake a self-assessment of its service against the standards.
- A review team visits the NHS Board/service on behalf of NHS QIS to follow up this self-assessment exercise with an external peer review of performance in relation to the standards.
- NHS QIS reports the findings for the NHS Board/service, based on the self-assessment exercise and on the external peer review.

All the processes being developed by NHS QIS are subject to review and evaluation, to help improve the quality assurance system.
An Introduction to Maternity Services

Having a baby is a life changing event. Over 50,000 babies are born in Scotland each year. However, in step with other nations in the developed world, the birth rate is falling. In the future our maternity services are likely to be supporting fewer pregnancies and births. However, advances in the care of women with health problems, and the trend for women to wait longer to have their first baby, means that many of these pregnancies and births will be more complex.

Pregnancy is not an illness. It is, however, a significant life experience with major psychological and social impact for women and their families. Women want integrated, individualised and involved care. This is best achieved by ensuring that they are empowered as equal partners in their care throughout their contact with the maternity services.

The vision for Scotland’s maternity services is set out in the policy document, *A Framework for Maternity Services in Scotland* (SEHD 2001). This vision:

- supports partnership between women, their families and the professionals providing care
- affirms pregnancy and childbirth as ‘normal’ physiological events in a woman’s life
- sets out principles for care with actions for all stakeholders in maternity care provision
- seeks to drive up the standard of care by challenging professionals and NHSScotland to meet the needs of women and their partners.

For the purpose of this document we have limited the scope of our standards to the period of time between confirmation of pregnancy, through until the baby is 6-8 weeks old. These standards, therefore, cover pregnancy, childbirth, the postnatal period and parenthood. They reflect best practice in the area of pre-conception services, and also incorporate key areas of the organisation and provision of maternity services, the assessment and management of risk, and the importance of good information and communication strategies; these are reflected in the core principles.

Maternity care is a key contributor to the wellbeing of the family, and thus the wider public health. Education about pregnancy and childbirth starts in school. There is also an ever increasing emphasis on public health education among healthcare professionals.

Maternity care and parent education are provided in a variety of settings: the woman’s home; the local GP surgery; local and regional maternity units; and leisure centres for aquanatal and exercise classes. The emphasis is on care tailored to meet the needs of each individual woman, taking account of her unique social, cultural, physical, and emotional needs. This care is delivered by an integrated team of healthcare professionals. Most often midwives are the main providers of care. Other team members include GPs, obstetricians, anaesthetists, paediatricians, health visitors and other associated healthcare providers, depending on the needs of the individual woman and her baby.
The recent overview report of the Expert Group on Acute Maternity Services (EGAMS), *Implementing A Framework for Maternity Services in Scotland* (SEHD 2002), re-enforces the principles that care should be:

- based on the best available evidence
- of a consistently high quality
- delivered by skilled, appropriately trained professionals.

Such statements remind us that service providers must aim to demonstrate that this is the case, not be complacent, and continue to strive for equitable services for all women.
4 Development of the Clinical Standards for Maternity Services

The maternity services standards apply to specific elements of the service. As a first step in addressing the standards for maternity services, NHS Quality Improvement Scotland (NHS QIS), appointed a project group, chaired by Dr Jane Magill, Director, Robert Clark Centre for Technological Education, University of Glasgow. The Maternity Services Project Group is multidisciplinary and includes healthcare professionals and members of the public. The Group first met in June 2002, and its membership can be found in Appendix 1.

The standards produced by the Group have been split into five broad areas.

Standard 1 - Core Principles
Standard 2 - Pre-conception and Very Early Pregnancy
Standard 3 - Pregnancy
Standard 4 - Childbirth
Standard 5 - Postnatal and Parenthood

The standards will be used by NHS QIS to assess performance in these areas in NHS Boards throughout Scotland where maternity services are provided. Although these standards apply only to NHS services, independent midwives would be encouraged to use the standards in relation to their own practice where applicable.

Format of standards and definition of terminology

All standards set by NHS QIS follow the same format.

- Each standard has a title, which summarises the area on which that standard focuses.
- This is followed by the standard statement, which explains the level of performance to be achieved.
- The rationale section provides the reasons why the standard is considered to be important.
- The standard statement is expanded in the section headed criteria, which states exactly what must be achieved for the standard to be reached. Most criteria are essential, in that it is expected that they will be met wherever a service is provided. Other criteria are desirable, in that they are being met in some parts of the service and demonstrate levels of quality which other providers of a similar service should strive to achieve. Each project group is responsible for determining which criteria are essential and which are desirable. The criteria are numbered for the sole reason of making the document easier to work with, particularly for the assessment process. The numbering of the criteria is not a reflection of priority. The distinction between ‘essential’ and ‘desirable’ is the only way in which criteria have been prioritised.

Evidence base

The evidence base for the maternity services standards can be found in Appendix 2.
5 Clinical Standards for Maternity Services

<table>
<thead>
<tr>
<th>Standard 1 -</th>
<th>Core Principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard 2 -</td>
<td>Pre-conception and Very Early Pregnancy</td>
</tr>
<tr>
<td>Standard 3 -</td>
<td>Pregnancy</td>
</tr>
<tr>
<td>Standard 4 -</td>
<td>Childbirth</td>
</tr>
<tr>
<td>Standard 5 -</td>
<td>Postnatal and Parenthood</td>
</tr>
</tbody>
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Standard 1 ~ Core Principles

Standard Statement 1a: Accountability
There are clear lines of responsibility for the planning and delivery of maternity services, with evidence of public involvement.

Rationale
The consultation processes on planning, delivery and evaluation of maternity services at local, regional and national levels should involve all key stakeholders: commissioners, providers and users of services, and the general public.

Reference: 13

Essential Criteria

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

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

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.

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

Rationale

Risk is not easy to assess in maternity care. Nevertheless, maternity care professionals must take all possible steps to identify and effectively manage risk, with a view to minimising potential harm. Risk assessment and management should, therefore, become core functions of care in pregnancy and childbirth.

References: 10, 11, 13, 15, 18

Essential Criteria

Assessment

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

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

1b.3 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.

Referral

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

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

Training and Audit

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

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

Clinical Complications

1b.8 A clinical risk assessment process for individual women, including a communications strategy, is in place, which addresses escalating risk.
Standard 1 ~ Core Principles (continued)

1b.9 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.

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

1b.11 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.

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

1b.13 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.

1b.14 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.

1b.15 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.

1b.16 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.

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

**Rationale**

High-quality communication between professionals, women and their families, and between professionals and colleagues, must be central to the provision of excellent maternity care.

References: 4, 14

**Essential Criteria**

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

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

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

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

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

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

1c.7 Information giving (verbal, written and other media) is monitored and evaluated.
Standard 1 ~ Core Principles (continued)

**Standard Statement 1d: 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.

**Rationale**

Studies have shown that women who are supported during labour need to have fewer painkillers, experience fewer interventions and give birth to stronger babies. After their babies are born, supported women feel better about themselves, their labour and their babies.

Reference: 38

**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).
Standard Statement 1e: 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’).

Rationale

Maternity care should be documented and managed using a unified, handheld maternity record in which all professionals, sharing the woman's care, record their findings. The single document should contain a full record of the woman's care during pregnancy and, ideally, the woman should take responsibility for it during her pregnancy.

Reference: 32

Essential Criteria

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

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

Desirable Criterion

1e.3 The national unified handheld record and national electronic record are completed for all women and newborn babies.
Standard 2 ~ Pre-conception and Very Early Pregnancy

Standard Statement 2a: 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.

Rationale

The planning and delivery of maternity services should focus on approaching each woman as an individual with different social, physical, and emotional needs, as well as any specific factors that may affect her pregnancy. Her pregnancy must not be viewed in isolation from other important factors that may influence her health, or that of her developing baby.

References: 10, 11, 13, 14, 19

Essential Criterion

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

Desirable Criterion

2a.2 There are specific pre-conception services for women with a personal or family history of significant illness (e.g., epilepsy, neural tube defect, chromosomal abnormality).
Standard Statement 2b: Early Pregnancy Complications

All women who experience complications in early pregnancy have access to an early pregnancy assessment service.

Rationale

There should be specific services for women with complications in early pregnancy in line with the principles of *A Framework for Maternity Services in Scotland*.

Reference: 14

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.

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.

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

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

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

Desirable Criterion

2b.6 Telemedicine is used to promote regional networking, and to expedite the reporting of results.
Standard 3 ~ Pregnancy

Standard Statement 3a: Education Programme

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

Rationale

Antenatal education should be understood to be an integral part of a woman’s antenatal care. Women and healthcare professionals should be encouraged to place an equal value on antenatal education and clinical care, as they are both important and interlinked elements of optimal antenatal care.

References: 12, 14

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.

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.

Desirable Criteria

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

3a.4 Parent education programmes include a postnatal reunion.
Standard Statement 3b: Screening Services

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

Rationale

A comprehensive antenatal screening and diagnostic service should be available and offered to women, in order to detect, where possible, any maternal problems or fetal abnormalities at an early stage.

References: 10, 11, 13, 14, 34

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.

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.*
Standard 3 ~ Pregnancy (continued)

**Standard Statement 3c: 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.

**Rationale**

Services should be based on a multidisciplinary approach to care.

Reference: 13

At booking, a risk and needs assessment should take place to ensure that every woman has a flexible care plan adapted to her own particular requirements for antenatal care. This should be reviewed regularly.

References: 10, 11, 14

**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.

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.

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.
Standard 4 ~ Childbirth

Standard Statement 4a: 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.

Rationale

Each woman in labour should receive individual care from a competent and skilled midwife. This is vital if women are to receive the emotional support, information and advocacy they require, and its provision has proven benefits for maternal and child health, and for maternal satisfaction.

References: 5, 8, 10, 11, 14

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.

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

4a.3 There are agreed multidisciplinary, evidence-based policies for the management of all key labour practices, when care deviates from the norm.
Standard 4 ~ Childbirth (continued)

Standard Statement 4b: 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.

Rationale

Women must have the opportunity to make informed choices about pregnancy, delivery, analgesia and anaesthetic interventions. They need to be given adequate and timely information. Access to an anaesthetist during childbirth and in the antenatal and postnatal period is the right of every woman. Appropriate audio-visual and printed material must be available during the antenatal period.

Reference: 2

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.

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

Desirable Criterion

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

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

Rationale

Anaesthetists are an integral part of the maternity team. Their presence allows early consultation on the management of labour, including life-threatening obstetric complications.

Delivery at emergency caesarean section for maternal or fetal compromise should be accomplished as quickly as possible, taking into account that rapid delivery has the potential to do harm. A decision to delivery interval of less than 30 minutes is not in itself critical in influencing baby outcome, but has been accepted as an audit standard for response to emergencies within maternity services.

References: 10, 11, 13, 23, 27, 29, 33, 36

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.

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

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

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.

4c.5 There is a system in place to ensure that ‘decision to delivery’ intervals and perceived urgency are 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.
Standard 5 ~ Postnatal and Parenthood

**Standard Statement 5a: Care of Women**

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

**Rationale**

Maternity services should give high priority to supporting women and their partners through a confident and effective transition to parenthood, especially in the postnatal period.

References: 4, 8, 10, 11, 14

**Essential Criteria**

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

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

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

5a.4 Women receive information on contraception within 2 weeks of childbirth.
Standard Statement 5b: Infant Feeding

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

Rationale

The establishment and maintenance of breast feeding is one of the major goals of good postnatal care (WHO 1989, 1993, 1998). Midwives play a central role in supporting women and their partners and families in the feeding method of their choice for their baby.

References: 4, 5, 8, 31

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.

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

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.

5b.4 Admission rates for babies due to inadequate nutrition are monitored.
Standard 5 ~ Postnatal and Parenthood (continued)

Standard Statement 5c: Care of Babies

All babies receive appropriate care and assessment from birth until 6 weeks post birth.

Rationale

Acute and Primary Care NHS Operating Divisions should plan jointly and provide a fully integrated neonatal service, responsive to the needs of newborn babies and their parents.
Reference: 14

Essential Criteria

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

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

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.

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

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

Rationale

Maternity services should provide postnatal care to facilitate the transition to motherhood by reducing ill health through prevention, or detection and appropriate management.

Reference: 14

Essential Criteria

5d1 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.

5d2 Guidelines for transfer and post transfer care are in place.
6 Appendices

Appendix 1 - Membership of the Maternity Services Standards Project Group

Appendix 2 - Evidence Base

Appendix 3 - Glossary of Terms
## Appendix 1: Membership of the Maternity Services Standards Project Group

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>NHS Board Area/Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Jane Magill (Chair)</td>
<td>Director, Robert Clark Centre for Technological Education</td>
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<tr>
<td>Ms Gill Allan</td>
<td>Sister Midwife</td>
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</tr>
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</tbody>
</table>

Support from NHS QIS is provided by Ms Frances Smith, Director of Nursing and Quality, Mrs Fiona Dagge-Bell, Professional Practice Development Officer, and the Standards Development Team, led by Ms Hilary Davison, Team Manager.
Appendix 2: Evidence Base

Documents cited are marked like this: ②

Royal College publications


7 Royal College of Midwives (RCM). [various dates]. Position Statements (1, 1a, 2, 3). RCM. www.rcm.org.uk/data/info_centre/data/position_papers.htm [access to documents]. URL accessed 05/02/05.


**Scottish Executive Health Department publications**


Audit and other studies, standards and guidelines


Useful websites

37 British Association of Perinatal Medicine (BAPM). Website [ongoing]. BAPM. www.bapm.org/publications.php [publications list/ordering and access to online documents]. URL accessed 05/02/05.

38 National Childbirth Trust (NCT). Website [ongoing]. NCT. www.nctpregnancyandbabycare.com [publications list/ordering and access to online information]. URL accessed 05/02/05.
### Appendix 3: Glossary of Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td><strong>acute care</strong></td>
<td>Hospital-based health services which are provided on an inpatient or outpatient basis.</td>
</tr>
<tr>
<td><strong>allied health professions</strong></td>
<td>Healthcare professionals directly involved in the provision of primary and secondary healthcare. Includes several groups such as physiotherapists, occupational therapists, dietitians, etc. Formerly known as professions allied to medicine (PAMs).</td>
</tr>
<tr>
<td><strong>anaesthesia</strong></td>
<td>Loss of feeling or sensation. This can be anaesthesia of a limited area of the body (local anaesthesia), or the whole body (general anaesthesia). Different drugs and techniques are required for each type of anaesthesia.</td>
</tr>
<tr>
<td><strong>analgesia</strong></td>
<td>Pain relief.</td>
</tr>
<tr>
<td><strong>antenatal</strong></td>
<td>Relating to the period between conception and birth.</td>
</tr>
<tr>
<td><strong>antenatal care</strong></td>
<td>Care of women during pregnancy by professionals in order to detect, predict, prevent and manage problems with the women or their unborn babies. This care also includes education, advice and support.</td>
</tr>
<tr>
<td><strong>audit</strong></td>
<td>The measuring and evaluation of care against agreed standards with a view to improving practice and care delivery.</td>
</tr>
<tr>
<td><strong>bereavement</strong></td>
<td>The period of grief and mourning following death.</td>
</tr>
<tr>
<td><strong>breastfeeding</strong></td>
<td>The nursing of an infant at the mother's breast.</td>
</tr>
<tr>
<td><strong>breech presentation</strong></td>
<td>The position of a baby in the uterus such that it will be delivered buttocks first (instead of the normal head first position).</td>
</tr>
<tr>
<td><strong>caesarean section</strong></td>
<td>An operation where the baby is delivered through an incision in the abdominal and uterine wall.</td>
</tr>
<tr>
<td><strong>childbirth</strong></td>
<td>The process of labour and delivery in the birth of a child.</td>
</tr>
<tr>
<td><strong>clinical governance</strong></td>
<td>A framework through which NHS organisations are accountable for both continuously improving the quality of their services, and safeguarding high standards of care, by creating an environment in which excellence in clinical care will flourish.</td>
</tr>
<tr>
<td></td>
<td>Management of clinical risk at an organisational level is an important aspect of clinical governance. Clinical risk management recognises that risk can arise at many points in a patient's journey, and that aspects of how organisations are managed can systematically influence the degree of risk.</td>
</tr>
<tr>
<td><strong>college</strong></td>
<td>In the UK, the term ‘college’, when used relating to healthcare, as for example in 'The Royal College of…', refers to organisations which usually combine an educational role with promotion of professional standards.</td>
</tr>
<tr>
<td><strong>criterion(sing)/criteria(pl)</strong></td>
<td>Provide the more detailed and practical information on how to achieve the standard, and relate to structure, process or outcome factors.</td>
</tr>
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<td>Term</td>
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<tr>
<td>critical incident</td>
<td>An incident relating to clinical systems or procedures, which results in harm, or an injury, or near miss to a patient/user or member of staff.</td>
</tr>
<tr>
<td>data</td>
<td>A collection of information or facts.</td>
</tr>
<tr>
<td>data source</td>
<td>The source of evidence to demonstrate whether a standard or criterion is being met.</td>
</tr>
<tr>
<td>desirable</td>
<td>Good practice that is being achieved in some parts of the service and demonstrates levels of quality to which other providers of a similar service should strive.</td>
</tr>
<tr>
<td>diabetes</td>
<td>A disorder characterised by high levels of glucose (sugar) in the bloodstream.</td>
</tr>
<tr>
<td>diagnosis</td>
<td>Identification of an illness or health problem by means of its signs and symptoms. This involves ruling out other illnesses and causal factors for the symptoms.</td>
</tr>
<tr>
<td>discharge</td>
<td>A discharge marks the end of an episode of care. Types of discharge include inpatient discharge, day-case discharge, day-patient discharge, outpatient discharge and allied health professions (see AHPs) discharge.</td>
</tr>
<tr>
<td>early pregnancy</td>
<td>The first trimester of pregnancy, up to and including 14 weeks from the last menstrual period.</td>
</tr>
<tr>
<td>eclampsia</td>
<td>Convulsions occurring in a pregnant woman, associated with pre-eclampsia. See pre-eclampsia.</td>
</tr>
<tr>
<td>EGAMS</td>
<td>Expert Group in Acute Maternity Services in Scotland</td>
</tr>
<tr>
<td>epidural anaesthesia</td>
<td>Regional anaesthesia produced by injection of local anaesthetic solution into the spinal epidural space, to provide pain relief during childbirth.</td>
</tr>
<tr>
<td>essential</td>
<td>A criterion that should be met wherever a service is provided.</td>
</tr>
<tr>
<td>established labour</td>
<td>The stage of labour following the onset of regular and painful contractions causing the cervix to dilate.</td>
</tr>
<tr>
<td>evaluation</td>
<td>The study of the performance of a service (or element of treatment and care) with the aim of identifying successful and problem areas of activity.</td>
</tr>
<tr>
<td>evidence-based medicine</td>
<td>Evidence-based clinical practice is an approach to decision-making in which the clinician uses the best evidence available, in consultation with the patient, to decide upon the option which suits that patient best.</td>
</tr>
<tr>
<td>expectant</td>
<td>Pregnant.</td>
</tr>
<tr>
<td>expectant</td>
<td>Relating to criterion 2(b)4, an expectant management option is one in which the woman is observed and monitored, and surgical or medical intervention is not undertaken at this stage.</td>
</tr>
<tr>
<td>fetal</td>
<td>Relating to, or resembling a fetus (clinical term for an unborn child more than 8 weeks after conception).</td>
</tr>
<tr>
<td>Term</td>
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<tr>
<td><strong>fetus</strong></td>
<td>Clinical term for the unborn baby, usually referring to its development from more than 8 weeks after conception until birth.</td>
</tr>
<tr>
<td><strong>generic standards</strong></td>
<td>Standards that apply to most, if not all, clinical services.</td>
</tr>
<tr>
<td><strong>GP</strong></td>
<td>General practitioner</td>
</tr>
<tr>
<td><strong>guidelines</strong></td>
<td>Systematically developed statements which help in deciding how to treat particular conditions.</td>
</tr>
<tr>
<td><strong>gynaecology</strong></td>
<td>A branch of medicine dealing with the diagnosis and treatment of disorders affecting the female reproductive organs.</td>
</tr>
<tr>
<td><strong>haemorrhage</strong></td>
<td>The escape of blood from the blood vessels, bleeding.</td>
</tr>
<tr>
<td><strong>healthcare professional</strong></td>
<td>A person qualified in a health discipline.</td>
</tr>
<tr>
<td><strong>intramuscular</strong></td>
<td>Within a muscle.</td>
</tr>
<tr>
<td><strong>intrauterine</strong></td>
<td>Within the uterus.</td>
</tr>
<tr>
<td><strong>Island NHS Board</strong></td>
<td>There are three Island NHS Boards (Orkney, Shetland and the Western Isles). They have always had a combined strategic and operational role. See NHS Board and NHS Operating Division.</td>
</tr>
<tr>
<td><strong>jaundice</strong></td>
<td>A yellowing of the skin or whites of the eyes, indicating excess of a bile pigment in the blood.</td>
</tr>
<tr>
<td><strong>lead professional</strong></td>
<td>The professional who will give a substantial part of the woman’s care personally and who is responsible for ensuring that the woman has access to care from other professionals as appropriate.</td>
</tr>
<tr>
<td><strong>level II unit</strong></td>
<td>Community-based care from a midwife, GP or obstetrician is described as level IIa. Maternity-unit based care from an obstetrician linking with GP and midwife is described as level IIb. Full maternity unit and support services with easy access to special care baby unit/neonatal intensive care and access to adult high dependency care and adult intensive care is described as level IIc.</td>
</tr>
<tr>
<td><strong>level III unit</strong></td>
<td>Tertiary (third-level) maternity-unit based care from a specialist consultant in maternal fetal medicine.</td>
</tr>
<tr>
<td><strong>maternity</strong></td>
<td>Motherhood.</td>
</tr>
<tr>
<td><strong>midwifery</strong></td>
<td>The profession which leads on normal pregnancy and birth and provides expert care to mother and baby during pregnancy, childbirth and the postnatal period within a family centred environment.</td>
</tr>
<tr>
<td><strong>miscarriage</strong></td>
<td>Loss of products of conception from the uterus before the fetus is viable, spontaneous abortion.</td>
</tr>
<tr>
<td><strong>monitoring</strong></td>
<td>The systematic process of collecting information on the performance of clinical or non-clinical activities, actions or systems. Monitoring may be intermittent or continuous. It may also be undertaken in relation to specific incidents of concern or to check key performance areas. Monitoring is used to appraise strengths, weaknesses, opportunities and threats.</td>
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<td>Term</td>
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<tr>
<td>multidisciplinary team</td>
<td>A multidisciplinary team is a group of people from different disciplines (both healthcare and non-healthcare) who work together to provide care for patients with a particular condition. The composition of multidisciplinary teams will vary according to many factors. These include the specific condition; the scale of the service being provided; and geographical/socio-economic factors in the local area.</td>
</tr>
<tr>
<td>multigravida</td>
<td>A woman who has been pregnant at least twice.</td>
</tr>
<tr>
<td>neonatal resuscitation</td>
<td>The purpose of the neonatal resuscitation is to establish or restore oxygenation, ventilation, and circulation to a newly-born child.</td>
</tr>
<tr>
<td>neonatology</td>
<td>The art and science of diagnosis and treatment of disorders of the newborn infant.</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NHS Board</td>
<td>NHS Boards are responsible for the strategic planning, service delivery, performance management and governance of each of Scotland's 15 local health systems. See NHS Operating Division and Island NHS Board.</td>
</tr>
<tr>
<td>NHS Operating Division</td>
<td>NHS Trusts were abolished on 1 April 2004. Single-system working is now being introduced across NHSScotland. NHS Operating Divisions are committees of an NHS Board, with schemes of delegated authority setting out operational freedom for the delivery of services. They have no separate legal identity from the NHS Board. See NHS Board.</td>
</tr>
<tr>
<td>NHS priorities</td>
<td>The three national clinical priorities are mental health; coronary heart disease and stroke; and cancer.</td>
</tr>
<tr>
<td>NHS QIS</td>
<td>See NHS Quality Improvement Scotland.</td>
</tr>
<tr>
<td>NHS Quality Improvement Scotland (NHS QIS)</td>
<td>NHS Quality Improvement Scotland is a statutory body, established as a Special Health Board in January 2003. Its role is to focus on improving the quality of patient care and the health of patients. It has a particular emphasis on the quality of care and the patient journey for vulnerable groups. Website: <a href="http://www.nhshealthquality.org">www.nhshealthquality.org</a></td>
</tr>
<tr>
<td>NHSScotland</td>
<td>The National Health Service in Scotland.</td>
</tr>
<tr>
<td>NICU</td>
<td>Neonatal intensive care unit</td>
</tr>
<tr>
<td>NMC</td>
<td>Nursing &amp; Midwifery Council</td>
</tr>
<tr>
<td>obstetric(s)</td>
<td>The branch of medicine and surgery that deals with pregnancy and childbirth.</td>
</tr>
<tr>
<td>obstetrician</td>
<td>A doctor specialising in pregnancy and childbirth.</td>
</tr>
<tr>
<td>outcome</td>
<td>The end result of care and treatment and/or rehabilitation. In other words, the change in health, functional ability, symptoms or situation of a person, which can be used to measure the effectiveness of care and treatment, and/or rehabilitation.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>ovulation</td>
<td>The process by which an ovum (female reproductive egg cell) is released from a mature follicle within the ovary.</td>
</tr>
<tr>
<td>oxytocin</td>
<td>A hormone released by the pituitary gland. Oxytocin causes contraction of the uterus during labour and stimulates milk flow from the breasts through contraction of muscle fibres in the milk ducts.</td>
</tr>
<tr>
<td>paramedic</td>
<td>Ambulance paramedics provide specialist pre-hospital care and treatment to acutely ill or injured patients using advanced life support skills.</td>
</tr>
<tr>
<td>pathology</td>
<td>The study of disease processes with the aim of understanding their nature and causes. This is achieved by observing samples of blood, urine, faeces, and diseased tissue obtained from the living patient or at autopsy, by the use of X-rays, and by many other techniques.</td>
</tr>
<tr>
<td>peer review</td>
<td>Review of a service by those with expertise and experience in that service, either as a provider, user or carer, but who are not involved in its provision in the area under review. In the NHS Quality Improvement Scotland approach, all members of a review team are equal.</td>
</tr>
<tr>
<td>perinatal</td>
<td>Relating to the period starting a few weeks before birth, including the birth, and a few weeks after the birth.</td>
</tr>
<tr>
<td>perineal</td>
<td>Relating to the region between the thighs surrounded by the anus and the urethral opening.</td>
</tr>
<tr>
<td>physician</td>
<td>A specialist in medicine.</td>
</tr>
<tr>
<td>physiotherapy</td>
<td>Physiotherapy is a healthcare profession concerned with human function and movement and maximising potential: it uses physical approaches to promote, maintain and restore physical, psychological and social wellbeing, taking account of variations in health status. Physiotherapists in maternity care specialise in the care of women in relation to childbirth and postnatally, including the teaching of antenatal classes.</td>
</tr>
<tr>
<td>placenta</td>
<td>An organ within the uterus joining mother and offspring, and which sustains the pregnancy.</td>
</tr>
<tr>
<td>placenta praevia</td>
<td>A placenta which develops in the lower and non-contractile part of the uterus.</td>
</tr>
<tr>
<td>postnatal depression</td>
<td>A state of psychological sadness that can affect a woman after the birth of her baby.</td>
</tr>
<tr>
<td>pre-eclampsia</td>
<td>A multi-system disorder specific to pregnancy, frequently having high blood pressure as one of the key features.</td>
</tr>
<tr>
<td>pre-conception</td>
<td>The period prior to the onset of pregnancy.</td>
</tr>
<tr>
<td>pregnancy</td>
<td>The period during which a woman carries a developing fetus, normally in the uterus.</td>
</tr>
</tbody>
</table>
primary care  The conventional first point of contact between a patient and the NHS. This is the component of care delivered to patients outside hospitals and is typically, though by no means exclusively, delivered through general practices. Primary care services are the most frequently used of all services provided by the NHS. Primary care encompasses a range of family health services provided by family doctors, dentists, pharmacists, optometrists and ophthalmic medical practitioners.

primigravida  A woman experiencing her first pregnancy.

prolapsed cord  Premature expulsion of the umbilical cord in labour before the fetus is delivered.

prophylactic  An agent that prevents the development of a condition or disease.

prostaglandin  One of a group of hormone-like substances present in a wide variety of tissues and body fluids (including the uterus). These prostaglandins cause the smooth muscle of the uterus to contract.

protocol  A policy or strategy which defines appropriate action in specific circumstances. Protocols may be national, or agreed locally to take into account local requirements.

quality assurance (QA)  Improving performance and preventing problems through planned and systematic activities including documentation, training and review.

rationale  Scientific/objective reason for taking specific action.

referral  The process whereby a patient is transferred from one professional to another, usually for specialist advice and/or treatment.

review  See peer review.

rupture of uterus  Tearing or disruption of the membranes enclosing an infant during childbirth. See uterus.

SCBU  Special care baby unit

Scottish Executive Health Department (SEHD)  The Scottish Executive Health Department is responsible for health policy and the administration of NHSScotland. Website: [www.showscot.nhs.uk/sehd](http://www.showscot.nhs.uk/sehd)

Scottish Intercollegiate Guidelines Network (SIGN)  SIGN was established in 1993 by the Academy of Royal Colleges and Faculties in Scotland, to sponsor and support the development of evidence-based clinical guidelines for NHSScotland. On 1 January 2004, SIGN became part of NHS QIS. For further information relating to SIGN guidelines or the methodology by which SIGN guidelines are developed, contact: SIGN Secretariat, Royal College of Physicians, 9 Queen Street, Edinburgh, EH2 1JQ. Website: [www.sign.ac.uk](http://www.sign.ac.uk)

SEHD  See Scottish Executive Health Department.

self-assessment  Assessment of performance against standards by individual/clinical team/NHS operating division/NHS Board providing the service to which the standards are related.
| **SIGN** | See Scottish Intercollegiate Guidelines Network. |
| **SIGN guideline** | Scottish Intercollegiate Guidelines Network guideline. See guidelines and Scottish Intercollegiate Guidelines Network. |
| **SMRO2** | Scottish Morbidity Record 2 |
| **Special Health Board** | The name given to Health Boards with a national remit. These boards are focused on specific areas, eg NHS Education for Scotland, or NHS Quality Improvement Scotland. Special Health Boards match regional NHS Boards in terms of administrative grading. |
| **stakeholders** | Those people and organisations who may affect, be affected by or perceive themselves to be affected by a decision or activity. |
| **standard** | Agreed level of performance. |
| **standard statement** | An overall statement of agreed performance. |
| **stillbirth** | Birth of a baby that shows no evidence of life (heartbeat, respiration or independent movement) at any time later than 24 weeks after conception. |
| **streptococcal infection** | Infection caused by streptococcus bacteria. |
| **suitably qualified** | A healthcare professional possessing the appropriate skills and knowledge to deliver the required care for the woman and/or baby. This could include a midwife, obstetrician or GP. |
| **telemedicine** | Refers to any application of information and communications technology which removes or lessens the effects of distance on healthcare - sometimes referred to as 'telehealth'. |
| **TENS** | Transcutaneous electrical nerve stimulation. A method of reducing pain by the stimulation of a nerve by passing electrical currents through the skin. |
| **thrombo** | Relating to a blood clot. |
| **thromboembolism** | The condition in which a blood clot (thrombus), formed at one point in the circulation, becomes detached and lodges at another point causing obstruction of a blood vessel. |
| **UKCC NMC** | United Kingdom Central Council for Nursing, Midwifery & Health Visiting. Website: www.nmc-uk.org/ |
| **ultrasound** | An image created by the use of sound waves above the audible range of the human ear. It is useful in the confirmation of pregnancy, and the determination of fetal size and wellbeing. |
| **uterus** | The hollow muscular organ in which the fertilised ovum normally becomes embedded and in which the developing embryo and foetus is nourished. |
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