The Board is asked to:

- Approve the Maternity Services Strategy and Strategy Workplan

1 Background and Policy Context

Previous Scottish Government policy documents have supported women-centred models of maternity care which recognise that pregnancy is a normal life experience, with significant social and psychological impact on the woman and her family (The Framework for Maternity Services in Scotland, 2001) and the subsequent Expert Group Report on Acute Maternity Services in Scotland (EGAMS 2003). The Refreshed Framework for Maternity Care in Scotland (SG 2011) acknowledges the progress made towards implementing this social model of care, and builds on this foundation with an emphasis on influencing health and improved outcomes for women and families. The focus on reducing inequalities is further endorsed by the Antenatal Inequalities Guidance: Evidence into Action (SG 2011) and the Maternal and Infant Nutrition Framework, launched at the same time as the Refreshed Framework (SG 2011).

This new NHS Highland Maternity Services Strategy is closely linked to all these policy documents, the Healthcare Quality Strategy for Scotland and NHS Highland’s Strategic Framework. It recognises that the public expect quality care at all times and embraces the characteristics of quality service delivery outlined in the NHS Highland Strategic Vision. The recommendations in these policy documents and the NHS Highland Maternity Services Strategy are closely linked and the implementation will run concurrently.

2 Summary of Maternity Services Strategy

For NHS Highland this new strategy and the implementation of the Refreshed Framework (SG 2011) represents a continuation of work started and achieved in the previous Maternity Services Strategy 2009-2011.

The focus will be on vulnerable families and early years in order to achieve the ‘best possible start in life’ for new families and children, and to decrease the gap between rich and poor. This can only be done by working more closely with communities and local government partners in order to influence social, economic and lifestyle factors which are important determinants of health.

The wider Women and Families policy context within which maternity services function support the same principles. The Getting it Right for Every Child (GIRFEC) model of ‘getting it right for every child’ is embedded in NHS Highland and the maternity service will work closely with the new Children’s service within the Lead Agency model to ensure that pathways of care for women and their families are as seamless as possible.

While the focus of policy has shifted to improve outcomes for vulnerable families, it is important that we do not loose the core principles of clinical safety for mothers and babies from our maternity service: mothers and babies still die or suffer severe morbidity during pregnancy and birth. The recent Centre for Maternal & Child Enquiries (CMACE) report
(BJOG 2011) highlighted the increase in maternal deaths from sepsis; recognised the need for a ‘back to basics campaign’ in order to ensure that professionals are adequately trained and aware of basic clinical conditions, and recognition of signs and symptoms of complications of pregnancy. In addition, the UK stillbirth rate is static and high in comparison with other developed countries. While these matters are linked with the social indices and deprivation they are not exclusive to it and therefore we must ensure that they remain core to our service delivery. In this respect, maternity services will continue to work closely with the Scottish Patient Safety Programme (SPSP) and the development of a Maternity Improvement Programme with HIS in order to monitor, identify and act upon outcomes that are out with agreed parameters.

The Maternity Services Strategy has two parts: Firstly, The Maternity Strategy which outlines the Vision and Principles which NHS Highland sees as key to the development of maternity services over the years from 2011-14. Secondly, the Strategy Work Plan which outlines in more detail how the strategic vision is translated into operational practice and measurable outcomes. Operational Implementation plans are currently being updated to bring them in line with the new operational units.

The Strategy and Refreshed Framework Implementation Plans will be monitored through the Maternity Services Strategy Co-ordination Group (MSSCG) with operational updates at each meeting. The MSSCG is accountable to the Clinical Governance Committee and submits an annual report to this Committee.

2.1 The NHS Highland Vision for Maternity Services

NHS Highland Vision for Maternity Services is that Maternity services will be **women and family centred**, encompassing **safety, effectiveness and accessibility** (efficiency & sustainability) in order to achieve the **best possible start** in life for new families and our children.

2.2 The Principles that support the Vision

The Vision is developed through a set of Principles which describe the key areas of work. These are outlined below, along with some examples of outputs that are expected in order to achieve the Vision. The detail of this is contained in the Strategy p 8-10.

2.2.1 Women and family centred & Best Possible Start

- Apply a public health approach during pregnancy and following birth through the development of NHS Highland multi-agency policies and practice that improve the overall wellbeing of women, their families and their children in order to address health inequalities.
- Promote and develop integrated working with social/agency/voluntary and community planning.
- Develop methods of public engagement and communication that will ensure the involvement of women and families in service delivery and change.

2.2.2 Safe:

- Reduce avoidable harm through appropriate risk management and assessment, learn from untoward incidents, participate in SPSP, ensure adequate staff training.
2.2.3 Effective:

- Develop a clinical and managerial structure for maternity services that ensures the model of maternity care can deliver safely, efficiently and effectively.

2.2.4 Accessible:

- Tailor maternity services to meet the needs of women and families, particularly those that are most vulnerable.
- Ensure that pregnancy and birth are treated as a normal and natural process, reflected by midwife-led and managed services as far as possible.
- Ensure that as far as possible services are delivered locally—this will include intra-partum care and the promotion of local CMUs as part of the Maternity Network.

Each Operational Unit has developed priority workstreams. These are detailed on pages 10-12. These are currently being re-aligned to reflect the new operational structures. The Framework that we see supporting all this work is condensed in Diagram 1 on page 13.

2.3 Remote and Rural Maternity Services

In addition to these core principles, NHS Highland recognises the uniqueness of specific maternity care provision in very remote and island communities, and the challenge created by geography, distance and travel to acute maternity care centres. In addition to the new Strategy, NHS Highland Maternity Service has a supplementary guidance document ‘Model of Maternity Care for very Remote and Island Communities’ (Highland Health Board, 2010). This concentrates on the type of maternity service that is required in such areas and was developed by the Islay and Jura Maternity working group and is used to support practice and service re-design in remote areas.

2.4 The Refreshed Framework for Maternity Services Implementation Plan.

With regard the implementation of the Refreshed Framework, Health Boards have agreed to focus on three main themes: firstly, workforce development to ensure that staff are adequately trained for the task; secondly, the development of e-systems to support robust data collection & outcomes measurements. Thirdly, pathways of care—which will include the development of a national SPSP Maternity Improvement Programme. All these will ensure that the principles of the Framework can be effectively implemented. These themes are incorporated into the work plans for the implementation of the MS Strategy.

2.5 Timescales for Implementation

The Strategy will be implemented over the next three years (January 2012- December 2014). Operational Implementation Plans have been drawn up and monitored through Operational Unit governance structures for maternity services and reported regularly to the MSSCG.

3 Contribution to Board Objectives

The Maternity Service Strategy sets out the direction that NHS Highland maternity services will develop in the next three years. It is aligned to the Health Board’s Strategic Framework and supports the Corporate Objectives of the Board in several ways: Enhances Board governance of maternity services; works to ensure that maternity service provision is safe and sustainable; ensures that resources are used efficiently and is cognisant of health inequalities in maternity care and will endeavour to address them through the promotion of health messages and delivery of locally based.
In addition the, following HEAT targets are addressed through the implementation of the recommendations of the strategy:

- At least 80% of pregnant women in each Scottish Index Multiple Deprivation (SIMD) quintile will have booked for antenatal care by the 12th week of gestation by March 2015 so as to ensure improvements in breast feeding rates and other important health behaviours.

4 Governance Implications

The implementation of the Maternity Services Strategy and Refreshed Framework Implementation Plan will be overseen by the MSSCG. Members of MSSCG will lead or identify leaders for the implementation of recommendations within Operational Units and the work will be monitored regularly. As the Strategy was completed prior to announcements about new organisational structures the priority workstreams for the Operational Units are being updated to ensure local implementation.

The Strategy and Refreshed Framework Implementation plan will run until December 2014. Annual Progress reports will be written for the Board and Clinical Governance Committee.

5 Impact Assessment

The NHS Highland Maternity Services Strategy and Refreshed Framework Implementation Plan will deliver government and health board targets. This strategy has been developed to ensure equitable access to services which enhance health services for women and their families during pregnancy. Any policies developed as a result of this strategy will be impact assessed.

Helen Bryers on behalf of Heidi May Board Nurse Director
Head of Midwifery
Assynt House

19th June 2012
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NHS Highland, 2010-11, Maternity Services Strategy

NHS Highland, 2009, Model of Maternity Care for Remote and Island Communities,

NHS Highland, 2001, A Review of Maternity Services

NHS QIS, 2006, QIS Standards Report NHS Highland Maternity Services


NHS Highland
Maternity Services Strategy and
Strategy Workplan

November 2011 – December 2014

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Prepared by: Helen Bryers, Lead Midwives & Clinical Leads (Raigmore and Caithness) and Members of Maternity Services Strategy & Co-ordinator Group (MSSCG)
Date of Review: November 2014
Lead Reviewer: Helen Bryers
Version: Final
Authorised by: (MSSCG) Date: January 2012

Distribution
- Maternity Services Strategy & Co-ordination Group (MSSCG)
- Medical Director
- Board Nurse Director
- All Consultant Obstetricians
- Midwifery Leads and Team Leaders
- All maternity departments
- Supervisors of Midwives
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1. BACKGROUND and POLICY CONTEXT

Previous Scottish government policy documents have supported women-centred models of maternity care which recognise that pregnancy is a normal life experience with significant social and psychological impact on the woman and her family. The Refreshed Framework for Maternity Care in Scotland (SG 2011) acknowledges the progress made towards implementing this social model of care and aims to build on this foundation with an emphasis on influencing the health and improved outcomes for women and families. The focus on reducing inequalities is further endorsed by the Antenatal Inequalities Guidance: Evidence into Action (SG 2011) launched at the same time as the Refreshed Framework.

The Refreshed Framework and this new NHS Highland Maternity Services Strategy are closely linked to the Healthcare Quality Strategy for Scotland and NHS Highland’s Strategic Framework. It recognises that the public expect quality care at all times, defined within the 7 ‘C’s’ and embraces the characteristics of quality service delivery outlined in the NHS Highland Strategic Vision. For NHS Highland this new strategy represents a continuation of work started and achieved in the previous Maternity Services Strategy 2009-11, agreed by NHS Highland Board.

The focus will be on vulnerable families and early years in order to achieve the ‘best possible start in life’ for new families and children and to decrease the gap between rich and poor. This can only be done by working more closely with communities and local government partners in order to influence social, economic and lifestyle factors which are important determinants of health.

The wider Women and Families policy context within which maternity services function support the same principles. The GIRFEC model of ‘getting it right for every child’ is embedded in NHS Highland. Work towards integration of children’s services with local authorities is underway. Another important document is the Maternal and Infant Nutrition Framework, launched at the same time as the Refreshed Framework.

While the focus of policy has shifted to improve outcomes for vulnerable families, it is important that we do not lose the core principles of clinical safety for mothers and babies from our maternity service: mothers and babies still die or suffer severe morbidity during pregnancy and birth. The recent CMACE report (BJOG 2011) highlighted the increase in maternal deaths from sepsis; recognised the need for a ‘back to basics campaign’ in order to ensure that professionals are adequately trained and aware of basic clinical conditions and recognition of signs and symptoms of complications of pregnancy. In addition, the UK stillbirth rate is static and high in comparison with other developed countries. While these matters are linked with the social and vulnerability agenda they are not exclusive to it and therefore we must ensure that they remain core to our service delivery.

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1. Caring and compassionate staff and services; clear communication; effective collaboration; clean and safe environment; continuity of care and clinical excellence

2. 1. Promoting good health, self-care and independence
   2. high quality, integrated care
   3. community based
   4. integrated and complementary to local authorities, voluntary and independent sector
   5. healthy, flexible well motivated staff
   6. modern efficient green assets to maximum effect
   7. zero wastage and inefficiency
Finally, the maternity landscape is changing - the recent RCOG reports on the future of maternity services provision (RCOG 2011) advocates the development of Women’s Health Networks with the focus on intra-partum care as locally based as possible; the development of Community Maternity Units (CMUs) with midwives as lead carers as the norm for low-risk women; leaving obstetricians to care for the high risk categories in fewer but larger Consultant Led Units (CLU) and tertiary maternity units.\(^3\)

Over the next year, there will be changes to the organisational structure of NHS Highland. This Strategy will still apply but may need to be adapted to ensure local implementation.

This document is in three parts: The Maternity Strategy which outlines the Vision and Principles which NHS Highland sees as key to the development of maternity services over the years from 2011-14. This is followed by the Strategy Work Plan including improvement measures and implementation plan which outlines in more detail how the strategic vision is translated into operational practice and measurable outcomes.

Over and above these two documents, there is an implementation plan (Appendix 1) which will be used as the basis for the development of local Work Plans with Raigmore and the Operational Units.

### 2. NHS HIGHLAND STRATEGY AND VISION FOR MATERNITY SERVICES

The Maternity Service Strategy sets out the direction that NHS Highland anticipates the maternity service will develop in the next three years (August 2011-14). It is aligned with the Healthcare Quality Strategy and the Health Board’s Strategic Framework and the overall efforts to improve the health of the people of the Highlands and their healthcare provision. Maternity Services will contribute to this by ensuring that we provide safe care of the highest quality and use the pregnancy year to promote health messages that will have a positive impact on the transition to parenthood.

#### 2.1 NHS Highland Vision for Maternity Services

Maternity services will be women and family centred, encompassing safety, effectiveness and accessibility (efficiency & sustainability) in order to achieve the best possible start in life for new families and our children.

#### 2.2 Principles which underpin the Vision

2.2.1 To be women and family centred we will:

- Develop methods of public engagement and communication that will ensure the involvement of women and families in service delivery and change.
- Ensure that the NHS Highland model of maternity care is disseminated to all communities and is readily accessible to women and families seeking information about maternity services.
- Work towards a common understanding of how, where, when and why levels of maternity care provision are provided across NHS Highland.

2.2.2 To be safe we will:

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NHS Highland Maternity Services Strategy and Strategy Workplan

- Reduce avoidable harm through appropriate risk management and assessment.
- Learn from untoward incidents, and active participation in the Scottish Patient Safety Programme.
- Provide a safe environment for women and families during the pregnancy year.
- Ensure adequate staff training and skills updating and maintenance.

2.2.3 To be effective we will:

- Continuously work towards an evidence-based high quality maternity service.
- Ensure that all staff have the right skills and training at the right time.
- Ensure that workforce planning and development are up to date and informed by national workforce planning tools that are fit for purpose for NHS Highland including remote and rural maternity services.
- Base maternity care on a sustainable (realistic) model that reflects the current financial climate, without compromising safety and quality.
- Develop a clinical and managerial structure that ensures the model of maternity care can deliver safely, efficiently and effectively.

2.2.4 To be accessible we will:

- Tailor maternity services to meet the needs of women and families, particularly those that are most vulnerable.
- Ensure that pregnancy and birth are treated as a normal and natural process and reflected by midwife-led and managed services as far as possible.
- Ensure that as far as possible. Services are delivered locally- this will include intra-partum care and the promotion of local CMUs as part of the Maternity Network
- Promote and develop integrated working with social/agency/voluntary and community planning.
- Be explicit about the levels of maternity care which we are able to provide across NHS Highland to ensure quality and understanding of what is available and where/when.
- Use technology to support clinical services and professional decision making and to ensure best use of all resources (expertise and equipment) across the whole area.

2.2.5 To achieve the best possible start we will:

- Apply a Public Health approach to improve pre-conceptual health, health during pregnancy and following birth.
- Implement national policy and the development of NHS Highland multi-agency policies and practice that improve the overall wellbeing of women, their families and their children in order to address health inequalities.

2.3 NHS Highland recognises the uniqueness of specific maternity care provision in very remote and island communities and the challenge created by geography, distance and travel to acute maternity care centres. Recent work with Islay and Jura, Mull & Iona and Sutherland has resulted in the development of a model of maternity care which is transferable to other similar areas and we aim to be service leaders in this our field of expertise.

2.4 With regard to the implementation of the Refreshed Framework, Health Boards have agreed to focus on three main themes: firstly, workforce development to ensure that staff are adequately trained for the task; secondly, the development of e-systems to support
NHS Highland Maternity Services Strategy and Strategy Workplan

robust data collection & outcomes measurements. Thirdly, pathways of care – all these will ensure that the principles of the Framework can be effectively implemented.\(^4\)

2.5 NHS Highland aims to minimise medical intervention in maternity care provision and to support the focus on normal birth. We will do this by ensuring that while access to specialist services is maintained, we will promote the skills and confidence that support normal birth within local communities where possible.

2.6 In addition, Argyll and Bute Operational Unit continues to work with obstetric referral pathways to Greater Glasgow and Clyde Health Board.

3 THE MODEL OF MATERNITY CARE IN NHS HIGHLAND

Map of NHS Highland showing maternity units:

At present maternity care in Highland is provided in a variety of locations throughout the geographical area which include the following: Raigmore Maternity Unit, Caithness Maternity Unit, Community Midwifery bases, peripheral Consultant-led clinics, Midwifery/GP clinics, parenting classes and other services in local community settings. This ensures easy access for women and their partners to antenatal and postnatal services. Acute inpatient services are currently centralised in Raigmore Hospital, giving access to essential services e.g. Blood Transfusion, Laboratory Services, Adult Intensive Care Unit, Medical Imaging and other clinical specialities.

These services and the staff that work within them are governed within the local management structures within Raigmore and the Operational Units. In addition, there is a professional leadership structure for midwifery. At a strategic level, the service is brought together under the Maternity Services Strategy & Co-ordination Group (MSSCG).

The current maternity service consists of the following:

Table 1: Current maternity care provision in NHS Highland

<table>
<thead>
<tr>
<th>Area</th>
<th>Service</th>
<th>Level of care (EGAMS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raigmore</td>
<td>Consultant maternity unit</td>
<td>Level 2c</td>
</tr>
<tr>
<td>Inverness community</td>
<td>Community midwifery team</td>
<td>Level 1</td>
</tr>
<tr>
<td>SE &amp; Mid Operational Unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Badenoch &amp; Strathspey</td>
<td>Community midwifery team</td>
<td>Level 1</td>
</tr>
<tr>
<td>Nairn</td>
<td>Community midwifery team</td>
<td>Level 1</td>
</tr>
<tr>
<td>Ross, Cromarty and West Ness</td>
<td>Midwifery based within integrated community teams</td>
<td>Level 1</td>
</tr>
<tr>
<td>North &amp; West Operational Unit</td>
<td>Consultant maternity unit with</td>
<td>Level 2a</td>
</tr>
</tbody>
</table>

\(^4\) See NHS Highland template for the implementation of the Refreshed Framework – appendix to the Strategy Workplan
### NHS Highland Maternity Services Strategy and Strategy Workplan

<table>
<thead>
<tr>
<th><strong>Integrated Midwifery Service</strong></th>
<th><strong>Community Midwifery Team</strong></th>
<th><strong>Level 1</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sutherland Midwifery Team</td>
<td>Community midwifery team</td>
<td>Level 1</td>
</tr>
<tr>
<td><strong>North &amp; West Operational Unit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Belford</td>
<td>Belford CMU</td>
<td>Level 1</td>
</tr>
<tr>
<td>Skye and Lochalsh</td>
<td>Midwifery team</td>
<td>Level 1</td>
</tr>
<tr>
<td>Wester Ross</td>
<td>Midwifery team</td>
<td>Level 1</td>
</tr>
<tr>
<td>Argyll &amp; Bute</td>
<td>Oban- including Mull, Iona, Coll &amp; Colonsay</td>
<td>Level 1</td>
</tr>
<tr>
<td>Oban</td>
<td>Oban CMU</td>
<td>Level 1</td>
</tr>
<tr>
<td>Mid Argyll – including Islay &amp; Jura</td>
<td>Lochgilphead CMU</td>
<td>Level 1</td>
</tr>
<tr>
<td>Campbelltown</td>
<td>CMU</td>
<td>Level 1</td>
</tr>
<tr>
<td>Rothesay</td>
<td>CMU</td>
<td>Level 1</td>
</tr>
</tbody>
</table>

* Obstetric referral to GG&C- Royal Alexandra Maternity Unit, Paisley is the main referral unit.

The map and Table 1 outline the way maternity services are currently provided across NHS Highland. This is the foundation of the service. In order to achieve the aims of this strategy, we need to move to a more integrated way of working, both throughout the maternity service itself but also in relationships with locally-based services such as local healthcare services & disciplines, ambulance service, local communities and service users.

As with other services, it is paramount that professionals involved in delivering maternity care are skilled, competent and up-to-date in their clinical practice. This is a key priority detailed in Better Health Better Care Action Plan (SG 2007) and staff should be supported to acquire and maintain skills through the Personal Development Plan (PDP) process which should be evidence-based.

Established links with HEI providers: University of Aberdeen, Robert Gordon’s University and University of Stirling ensure that the education and training of professionals reflect the needs of future maternity services and has accreditation elsewhere in the world. Correspondingly professionals from other countries need to be screened to make sure that their practice is of an acceptable standard. NHS Education for Scotland (NES) and RRHEAL support post-graduate educational programmes. Clinical Governance, including professional registration, will play a major role in setting standards, promoting peer review, clarifying professional roles and creating a learning environment with a no-blame culture. The opportunity should also be taken to explore a learning environment with a no-blame culture.

### 4 POLICY AND EVIDENCE INTO PRACTICE: HOW THE VISION WILL BE ACHIEVED

**Quality Outcomes, HEAT Targets and Service Improvement Measures**

The Scottish Government has agreed 6 healthcare Quality Outcomes which provide a more comprehensive description of the priority areas for health improvement in support of the Quality Ambitions. The 6 healthcare Quality Outcomes are:
NHS Highland Maternity Services Strategy and Strategy Workplan

- **Quality Outcome 1** - Everyone gets the best start in life, and is able to live a longer, healthier life: NHS Scotland works effectively in partnership with the public and other organisations to encourage healthier lifestyles and to enable self care, therefore preventing illness and improving quality of life.

- **Quality Outcome 2** - People are able to live well at home or in the community: NHS Scotland plans proactively with patients and with other partners, working across primary, community and secondary care, so that the need for hospital admission is minimised. This is therefore reflected in the outcome indicators on emergency admissions and end of life care.

- **Quality Outcome 3** - Healthcare is safe for every person, every time: Healthcare services are safe for all users, across the whole system.

- **Quality Outcome 4** - Everyone has a positive experience of healthcare: Patients and their carers have a positive experience of the health and care system every time, which leads them to have the best possible outcomes. This should be demonstrable across all equalities groups.

- **Quality Outcome 5** - Staff feel supported and engaged: Staff throughout NHS Scotland, and by extension, their public and third sector partners, feel supported and engaged, enabling them to provide high quality care to all patients, and to improve and innovate.

- **Quality Outcome 6** - The best use is made of available resources: NHS Scotland works efficiently and effectively, making the best possible use of available resources.

These Quality Outcomes are integral to the principles within our maternity strategy and form the basis for the development of HEAT targets. One of the new HEAT targets is for early access to antenatal care for all pregnant women and this will be taken forward as part of the implementation of the Refreshed Framework for Maternity Services and the new NHS Highland maternity services strategy.

We aim to implement the Quality Framework and the recent Refreshed Framework for Maternity Care in Scotland, through the vision and principles set out in this strategy. In order to do this, there will be changes to the way maternity services are delivered and each operational area will develop a local action plan in order to achieve this. Based on the above principles, the following changes or outputs are required to successfully achieve our vision:

### 4.2 A Woman and Family Centred Model

- Develop effective ways of communicating with women and families making full and appropriate use of technology to achieve this.
- Aim to deliver maternity services as locally as possible for all women and families.
- Work hard with communities to ensure that a good understanding of the level of maternity service available to their area is agreed.
- Aim to have women and families involved in local maternity service development groups.
- Work with women and families to adopt relevant principles of ‘Self-care’ philosophy and support family interactions to grow self-sustainable communities.
- Women and their families should be fully involved in decisions regarding their care.
- Communication links between maternity services, the public and other multi-agency services need to be promoted and strengthened to realise their potential in the development and improvement of local maternity services.

### 4.3 A Safe Model
Meet the HSE & (Healthcare Environment Inspectorate (HEI) requirements within our acute maternity units, CMUs and community settings.

- Reduce Surgical Site Infection (SSI) in elective and emergency caesarean sections to 0% (no cases) for 100 days and overall annual rate to below 4% for both elective and emergency caesarean section (C/S).
- Have a fully functioning web-based maternity DASHBOARD by March 2012.
- Fully engage with the Scottish Patient Safety Programme (SPSP) as applicable within maternity services.
- Generate quarterly maternity service reports for the Maternity Services Strategy & Coordination Group.
- Annual maternity services report to the NHS Highland Board.
- The appointment of a clinical lead for a Highland wide maternity service.

4.4 An Effective Model

- Correct levels of appropriately trained and skilled medical and midwifery staff and support staffing for each level of maternity care provision.
- Meet the Nursing Midwifery and Allied Health Professional (NMAHP) mandatory training plan requirements for all midwifery staff.
- Review the provision of obstetric services across the model for NHS Highland and across the North of Scotland in order to make best use of obstetric expertise and manpower.
- Review the model of midwifery services across NHS Highland in order to make best use of expertise and manpower and midwifery led care as the norm.

4.5 An Accessible Model

- Maintain the principle of providing as much of the maternity care provision as close to the women’s home and community as possible.
- Consider the options for maternity service operational structure across NHS Highland in order to concentrate corporate, operational and clinical governance in one structure to ensure the most safe, efficient and effective maternity service.
- Review and propose a model for the future provision of a homebirth/Out of Hours maternity service for NHS Highland.
- Propose the development of a CMU for the Inverness area, in order to offer choice to women and to decrease intervention in low risk pregnancy and birth.
- Develop integrated working with the Local Authority and Third Sector agencies in order to deliver the public health agenda.
- Identification of special needs during pregnancy, such as Interpreter Services, ensuring equality of access for women from minority ethnic communities.
- Work with the Scottish Ambulance Service (SAS) and neonatal transport services to ensure that the current model is made more robust and as accessible as possible for remote Highland community services and CMUs.

4.6 To achieve a Best Possible Start Model

Mothers as healthy as possible

- Promote referral for pre-pregnancy counselling.
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- Tackling obesity through the development of service pathways for women with high body mass indexes (BMIs) including access to a dietitian and anaesthetic specialists during antenatal care if required.
- Ensuring a multi-disciplinary approach to addressing substance misuse and addictions, including smoking cessation, and alcohol brief intervention.
- Awareness of the risks associated with infection.
- Working with the multi-disciplinary and multi-agency teams to support and deliver services for vulnerable women and families.
- Ensuring all women have early access to appropriate levels of antenatal care and screening programmes.
- Informed choice for women over place of birth with clear risk assessment undertaken.

Healthy babies

- Ensure breast feeding rates as high as possible at birth and six weeks.
- Adequate support for breast feeding mothers, including best use of peer supporters.
- Provision of advice and support through clinic and telehealth for women with infant feeding problems.
- Newborn screening and surveillance undertaken
- Provision of postnatal care and services that promote attachment and supports parenting

4.7 Priority Workstreams for each operational area

Work has already begun on the implementation of this strategy. Each operational unit has identified priority workstreams. These are:

Priority workstreams

4.7.1 Overall

- Development of Highland wide maternity service to include:
  - corporate and operational governance
  - clinical governance- risk management, guidelines, training and development
- Implementation of HEAT target- early access to antenatal care.
- OOH provision, maternity triage, provision of local and homebirth services.
- Full Baby Friendly Accreditation for community.
- Implementation of the three main work streams of the Refreshed Maternity Services Framework:
  - workforce development to ensure that staff are adequately trained.
  - the development of a maternity e-systems to support robust data collection & outcomes measurements.
  - pathways of care.

4.7.2 Raigmore

Re-design of maternity services including:
• Re-design of triage and management of OOH maternity care- re-design of development of a Maternity Assessment Unit (MAU).
• Development of a CMU for the Inverness area.
• Review workforce & skill mix for maternity services.
• 24 hour access to dedicated obstetric theatre.
• Aligned with the development of CMU, specific revision of community midwifery services to support vulnerable families and the intensive caseload management required for this group of women.
• Re-design of Maternity Assessment Unit (MAU) – including day case.
• Full implementation of the national screening programme.
• Implementation of HEAT Target – early access to ante-natal care.
• Implement full accreditation of Baby Friendly status for Inverness and South and Mid Operational Unit.

4.7.3 North and West Operational Unit

• Clear identification and agreement of level of service provided at Caithness.
• Achieve a fully integrated midwifery service.
• Move from pilot to full implementation of single duty midwifery service for North and NW Sutherland.
• Maintain & sustain CMU model in Skye and Belford.
• Implement full accreditation of Baby Friendly status Initiative (BFI) for Caithness and Sutherland communities.
• Implementation of HEAT Target – early access to ante-natal care.

4.7.4 SE & Mid Operational Unit

• Co-ordination of midwifery services in Ross Cromarty West Ness (RCWN) through one midwifery team leader.
• Specific revision of community midwifery services in Ross Cromarty West Ness (RCWN), particularly in Alness area to support vulnerable families and the intensive caseload management required for this group of women.
• Implement Baby Friendly full accreditation.
• Implementation of HEAT Target – early access to ante-natal care.

4.7.5 Argyll & Bute

• Maintain model of practice.
• Agree Service Level Agreement (SLA) arrangement with GG&C.
• Attain Full Baby Friendly Status.
• In anticipation of workforce retirements, review the double duty nursing/midwifery service in Coll and Tiree and develop a realistic alternative model of practice.

These are identified as workstream priorities. The workplan that follows gives more detail for specific service changes and improvements throughout the pregnancy journey from pre-conception to post-natal and neonatal care. The Framework that we see supporting all this work is condensed in Diagram 1.
The Strategy

Workplan
5. THE STRATEGY WORKPLAN

In order to evidence that we are undertaking the activities that we outlined in our Strategy, (Section 4), we will have in place a range of improvement measures to support our work. These are outlined here following the pregnancy journey flow from pre-conception to postnatal and neonatal care. Local details are found in the Raigmore Hospital and Operational Unit’s action plans and these are cross-referenced to the Quality Outcomes.

5.1 Preconception and early pregnancy

The aim of pre-conceptual and early pregnancy care is to ensure that women and families are prepared for pregnancy and the resultant life changes. This preparation should include clinical and emotional wellbeing.

Pre-conceptual services are currently available to all women with a poor obstetric history or fetal outcome. We believe that the development of pre-conceptual care for all women is important and we aspire to this becoming the ‘norm’ for all women within NHS Highland. Pre-conceptual care should include:

- Pre-conceptual folic acid and a focus on a good diet
- Avoiding alcohol if pregnant or trying to conceive
- Not using recreational drugs
- Not smoking and having a smoke free environment
- Pre-pregnancy rubella immunisation
- Benefits of breast feeding to mother and baby
- Information on exercise in pregnancy
- Ensuring a healthy body mass index and assessment of nutritional status
- The consequences of prescription medication on a woman’s ability to conceive and the impact of medication on a developing foetus
- Consultation with specialist services for women with pre-existing medical conditions eg. Diabetes, epilepsy, cardiac disease and mental health issues
- What becoming a parent might be like and the impact on relationships

Service Improvement measure

Auditable pre-conceptual referral for counselling accessible throughout NHS Highland run by appropriately trained professionals – elements of this should be web-based

5.2 Antenatal Care

The aim of antenatal care is to ensure, as far as possible, the health and well-being of the woman and unborn child. The importance of involving all women and their partners as early as possible in planning their care with an emphasis on continuity of care and high quality information is recognised.

5.2.1 Lead Professional identified from booking

As part of the overall implementation of the National Pathways for Maternity Care (NHS QIS 2009), each woman is allocated a lead professional as early as possible (booking). This lead professional, allocated by risk category, is responsible for the co-ordination, planning and provision of antenatal care, with support from the wider service when
required. This will include forward planning for the care of the baby and development of
the baby's/child plan.

Linked to Quality Outcome 1, the new HEAT target Early Access to Antenatal Care by 12
weeks states:

At least 80% of pregnant women in each NHS Board deprivation quintile will have
booked for antenatal care by the 12th week of gestation by March 2015 so as to
ensure improvements in breast feeding rates and other important health behaviours.

This target is set in order to improve early access to antenatal services to support
mothers-to-be to breastfeed, improving maternal and infant nutrition, reduce harm from
smoking, alcohol and drugs, and improve healthy birth weight.

While the target is aimed at all women, it particularly focuses on:

- women under 20
- those living in the poorest SIMD quintiles

We aim to have all women in pregnancy booked by 12 weeks with earlier access for
women with pre-conceptual identified risks. Antenatal care should be delivered as
outlined in the National Pathways for Maternity Care (NHS QIS 2009) and other relevant
guidance such as the Maternal and Infant Nutrition Framework and A Pathway for Care
for Vulnerable Families (SG 2011). The development of local guidance including work
around vulnerable women in pregnancy that includes pregnancy and substance misuse,
perinatal mental health, nutrition and breastfeeding recognises the impact of social and
clinical risk and appropriate referral pathways and care options are identified.

Education and information are key aspects of the delivery of maternity services.
Information is important as it and plays a part in enabling women to make choices and
feel involved in their care. A recognised professional to co-ordinate parenthood education
would provide seamless care and advice throughout NHS Highland and enable the
development of the new Scottish Antenatal Education pack (NHS Health 2011). A
comprehensive health promotion programme should incorporate an opportunity for
discussion about the effects of parenthood on relationships.

Service Improvement measures

- Evidence of the impact of the appropriate allocation of a lead maternity care
  professional by risk category and appropriate multi-disciplinary and multi-agency
  working.
- Evidence the % of women who access antenatal care by 12 weeks- aim to have at
  least 80%
- Evidence how we try to increase the uptake of antenatal care & antenatal education
  for women at risk of poorer maternal and infant health outcomes
- Aim to increase the number of women in pregnancy who attempt to quit smoking to
  19%
- Evidence of implementation of Maternal and Infant Nutrition Framework
5.2.2 Pregnancy Screening

The aim of the Highland pregnancy screening programme is to ensure standardised, quality assured pregnancy screening services that meet the 2005 NHS QIS Pregnancy and Newborn Screening Standards and the CEL 31 (2008) Changes to Pregnancy and Newborn Screening programme.

All women should have the right information at the right time in order to make informed choice. Appropriate and timely pre-screening information can help women clarify their choices and inform decision making. All pregnant women attending for antenatal care are provided with information about the tests early in their pregnancy, as detailed in the Highlands Information Trail (NHS Highland 2011) to enable them to make an informed decision about whether or not to proceed with the screening tests.

Service Improvement Measures

- Evidence that all women have timeous access to the antenatal screening programme by 10 weeks.
- Evidence that staff involved in screening programme are appropriately trained and plan for ongoing training of sonographers to make the service sustainable is in place.

5.3 Intra-partum Services

The aim of intra-partum services is to ensure, as far as possible, a safe outcome of pregnancy for mother and baby and to ensure that women’s expectations of a positive birth experience are met.

This is underpinned by the following principles:

- Maternity services (across NHS Highland and not at each site), including obstetric and neonatal services, should provide a fully integrated childbirth service to include 24hr access to dedicated obstetric theatre and epidural anaesthesia on request in order to be responsive to the needs of mothers and their newborn babies.
- One to one midwifery care should be given to women during labour and childbirth in order to make sure they have individualised attention and support, preferably with continuity of carer.
- Women have the right to choose how and where they give birth. This choice should be supported by high quality information and evidence-based clinical advice that allows them to take part in the decision making process.

All women want a healthy baby but not all women want the same kind of care. The key to giving women the standard of care they want must be by informed choice, taking into consideration the safety of the mother and the baby. Choice is defined as the right of the mother to choose her place of delivery and option is defined as the services the provider units offer.

The choices and options should be fully explained by professionals without undue influence and a balance should be struck between choice and professional standards. This is an increasingly important area as more women properly wish to decide on and agree their own management. The implications for an increased number of homebirths, increase in mother’s choice for caesarean sections, or, more planned induction of labour...
for non-medical reasons may make the challenge between maternity care professionals providing safe and effective care and pregnant women’s choice greater.

In 2010, there were 45 planned homebirths in NHS Highland. The total number of births in NHS Highland in 2010 was 2548 births. Therefore, planned homebirths accounted for approximately 2% of all NHS Highland births. In addition, there were 22 unplanned homebirths or births before arrival in maternity units (BBAs) which carry greater risk to mother and baby.

Maternity services are expected to be responsive to local requirements and women’s choice and therefore, although there is no legal requirement, NHS Highland supports homebirths. However, the provision of this service is a considerable challenge for midwives in the community setting. The provision of two midwives on-call for a period of 5 weeks for each homebirth has implications for workforce planning, skills attainment and maintenance and competencies and is an additional financial tension on local midwifery team budgets.

When midwifery services are attached to a CMU (as in Argyll and Bute, Skye and Fort William) the homebirth service is provided as part of the routine service, therefore costs are not additional to core service provision and more importantly, homebirth in seen as a core service provision in this context, rather than an additional service.

The rise in Caesarean section rates is a matter which is of local, national and international interest and importance. Following a national audit of Caesarean section practice in the UK (published in 2001); the National Institute for Clinical Excellence (NICE) has commissioned a clinical guideline for patients and clinicians on Caesarean section. Our current (2011) rate of emergency caesarean section is 14.1%. This is at the lower end of the Scottish range. We will strive to maintain this and perhaps improve but with our increasingly complex population of pregnant women this may be a challenge. Our rate of elective caesarean section is 1% higher than the Scottish average (11.3%). We have introduced an information sheet promoting vaginal birth after caesarean section (VBAC) but the relative safety of elective caesarean, our rural population and the recent NICE guideline which supports women who wish delivery by caesarean section for no medical reason will make this hard to improve. Maintaining the status quo should be our target although we will shortly commence an audit of all elective sections and the decision making process to allow us to target appropriate groups of women.

In order to address the c/s rate within the labour suites at Raigmore and Caithness, midwifery expertise should be promoted and ways of appropriately extending the role of the midwife should be considered. One to one midwifery care will continue to be given to women during labour and childbirth in order to make sure they have individualised attention and support, although continuity of carer cannot be guaranteed.

Raigmore currently has a ‘Labour Suite Forum’ with direct involvement from lead obstetrician, midwifery manager and junior midwifery and medical staff. This Forum has been strengthened and promoted with formal representation from Anaesthetists and Neonatologists, and part of the remit of the Group is to consider practice and audit and inter-relate with existing Clinical Risk Management/Clinical Effectiveness and Governance groups.
Professionals should provide holistic and natural childbirth care at all times with opportunities created to ensure provision of equitable facilities across the delivery suite. The staff actively encourages low risk women to be ambulant whilst in labour and encourage women and their partners to utilise the Labour ward lounge. Staff encourage women to discuss any birth preferences and options with them during their labour and are willing to offer differing positions for delivery and water birth to women who are low risk.

**Service Improvement Measures**

*Review the Homebirth provision and develop a realistic and sustainable solution*

*Aim to increase the normal birth rate across NHS Highland by supporting local and CMU births*

*Maintain elective and emergency caesarean section rates and strive to reduce where possible.*

*Regular patient experience surveys, linked to the SPSP*

**5.3.1. Obstetric Consultant Unit in Raigmore**

The model of care in NHS Highland is designed to ensure that each woman receives care tailored to her individual needs. Raigmore Hospital is the referral centre for NHS Highland as well as the local maternity hospital for women who reside in and around Inverness. It comprises of:

- Community Midwifery service for women in and around Inverness. They provide Community based ante-natal care, homebirth service and post-natal care until mother and baby are suitable for transfer to Health Visitor/Public Health Nurse (HV/PHP).
- Ante Natal Clinic – mainly Consultant specialist clinics and referral clinics for those women with existing or developing complications in pregnancy.
- Ultrasound scanning - all women have access to an early scan around 10-12 weeks gestation, detailed anomaly scan at 18-20 weeks gestation. Amniocentesis is carried out as appropriate. Combined Ultrasound Biometric Screening (CUBS) has been implemented.
- Labour suite – this comprises of labour rooms and an obstetric theatre. There is a water birth room. Women are cared for in Labour Ward until they are fit for transfer to the ante natal or post natal wards and can go home soon after delivery if both mother and baby are well.
- The obstetric theatre currently operates on a part-time basis. Outwith the hours of 9-5, women who require use of theatre are transferred to the main theatre suite where negotiation is required with other specialities before access is permitted in any case other than to save the life of mothers or babies. This creates delay and conflict and requires a review of working access.
- Re-configuration of service provision is currently taking place. The following are under consideration:
  - the re-alignment of triage and maternity assessment (daycase and OOH)
  - the development of a CMU for the Inverness area
- Neonatal Unit – this is the referral centre for Highland.
NHS Highland Maternity Services Strategy and Strategy Workplan

- Raigmore maternity unit within Raigmore Hospital, has access to an intensive care unit, laboratory and transfusion facilities, and special care baby unit/neonatal intensive care, in line with the Maternity Services Framework recommendations.

Service Improvement Measures

- Establish a Raigmore Maternity Development Group to:
  - Review triage facilities and develop one system to address all calls in order to ensure consistency of care and management of calls 24/7
  - Develop the obstetric theatre to allow for 24 hour service.
  - In order to promote normal birth, develop a midwifery led unit (CMU) for the Inverness area for low risk women.
  - Consider the implications of our home birth service, including emergency transfer to hospital

- Further develop the "Labour Suite Forum" involving lay representation in order to ensure that intra-partum care is up to date and evidence-based.

5.3.2 Caithness Maternity Unit and Sutherland midwifery services

Caithness maternity unit is an EGAMS Level 2a Consultant maternity unit. While the unit is classified as an EGAMS Level 2a, Caithness General Hospital, a Rural General Hospital (RGH) does not provide adult or neonatal intensive care facilities. There is an adult High Dependency unit (HDU). Therefore criteria for local birth is under review with the aim of clearly identifying the level of service that can be safely provided within a rural general hospital. This will aim to have as many women as is safe booked for birth in Caithness. All women receive antenatal and post-natal care in Caithness. High risk women are referred to Raigmore consultant services for specialist care.

The maternity unit in Caithness consists of:

- The midwifery care is provided by a team of midwives who work in the maternity unit and the community under one manager and the aim is to have this team fully integrated.
- This integrated team provide a community service for women in Caithness with two main geographical areas: Wick and Thurso. They provide community based ante-natal care, homebirth service and post-natal care until mother and baby are suitable for transfer to Health Visitor/Public Health Nurse (HV/PHP).
- Ante Natal Clinic at Caithness General– mainly consultant clinics for those women with existing or developing complications in pregnancy.
- Ultrasound scanning - all women have access to an early scan around 10-12 weeks gestation, detailed anomaly scan at 18-20 weeks gestation. Amniocentesis is carried out as appropriate. Combined Ultrasound Biometric Screening (CUBS) has been implemented.
- Labour suite is part of the maternity unit. There are two labour rooms and a water birth room. Women are cared in the maternity unit until they are fit for transfer to go home.
- The obstetric team have 24/7 access to the theatre suite. The planned service operates Monday –Friday 9-5. Outwith the hours of 9-5 and at weekends, theatre staff are on-call.
Sutherland midwifery services are provided by single duty midwives based in Golspie for East Sutherland and Durness for NW Sutherland. The NW area is a pilot of single duty and is currently undergoing evaluation.

**Service Improvement measures**

- Continue the re-design of midwifery services to the development of a fully integrated midwifery services for Caithness.
- As part of the revision of the model of maternity services, review the description of the level of care provision at Caithness maternity unit to include interface with other clinical teams within Caithness General Hospital, Caithness and Sutherland community health teams and ambulance services
- Review booking criteria for Caithness
- Re-introduce low risk induction of labour to Caithness
- Maintain obstetric links with Raigmore
- Complete the re-design of the North West Sutherland single duty midwifery.

**5.3.3 Community Maternity Units and Community Midwifery Teams**

There are currently seven CMUs in NHS Highland. These can be seen in Map 1 (page 9) and are outlined in Table 1 (page 10). Each CMUs provides antenatal and post-natal care for all women, most with visiting consultant antenatal clinics run monthly. In addition, low risk women have the choice of intra-partum care in these units.

The care is provided by teams of midwives who provide an integrated service with a caseload across community and CMU settings.

In addition to the CMUs there are a number of community midwifery teams who provide midwifery care in a similar way to the CMU teams. Women in these areas can opt for homebirth and the community team will provide this service. The provision of on-call for homebirth is a challenge for these small local teams and one strategy adopted is to link with neighbouring teams to support the out-of-hours provision. However, this can be a challenge, especially in terms of geography, distance, travel and weather and cross boundary (Operational Unit) working.

**Service Improvement Measures**

- Work towards a solution to out-of-hours provision and a sustainable model for homebirth provision
- Develop a CMU for the Inverness area
- Appoint a Midwifery Team Co-ordinator/Team Leader for the RCWN area to bring in line with the midwifery structures across the rest of NHS Highland

**5.3.4 Argyll & Bute**

Argyll & Bute Operational Unit acknowledges the following key factors which have influenced the development of maternity services and uphold the policy direction of the Refreshed Framework for Maternity Care in Scotland (SG 2011). This includes:
Social influences before, during and after pregnancy have a significant and far-reaching impact on child and maternal health
Social investment in the next generation is the key to healthy families and healthy people
Government policies which cross-cut health and social care target resources to the 30% of children born in relative poverty in key areas such as childcare, education, employment, health, housing and welfare benefits
Pregnancy is an ideal opportunity to involve women, their partners and their families in a far greater understanding of their personal health, the benefits of health promotion and changes that can affect future health
Education for a healthy pregnancy should start in school and life skills and lifestyles should be a core part of personal and social development

Argyll & Bute Operational Unit has used the above factors to shape and frame maternity service provision locally. Within the widespread geographical area, there are CMU (5) and on a maternity bed on Islay. The remaining islands are served by local CMUs based on the mainland. All the units adhere to a similar model of practice where the philosophy of care for all women and families (irrespective of clinical risk) enables the greatest potential for birth, parenting and the future health of the population.

Argyll & Bute maternity services have evolved to encompass:
- Geographical imperative of the Operational Unit
- The needs of women and their families
- The facilitation of midwives to practice to their full potential
- The recommendations of current policy drivers
- The majority of care is provided locally and additional specialist obstetric and neonatal services are provided through service level agreements (SLA) with Greater Glasgow and Clyde Health Board. The main referral maternity unit is the Royal Alexandra Maternity Hospital in Paisley.

**Service Improvement Measure**

- Agree SLA with GG&C Health Board for consultant and neonatal services
- Achieve full Baby Friendly Status

### 5.4 Postnatal Care

The aim of post-natal care is to be sensitive and responsive to the needs of women and their families in order to facilitate the transition to parenthood. This care should detect or prevent ill health in mother and baby through appropriate clinical care, advice and support.

This section is underpinned by the following principles:

- Maternity services should provide postnatal care to facilitate the transition to motherhood by making sure that ill health is prevented or detected and managed appropriately. Women and their partners should be supported to make a confident and effective transition to parenthood.
- Midwives, HVs/PHP, GPs and Allied Healthcare Professionals should adopt a flexible approach to postnatal care, working in partnership with other agencies.
- Maternity Services should promote, support and sustain breastfeeding. Women should be informed of its benefits, while being supported in their chosen mode of infant feeding.
Women and their partners should be given the opportunity to reflect/debrief on their experience of pregnancy and childbirth in the postnatal period with an appropriate health professional.

There should be a comprehensive, multi-professional, multi-agency service for women who have, or are at risk of, postnatal depression and other mental illness.

Contraception should be offered and administered with the maternity units to vulnerable women who may have difficulty in accessing care.

The maternity service has a vital role to play in providing women, their partners and their babies with care and support. Midwifery support and advice is available 24 hours a day to all women in NHS Highland via Raigmore Maternity Unit. Emergency services are provided as required through SAS and NHS 24/ local Health Centre Hubs.

The maternity service will provide a flexible approach to postnatal care whereby, if birth has taken place in a maternity unit, early transfer/discharge is an option routinely offered to all women who have a normal pregnancy, labour and delivery. Care delivered should be in accordance with the woman's choice and those who choose to transfer home soon after the birth will be given appropriate support and advice by a comprehensive community service.

The early transfer option may be few hours following normal delivery of a baby or 12-24 hours following normal delivery of a baby depending on mother’s home circumstances and family support. Women being delivered by Caesarean section will require temporary high dependency care and the recuperation period will be longer. Transfer to community midwifery care should be offered depending on home circumstances and support.

Based on continuing risk assessment, selective post-natal visiting should be undertaken dependent on need. Continued midwifery input potentially beyond Day 28 providing an increase in midwifery involvement seems particularly appropriate and potentially beneficial within the context of the breastfeeding mother, socially deprived mother and the mother who is at risk of developing postnatal depression or undergoing any crisis in mental health. In addition to maternity service support in the post-natal period, a small number of postnatal support groups/new mums groups are already established in the Highlands and maybe provided by the Third Sector.

Where there has been continuity of care, a mother is generally more willing to have a more open discussion with her midwife about her feelings. The midwife will then be in a position to detect changes in a mother’s mood and behaviour. Evidence suggests that domestic violence often escalates during pregnancy and in the postnatal period. Health workers are in the key position to support women who may be subject to abuse. The increased involvement in postnatal care should not be in isolation, midwives should adopt a flexible approach to postnatal care, working in partnership with women and other healthcare professional and agencies and resources should reflect service provision.

NHS Highland actively promotes and encourages breast feeding and currently both Raigmore and Caithness General Hospitals have full Baby Friendly Award accreditation. The CMUs and community teams across NHS Highland currently have Certificates of Commitment and are working towards full accreditation The Infant Feeding Co-ordinators, as well as assisting in the role of breastfeeding, also provide evidence based information about formula feeding according to the needs of the women and their partners. Further information is available in the NHS Highland Breast Feeding Strategy. See Section 7.3 for breast feeding rates and targets.
• When birth occurs in hospital or CMU, all women who have a normal birth should be given the option of early transfer home to a comprehensive support service in the community.
• Promote a healthy lifestyle to all postnatal women and extending support groups/new mums groups throughout Highland.
• Review the role of the midwife in the post-natal period beyond the 28 day period and greater emphasis placed on selective visiting tailored to the individual needs of mother and baby.
• Review existing workforce in the context of the strategy, including the role of the maternity care assistant in postnatal care.
• Develop and implement a strategy to maintain any positive health gains made in pregnancy through appropriate professional support in the postnatal period i.e. healthy diet, smoking cessation, substance abuse, alcohol consumption and physical activity.
• Training in contraception advice and provision for midwives

5.5 Neonatal Care

The aim of neonatal care is to ensure that all babies have access to the appropriate level of care when required.

This section is underpinned by the following principles:

• Maternity services, including obstetric and neonatal services, will provide a fully integrated childbirth service responsive to the needs of mothers and their newborn babies.
• Acute and primary care within NHS Highland will jointly plan and provide a fully integrated neonatal service responsive to the needs of newborn babies and their parents.
• Maternity services will agree arrangements for both in-utero transfer and the transfer of a recently delivered mother and/or her newborn baby to a linked secondary or tertiary unit.

Midwives, nurses and doctors providing neonatal resuscitation services must be properly trained and supported by a programme of regular updates to facilitate the maintenance of skills. Doctors in paediatrics have a formal training session in neonatal resuscitation during their induction to the Neonatal Unit and continue to receive additional training as necessary. There is also a Neonatal Resuscitation Programme in place, which is run regularly throughout the year. In addition the Obstetric Emergencies training that all midwifery staff attend on a yearly basis has a neonatal resuscitation component.

The Neonatal Unit at Raigmore has 2 Intensive Care cots, 1 High Dependency cot and 8 Special Care cots, and is equipped to provide assisted ventilation, circulatory support with invasive monitoring and parenteral nutrition (Level II care). There is a single on-call rota for paediatrics and the neonatal unit. There are facilities for high dependency and special care patients as well as facilities in the postnatal wards for normal neonatal care. The possibility of a ‘transitional care’ area in the maternity unit is under consideration. Advanced Neonatal Nurse Practitioners (ANNP) work in close collaboration with the Paediatric team, giving support and training to Junior Doctors. They play a major role in the daily workload of the Neonatal unit and provide services to the Labour Ward and the postnatal wards. All infants are examined by a member of the paediatric staff or advanced neonatal practitioners before hospital discharge.

There is a close working relationship with the community children’s nursing team and the midwifery liaison community team. This liaison will be strengthened with the ongoing development of guidelines for post-discharge care of infants with ongoing clinical needs.
Physiotherapy colleagues are also involved in the Consultant paediatric follow up clinics for these infants.

The local Stillbirth and Neonatal Death Society have a close working relationship with the Neonatal Unit. Staff are encouraged to participate in bereavement awareness study days and there are guidelines and checklists to ensure that neonatal death is managed as sensitively as possible. There are plans to develop the facilities at Raigmore for women and families who have suffered stillbirths or neonatal bereavement.

The Neonatal Retrieval service for the North of Scotland is based in Dundee and Aberdeen. This travel distance can present challenges in response time and our services often have to manage the stabilisation and maintenance of neonates for several hours before the neonatal retrieval team arrives. The Neonatal transport service is currently being reviewed nationally along with the Scottish Ambulance Service. Procedures for emergency and elective transfers of neonates between Raigmore Hospital and other NHS providers are well established.

**Nice Neonatal Jaundice Guideline**

Approximately 60% of term babies develop neonatal jaundice in the first week of life. NICE recently updated the guideline on the management of this condition and this has implications for service delivery. The guideline recommends changes to the management of the condition which mean that more neonates must be identified and treated with phototherapy at an earlier stage- especially in the first 24 hours of life. This includes the use of a transcutaneous bilirubinometer or taking a serum bilirubin.

**Service Improvement Measures**

- All staff involved in neonatal care should be compliant with mandatory training requirements in neonatal life support courses. This will include regular practice of resuscitation skills by all staff that may be involved in resuscitation.
- Ensure the needs of parents of babies who have been in the neonatal unit are met including providing the opportunity to attend training in resuscitation skills.
- Consider introducing designated transitional care areas into the maternity unit or hotel beds within Raigmore.
- Re-design the facilities in Raigmore for women and families who have suffered stillbirth or neonatal loss.
- With the early discharge home, consider the appropriateness of re-admission of neonates under 10 days to the maternity unit rather than the paediatric ward.
- Strengthen liaison with community colleagues to ensure a smooth transition from hospital to community care and to implement national recommendations on discharge planning.
- Participate and influence the development of the NOS and national neonatal transport network.
- Training of additional midwives to carry out Examination of the Newborn.
- Implementation of Neonatal Jaundice Guideline; purchasing of bilirubinometers across NHS Highland; ensuring adequate training of midwives to deliver the changes in practice.

### 5.5.1 Newborn screening

NHS Highland provides a universal newborn blood spot screening programme for Cystic Fibrosis, Phenylketonuria and Congenital Hypothyroidism. This involves taking a small quantity of blood through a heel prick when the infant is at least 96 hours old. The programme is run along the same principles of informed consent and compliance with NHS Scotland Quality
Improvement Pregnancy and Newborn Screening standards. Haemoglobinopathy screening has recently been introduced along with MCADD (Medium Chain Acyl CoA Dehydrogenase Deficiency) on the blood spot screening test.

**Service Improvement Measure**

- Further good practice guidelines and protocols are developed as additions are made to the newborn screening programme

6. **CORPORATE AND CLINICAL GOVERNANCE**

Clinical governance is the system through which NHS organisations are accountable for continuously monitoring, improving quality and safeguarding high standards of care (NHS/QIS 2005).

The three most recognisable components of clinical governance are those which involve quality improvement and are:

- Corporate Accountability including audit and redesign
- Clinical Effective and Risk Management – including patient safety
- Patient focus and public involvement

The aim of corporate and clinical governance is to identify, assess and manage risk and this is a core function of all those who provide maternity services. This risk management is essential for all those who provide maternity services across a wide range of settings within NHS Highland.

6.1. **Corporate Accountability**

**Role of the Maternity Services Strategy and Co-ordination Group (MSSCG)**

The work of the MSSCG aims to support the development of maternity services quality framework and the appointment of a Highland wide clinical lead for maternity services whose role will include the implementation the Quality Framework.

This will be accomplished through the following principles:

- To make recommendations, support and interpret the implementation of national, regional and local policy and strategy development for maternity and women’s health in NHS Highland.
- To support the governance of maternity services, including clinical guidelines for midwifery and obstetric care, pathways of care and service design, training, development and research.
- To support the development of a Highland wide Maternity Service.
- To build on and inform existing midwife managed care.
- To ensure the provision of high quality maternity care for women who require more specialist clinical care.
- To ensure the development of quality assured clinical services for women within the community or in acute care settings.
- To support health promotion and public health interventions.
- To support and link with related service initiatives e.g. cancer, peri natal mental health, sexual health.
• To engage with women and their partners who use NHS services as appropriate, to ensure service design and delivery is informed by their perspective through oversight of the local Highland Maternity Services Liaison Committee network.

This brings maternity services together under one governance structure and ensures effective clinical and corporate leadership of the service through appropriate membership and direction of the group.

**Service Improvement Measure**

• *The Maternity Services Strategy Co-ordination Group delivers the actions of the Maternity Services Strategy*

The Diagram below highlights the governance and communication structures.
6.2 Risk Management – including patient safety

Within the maternity units in Raigmore and Caithness General Hospitals there is a maternity services risk reporting system which is guided by a ‘Trigger form.’ In addition, Raigmore has a Risk Management Strategy.

The risk list for cases within Raigmore is reviewed by a Risk Management Steering Group. This meeting currently reviews the cases delivered in Raigmore only. The meeting is responsible for:

- Screening clinical incident reports
- Reviewing significant event analyses
- Working with clinical team leads within the maternity unit on additions to local risk registers

There are 6 perinatal mortality/morbidity meetings and 4 maternal morbidity meetings per year. NHS Highland cancels clinics and theatres to release staff for audit purposes on 10 afternoons per year, ensuring high attendance rates. These are multi-disciplinary meetings. The review and outcome of each case is recorded and appropriate action taken.

Maternity services also participate in mandatory caesarean section wound surveillance through Health Protection Scotland. This has been in place for a relatively short time so data analysis and benchmarking information is not yet available. However this demonstrates one strand of patient safety that is being addressed and will assist in measuring performance against set standards and effect change.

Resource

A report for NHS Highland (2009)\(^5\) maternity services identified that across maternity services in Scotland many units had dedicated for risk management and this varied between 1 day and full time. If a clinician is in a substantive post it tends to be a 4-5 day post and in some areas risk management forms part of another role e.g. labour suite midwife, practice development midwife.

NHS Highland currently has one consultant obstetrician who has some dedicated time (1 session per week) for risk management. In this time, the risk management forum and the perinatal morbidity meetings for Raigmore are organised and reported. Outwith Raigmore, the Lead Midwives lead on risk management, but without dedicated time to undertake this task.

NHS Highland requires that its maternity risk management structure is robust and able to report to MSSCG quarterly on risk status. In order to do this across the Board area, a dedicated risk management post is required.

Service Improvement Measure

- Complete the roll out the Maternity Dashboard across NHS Highland by March 2012

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- Set up a Quality and Safety Sub Group of the MSSCG in order to bring maternity risk management systems together to support reporting and safety. This will include Datix, Maternity Trigger Forms, reporting and audit of Critical Incident Review processes
- Review the need for dedicated risk management time within the Highland wide maternity service.

6.3 Patient Focus and Public Involvement

The NHS Highland Maternity Services Liaison Committee is a service user-led group. Members are encouraged to register with the Highland Health VOICES Network (the Public Partnership Forum for NHS Highland) so that the MSLC is a special interest group within that wider network. This arrangement facilitates wider engagement with service users and families according to need and it provides MSLC members with access to the Health VOICES support staff.

The Scottish Government Health Department defined the role of an MSLC\(^6\) as a means of bringing together maternity professionals with service users in order to:

- Maintain links with current and recent users of maternity services, allowing women from all parts of the community to have an opportunity to comment on services
- Encourage and facilitate user involvement in maternity services
- Offer a vehicle for change and improvement, driven by suggestions coming directly from service users.

NHS Highland has a local network of MSLCs which provide service users an opportunity to feed directly into the maternity services elements of local health services and the MSSCG.

Service Improvement Measure

- Ensure public involvement in all consultant units, CMUs and community teams
- Ensure maternity services involvement in SPSP patient surveys

6.4. Statutory Supervision of Midwives

Supervisors of Midwives have a defined role in protecting the public and their activity is designed to assist midwives to provide a safe service to women and babies through reflection on individual midwives’ practice, identifying and addressing training and education needs, investigating practice when there are concerns expressed from any source and confirming that appropriate learning has taken place when necessary.

The Supervisor of Midwives process ensures that learning is shared across NHS Highland and standards of practice remain consistent and monitored constantly. Supervision of Midwives’ activity is statutory and as such is subject to audit and annual written reports submitted to the Nursing and Midwifery Council by the Health Board. These audits and annual reports are written by the LSAMO for the North of Scotland Consortium. The annual report is submitted to the Clinical Governance Committee and NHS Highland Board and is placed on the public web site. Patient safety is therefore embedded in midwifery practice.

The NMC reviewed the LSAs in the North of Scotland in July 2011.

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\(^6\)“Implementing A Framework for Maternity Services in Scotland” (SEHD, December 2002)
While supervision is working well within NHS Highland there are areas that require strengthening. The Highland SOMs and the Lead Midwife Group agreed that the current system of an availability rota, is adequate to cover 24/7 access to an SOM as required by the NMC. The LSAMO has recently introduced a system of Contact SOM across the North of Scotland consortium. NHS Highland is yet to agree on how this will be implemented. In addition, there are other specific service improvements. These are:

Service Improvement Measure:

- There should be auditable public involvement in the statutory supervision of midwives
- Implement the agreement (MSSCG, the Lead Midwives and the SOM Group) for 4 hours per month (flexible and as suits the service)) for each SOM to undertake SOM duties.
- Local arrangements re time allocation should be made with managers, team leaders and Lead Midwives for an SOM to carry out a supervisory investigation or to represent supervision within a Critical Incident Review.
- Encourage regular recruitment and training of SOMs to ensure sustainability of the role

7. PUBLIC HEALTH AND MATERNITY SERVICES

Public Health in maternity services spans a wide range of healthcare topics: infant feeding; nutrition in children and young adults; healthy weight and obesity in pregnancy; substance misuse; domestic violence; child protection and peri-natal mental health. In all these areas, the aim is to reduce the impact of such factors on our population of childbearing women and to endeavour to improve the health of this population and the next generation.

The Midwifery Development Officer for NHS Highland works at a local and national level to ensure services for vulnerable women in pregnancy are improved and that national policy is influenced by and translated in practice for staff to enable them to support this group of service users and their families. The role that midwives have in the Public Health agenda is extremely important to improving health outcomes and pregnancy offers an ideal opportunity to instill Public Health messages at the earliest stages.

Providing consistent advice and support to women and their families around health promotion and health improvement issues are important. The Highlands Information Trail (2011) details the information that women should be given on their pregnancy journey and up until their child is 5. It includes all of the screening and surveillance that is undertaken during this time and is in line with national recommendations. It is regularly updated and should be used by all staff who have contact with these client groups.

7.1. Child Protection

Protecting children is embedded within the model of maternity care and assessments of the impact that a parental role may have on a baby, born or unborn will always be a priority. To assist staff with understanding their role in Child Protection all staff providing maternity care should attend Child Protection training at least every 3 years and more often when their caseloads suggest more updates are required.

There are designated Child Protection Advisors (CPA) in posts across the Operational Units and in Raigmore and all staff should ensure who their local CPA is and how to contact them. All staff should be working to the Interagency Guidelines to Protect Children and Young people in Highland (2011) and induction of new staff should include raising awareness about
NHS Highland Maternity Services Strategy and Strategy Workplan

Child Protection issues and outlining the personal responsibilities all have towards children in their care.

Where there are any concerns staff should follow the child protection guidelines and seek advice from their manager or CPA and an appropriate assessment using the GIRFEC principles should be undertaken. During pregnancy this should be through an Antenatal Plan which will determine the strengths and pressures for the family which will impact on the outcomes for the baby, born or unborn. Direct referral to social work may be required.

The Guidelines for Maternity services getting it Right for Every Mother and Child (2011) will assist staff when applying the principles of GIRFEC and completing an Antenatal Plan. The CPAs will also assist staff to complete plans and undertake robust assessments.

Service Improvement Measure

- Ensure that Child Protection remains at the forefront throughout the pregnancy episode by providing regular awareness training for all staff.
- Continue to support more specific training for caseload holders and those contributing to Child Protection Case Conferences.

7.2 Maternal Nutrition

The Improving maternal and Infant nutrition: A Framework for Action (SG 2011) is a ten year plan that sets out the vision for improving maternal and child nutrition in Scotland. A National Framework group will support the implementation of the action plan detailed in it in local areas.

The activities in the action plan are at different stages of development across Boards in Scotland but the main drivers of the Framework are:

- Women entering pregnancy are a healthy weight, in good nutritional health and that this continues throughout their pregnancy and beyond.
- All parents receive full information they can understand on infant feeding to enable them to make an informed choice.
- All women receive the support they need to initiate and continue breastfeeding for as long as they wish.
- Further promote and support breastfeeding and the principles of the World Health Organisation (WHO) /UNICEF baby Friendly initiative.
- Infants are given appropriate and timely complementary foods to continue to have a wide and varied healthy diet throughout early childhood.

Within NHS an Infant feeding advisor is in post and together with the Health Promotion department Nutrition Specialist within Public Health a programme of support and development is in place.

Pathways for women who have a high BMI are being developed together with the Obstetricians at Raigmore to ensure women are directed to the correct level of support through their pregnancy journey.
Service Improvement Measure

- Ensure that maternal and infant nutrition and the action plan detailed in the Maternal and Infant Nutrition Framework are supported and implemented across NHS Highland for all women
- Audit the implementation of the local pathways for obesity in pregnancy to ensure women receive a safe and effective assessment of their needs and enter motherhood in the best nutritional state possible.
- Monitor the pregnancy outcomes of women with high BMIs within the maternity dashboard to ensure services are meeting the needs of this client group

7.3. Infant Feeding

The Breastfeeding Strategic framework 2010-2013 has been ratified by the Area Nursing and Midwifery Committee.

The framework’s overarching strategic aims are to

- Increase breastfeeding rates at birth by 5% by 2013
- Increase breastfeeding rates at 6 – 8 weeks to 33.3% by 2011
- Ensure that both maternity units and Operational Unit’s achieve full Baby friendly Accreditation by 2011

It adopts a logic model approach to implement the strategic objectives which are:

1. Implement UNICEF Baby Friendly Initiative (BFI) throughout NHS Highland
2. Train volunteers to support breastfeeding throughout NHS Highland
3. Promote the participation of the NHS Highland baby welcome sticker scheme in NHS premises, partnerships and the public sector. This in turn will raise the profile of breastfeeding and support and encourage mothers who choose to breastfeed
4. Implement a system of data collection which is accurate and performance-monitored by NHS Highland Improvement Committee from both the Scottish Birth Register (S.B.R.) and the Child Health Surveillance Programme – Pre-School (CHSP-PS) system

7.3.1 UNICEF Baby Friendly Initiative

- Raigmore Hospital was re-accredited with the Baby Friendly status in October 2009.
- Caithness General achieved the Baby Friendly status in November 2009 and is currently undergoing re-validation.
- All 3 Operational Units have reached Stage 2 in the BFI process and are currently working towards Stage 3 in early 2012.
- A strong network of breastfeeding trainers is thriving throughout NHS Highland offering local training and advice. The network is managed by the infant feeding advisors and consists of midwives, health visitors, public health nurses and community nurses.

7.3.2. Breastfeeding Peer Support

NICE 11 guidance, CEL 36 and UNICEF BFI all request the development of an externally accredited peer support network to support, promote and encourage breastfeeding. Research has demonstrated that provision of such a network can
enable women to breastfeed for longer. This is currently being implemented in NHS Highland. Breast feeding support workers have been recruited and trained in Inverness, Rothesay and Alness, Golspie and Thurso, Skye and Wester Ross, Lochaber and Argyll &Bute. All training follows the NHS Highland Draft Volunteer Strategy and targets areas of low breastfeeding rates.

7.3.3. Promote the participation of the NHS Highland baby welcome Sticker scheme in NHS premises, partnerships and the public sector.

With the support of the Breast Feeding etc Scotland Act (2005), this scheme was re-launched in 2007 and participating businesses are listed on the NHS Highland website. Further details of implementation is outlined in the Breastfeeding Strategic Framework.

7.3.4. Implement a system of data collection which is accurate and performance monitored by NHS Highland improvement committee.

To collect accurate statistics, as shown in Section 3 of the Breastfeeding Strategic Framework, NHS Highland uses the:

1. Scottish Birth Record, (breast feeding rates at birth, discharge from hospital) and
2. Child Health Surveillance System- pre-school (breast feeding rates at 6-8 weeks)

NHS Highland data for 2010 is as follows in Table 2

<table>
<thead>
<tr>
<th></th>
<th>1st visit</th>
<th>6-8 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argyll and Bute</td>
<td>41%</td>
<td>31%</td>
</tr>
<tr>
<td>Mid CHP</td>
<td>43%</td>
<td>33%</td>
</tr>
<tr>
<td>North CHP</td>
<td>35%</td>
<td>25%</td>
</tr>
<tr>
<td>S.E CHP</td>
<td>45%</td>
<td>31%</td>
</tr>
<tr>
<td>NHS Highland</td>
<td>42%</td>
<td>31%</td>
</tr>
</tbody>
</table>

(data from ISD)

Work is underway through implementation groups to ensure that data recording in both these systems is accurate and improved. The groups are chaired by Sally Amor (Child Health Commissioner for NHS Highland)

7.3.5 Infant Feeding Clinic at Raigmore

In order to support mothers who have significant difficulties in maintaining breast feeding, the Infant Feeding Advisor runs a regular clinic at Raigmore hospital. The clinic deals with complicated breastfeeding problems. In addition, a “tongue tie” frenulectomy division service is included in this clinic. ENT Dept has supported this with emergency cover in the rare event of any problems.

NHS Highland has an Infant Feeding Strategy. The main focus of activity around breast feeding is
NHS Highland Maternity Services Strategy and Strategy Workplan

- The maintenance of Raigmore Maternity Unit as a fully accredited Baby Friendly Hospital
- The re-accreditation of Caithness General as a Baby Friendly Hospital
- The accreditation of all CMUs and community areas with the BFI community award.

Service Improvement Measures

- Increase breastfeeding rates at birth by 5% by 2013
- Increase breastfeeding rates at 6 – 8 weeks to 33.3% by 2011
- Ensure that both maternity units and Operational Unit’s achieve full Baby friendly Accreditation by 2012
- Audit the uptake of the NHS Highland baby welcome sticker scheme in NHS premises, partnerships and the public sector.
- Implement a system of data collection which is accurate and performance monitored by NHS Highland Improvement Committee from both the Scottish Birth Register (S.B.R) and the Child Health Surveillance Programme – Pre-School (CHSP-PS) system
- Audit the work of the Infant Feeding Clinic and the Tongue Tie service to support the continuation of the service.

7.4 Substance Misuse

Smoking, alcohol and drug intake are discussed with all women from the booking appointment and recorded within their maternity record - the Scottish Women Held Maternity Record (SWHMR). Women who have problems with drug or alcohol misuse should have access to a full range of services within a multi-disciplinary and multi-agency process. The principles of assessment of risks and needs will be in line with GIRFEC and an Antenatal Plan should be completed where there are concerns around the impact of substance use on the baby or any other children in the family.

Professionals work together as a team providing individualised care for a very complex group of women, partners and babies. The Good Practice Guidelines, Women, Pregnancy and Substance Misuse (2010) have recently been updated and staff should be familiar with their content which will help to support their practice.

The aim of an integrated approach working closely with the Highland Drug and Alcohol Partnership (HDAP), drug and alcohol services and child protection team is to ensure that the potential impact of drug and alcohol abuse are identified as early as possible and that women and their partners find services accessible and that harm reduction strategies are offered to ensure stability and safety of the child.

Many maternity staff across NHS Highland have been trained in Alcohol Brief Intervention and use these strategies when working with pregnant women who have consumed alcohol in pregnancy. The Revised NHS Highland Good Practice Guidelines, Women, Pregnancy and Substance Misuse should be followed by all staff who have contact with pregnant women...
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**Service Improvement Measure**

- All women will be asked about the use of all substances including tobacco, alcohol, drugs – both legal and illegal, at booking and this will be recorded in the SWHMR and assessment of risk and need undertaken. If required this must be repeated at regular intervals during pregnancy and the postnatal period.
- All women should be advised about the implications of their substance use and be given contact details of local support agencies.
- Training available to all staff to implement good practice should be supported in line with HDAP and Child Protection requirements.
- Brief intervention approaches are offered for all women attempting to stop smoking or consume alcohol.

**7.5 Smoking Cessation**

Smoking in pregnancy remains a concern for service providers and there is a lot of evidence that supports the need for women to attempt to stop smoking when trying to conceive and once pregnant. The Scottish Government have described a need to demonstrate an overall reduction in the number of pregnant smokers.

Obtaining data on smoking rates is difficult as smokers often under report their levels of smoking. The SMR02 remains the only source of nationally available data on smoking in pregnancy. Highland’s percentage of unknown smoking status is relatively low as outlined in Table 3.

**Table 3: Smoking Prevalence in pregnancy in NHS Highland**

<table>
<thead>
<tr>
<th>NHS Board of Residence</th>
<th>2009 Current %</th>
<th>2009 Not Known %</th>
<th>2008 Current %</th>
<th>2008 Not Known %</th>
<th>2007 Current %</th>
<th>2007 Not Known %</th>
<th>2006 Current %</th>
<th>2006 Not Known %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highland</td>
<td>21.5</td>
<td>3.4</td>
<td>23.3</td>
<td>5.4</td>
<td>23.7</td>
<td>4.4</td>
<td>24.2</td>
<td>7.8</td>
</tr>
<tr>
<td>Scotland</td>
<td>18.1</td>
<td>14.3</td>
<td>19.1</td>
<td>14.2</td>
<td>20.8</td>
<td>12.0</td>
<td>21.7</td>
<td>9.4</td>
</tr>
</tbody>
</table>

NHS Highland’s HEAT targets for smoking for 2011-2014 are focused on a need to see an increase in the number of smokers who remain quit:
- 7 ½ % of the smoking population should remain quit after 1 month
- 55% of those who remain quit at 1 month should be from the most deprived in Board SIMD quintile

All women are asked about smoking at booking and are given information about the risks for women and their babies and a behaviour change approach should be adopted that enables the women to take responsibility for her reasons to stop smoking. Women who wish to stop smoking will be given advice and contact details of local Smoking Cessation Advisors who are available in all areas.

There are also Midwifery Smoking Cessation Advisors (0.4wte) who not only give advice and support to pregnant women but also deliver training throughout Highland to hospital based midwives and community midwives. Training ranges from brief advice to more in depth training to enable community midwives to deliver the smoking cessation service directly to pregnant women. Midwifery smoking cessation advisors also continue to support ‘at risk’...
families via antenatal referrals in the Inverness area. Outwith this area, referrals are passed to the local Community Smoking Cessation Advisors.

18% of pregnant smokers attempted to quit using NHS Cessation Services in Highland in calendar year 2010 compared to the Scottish average of 17%.

**Service Improvement Measure**

- **Aim to increase the number of women in pregnancy who attempt to quit smoking to 19%**

### 7.6. Perinatal Mental Health

Within NHS Highland, there are just approx 2600 births per annum (including Argyll & Bute). Out of this, 34 women will be users of mental health services; 4 may require hospital admission due to puerperal psychosis; up to 300 will experience post-natal depression and up to 200 will experience emotional distress (based on CRAG incidence modelling)

A number of strategic documents stress the importance of a coordinated approach to perinatal mental illness. These include NHS MEL (27) that emphasised the need for all Health Boards to establish an integrated care pathway for women suffering mental ill health in the peri-natal period. Others include:

- SIGN Guideline (No60): Postnatal depression and Perinatal Psychosis, 2002
- A Framework for Mental Health Services in Scotland, 1999
- The CRAG report on Early Intervention in Postnatal Depression, 1996
- The recent publication of the Confidential Inquiry into Maternal and Child Deaths 2002-5, 2007

For mothers who are acutely unwell, admission to a specialist unit may be required. The Mental Health (Care and Treatment) Act 2003 place a responsibility on NHS Boards to provide specialist facilities for mothers and babies. HDL 6 (2004) details the standards of care required and NHS Highland are partners in the new specialist mother and baby unit in Livingston.

All pregnant women should be given information on mental health issues and post-natal depression and this can be found in the ‘Ready, Steady, Baby’ book (available on-line at [www.readysteadybaby.org.uk](http://www.readysteadybaby.org.uk)). Together with the ‘talking about post-natal depression’ booklet they are available from the Health information and Resources Library, Assynt House and are detailed in the Highland Information Trail (2011).

Dr Ken Proctor is the Executive Lead for mental health and mental health services are currently being reviewed with a view to service redesign. Women who require access to specialist services should be assessed and reviewed in line with the principles of GIRFEC and recommendations in the Perinatal health Good Practice Guidelines which are about to be updated to reflect changes in practice and policy. The peri-natal mental health nurse is in post and will lead on this area of review. There are also training programmes available to update midwives in the key issues and recognition of signs of mental illness in pregnancy.
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The Perinatal Mental Health Good Practice Guidelines is due to be reviewed in order to improve detection and care of women who are at risk of developing postnatal depression and other mental illnesses using a multi-agency approach.

Service Improvement Measures

- The Peri-natal Mental Health Care Pathway is implemented.
- The Peri-natal Mental Health Nurse carry out appropriate education and training programmes for key staff including midwives, health visitors and community psychiatric nurses.

7.7 Violence Against Women

Far from pregnancy being a time of peace and safety, the Confidential Enquiries into Maternal Death in the UK (Why Mothers Die Report 2000-2005) estimated that over one third of domestic abuse start during this time. Neither does pregnancy offer any protection for women in abusive relationships as it often escalates at this time. The links between domestic abuse and adverse pregnancy outcomes suggest that maternity care providers should be proactive in identifying the prevalence and implications to women and children.

Domestic Abuse covers a range of abusive behaviours including physical, sexual and emotional/mental abuse and control. They may occur in a close relationship regardless of age, class, religion or ethnic group.

Domestic abuse can have a direct and indirect impact on children (including the unborn child) and is likely to have a damaging effect on the health and development of children (Highland Child Protection Policy Guideline, 2011)

All maternity care providers require to undertake routine enquiry in a sensitive manner and to establish good relationships with women in order to empower them to escape abusive situations. This requires regular updating, training and supervision to develop enquiry and counselling skills.

The Domestic Abuse: Pregnancy and The Early Years (2010) protocol for Midwives, Health Visitors, GPs and Obstetricians has recently been updated and staff should be familiar with its content. A programme of training is provided for all NHS Highland staff which includes the links to child protection and implementing the principles of GIRFEC.

Service Improvement Measures

- All women are asked about domestic abuse routinely at booking or at some point in pregnancy which will be dependent on when a midwife can see the woman on her own.
- As in accordance with the protocol, if women are never seen alone to enable discussion, this must be documented and shared with the maternity care team and discussions must take place with the woman’s GP and HV/PHN
- The multi-disciplinary maternity care team will have regular access to training and ensure appropriate skills exist to manage any disclosure which occurs. This should be audited
8. CONTROL OF INFECTION

This work is focused on four main areas:

- The maternity services environment
- The Reduction of Surgical Site Infection (SSI) following elective and emergency C/S
- The prevention and management of sepsis
- The prophylaxis of the Influenza virus in pregnant women and maternity service staff

For more information, please see the Infection Control Annual Workplan and local policies on the NHS Highland intranet pages.

**Service Improvement Measure**

- Ensure that all maternity services environments are fit for purpose and comply with national and local HAI policy and requirements
- Continue to reduce the number of SSI in Raigmore and Caithness and aim for 300 days without a recorded elective or emergency SSI in both sites
- Develop and implement guideline on sepsis in pregnancy and ensure that all cases are recorded as critical incidents for case review and learning – aim for 0% cases per annum
- Develop guidance for women regarding genital tract sepsis
- Aim for 60% uptake of influenza vaccine in low risk pregnant group; 75% in high risk pregnant group; 60% of maternity staff

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7 CMO Letter 2011
9. WORKFORCE PLANNING

The aim of workforce planning is to identify the unique workforce requirements for maternity services. The service requires constant availability of midwifery; obstetric, anaesthetic and neonatal cover at all times and specific strategies to ensure that services are sustainable. At present the challenge is to manage the workload and workforce requirements during a period of change happening nationally and in response to drivers beyond our control. Such influences are:

- The impact of the European Working Time Directives on all services.
- The reforms created by Modernising Medical Careers on all services.
- The expectation that non medical staff will expand their roles to include that previously done by medical staff.
- The introduction of more screening tests requiring midwives in particular to spend more time in obtaining informed consent and results feedback.
- Greater emphasis on public health initiatives such as smoking cessation, domestic abuse, breastfeeding and mental health requiring more discussion with women and documentation to evidence this.
- Demographic changes leading to increased workload in particular with European immigrants.
- Increased complexity in both mental and physical health as well as increasing social deprivation in a growing number of families.
- In addition, service provision will require to be considered on a regional as well as a local basis using clinical networks to ensure.
- Locally provided, practical and safe out of hours care.
- As much care as possible provided in local settings.
- Equity of access for specialist services.
- The best use of training and education opportunities for the health care team.

NHS Highland has midwives and radiographers with level 1 and 2 obstetric scanning diplomas Education and training around this is mandatory to ensure effective governance of this service.

NHS Highland has three Advanced Neonatal Nurse Practitioners. These practitioners have a role in education and training, in Raigmore and across NHS Highland.

Across NHS Highland there are 3 Maternity Care Assistants currently undertaking the new course at Robert Gordon University Aberdeen. This new role has potential to alter the skill-mix within the maternity workforce once established. This should include CMU’s and community midwifery teams.

With the increase in the number of homebirths across NHS Highland, and the difficulty in covering the out of hours rota around each homebirth, the provision of unscheduled maternity care needs to be explored with the development of the unscheduled c care practitioner model.

Service Improvement Measure

- Meet the needs of Modernising Medical Careers and Working Time Directives for medical staff in all areas.
- Agree midwifery establishment using the new national midwifery workforce tool when launched (November 2011) to ensure midwifery staffing is adequate
- Ensure that the tool is suitable for remote and rural CMUs and island communities.
- Undertake work to identify the roles of maternity support workers within our maternity service
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- Develop new roles in order to support maternity service development. This will include areas such as risk management and further work around the involvement of OOH services in the cover of OOH maternity services,
- Work across the North of Scotland region to maximise potential workforce and training needs.

10. EDUCATION AND TRAINING

10.1 Skills Maintenance and Updating

NHS Highland has a robust programme of maternity and neonatal skills maintenance and updating. This training aims ensure that all practitioners involved in maternity care provision are skilled and able to deal with obstetric & neonatal emergencies regardless of practice environment. It is essential that mechanisms are in place, embedded into practice and that all practitioners are aware of these opportunities essential to keeping themselves updated on a regular basis. It is expected that the intervals between updates are no less than annually with 6 monthly attendance desirable particular in remote environments with low caseloads therefore exposure to ‘hands on’ practice reduced.

Opportunities to attend obstetric & neonatal updates are frequent throughout NHS Highland, monthly within Raigmore and 6 monthly throughout the localities. All practitioners involved in maternity care provision are invited and include:

- Midwives
- Obstetricians
- GP’s
- Ambulance Personnel
- Out of Hours Practitioners
- A&E Staff
- General Surgeons in Rural General Hospital
- Midwifery Assistants

Topics covered include:

- Neo Natal Resuscitation
- Shoulder Dystocia
- Mal Presentation & Position
- Post partum Haemorrhage
- Maternal Resuscitation
- Anaphylaxis
- Modified Obstetric Early Warning Systems (MEOWS)
- Emergency Ventouse Delivery (Midwifery Led settings only) ??? take out
- Management of Pre eclampsia & Eclampsia
- Emergency Unplanned Birth

All trainers involved in the delivery of training have undergone certified training with recognised national training organisations i.e. Advanced Life Support in Obstetrics, Neo Natal Resuscitation, Neo natal Life Support, Scottish Multiprofessional Maternity Development Programme. If not they are supported and encouraged to do so. Annual instructor updates are held to ensure consistency, development and progression of future training to meet the needs of practitioners.
Training & Practice Development is co-ordinated by two experienced midwives who ensure that training is managed, delivered and evaluated throughout the organisation. Their role also includes ensuring collaborative working with national organisations such as Health Improvement Scotland & NHS Education for Scotland. Both practitioners are members of the Scottish Midwifery Practice Development Group which significantly contributes to consistency in approach to maintenance of skills for maternity care providers throughout Scotland.

The approach to training & practice development is very much influenced by national drivers including:

- QIS Maternity Service Standard Jan 2007
- NHS Education for Scotland
- Health Improvement Scotland
- Confidential Enquiry into Maternal & Child Health – ‘Saving Mothers’ Lives’ 2006-8
- Nursing & Midwifery Council
- Midwifery Supervision/Local Supervision Authority

All of the above give clear guidance regarding the importance of skills maintenance in order to ensure the safety of mothers and babies.

The development of all key trainers throughout NHS Highland continues in order to enable them to conduct local training days/sessions without the support of the Training & Practice Development Co-ordinators. In addition the team are working with RRHEAL to develop common grounds for working together using technology to ease this process given the significant geographical challenges within NHSH. Obstetricians are now working with the T&D team to deliver multi-disciplinary drills and training sessions.

**Service Improvement Measures**

- Linked to e-KSF and PDP & NHS Highland Training Guideline, implement and audit training & skills maintenance record for each midwife
- Increase participation and attendance by obstetric team in training sessions and audit
- Implement Back to Basics training for all maternity care professionals and audit compliance
- Ensure cascade training for Influenza vaccination to ensure uptake programme can be implemented successfully
- Encourage multi disciplinary participation in skills maintenance.
- Implement MEOWs charts across the maternity service
- Implement and audit compliance of maternity CQIs

**10.2 Undergraduate Midwifery Education**

This year (2011) has seen the move to three Midwifery Schools for Scotland: University of the West of Scotland (UWS); Napier University and Robert Gordon’s University (RGU). Within NHS Highland we expect student placements from RGU and UWS for Argyll & Bute. For the next two years, we will have students from University of Stirling still in training.
Service Improvement Measures

- Ensure that the UOS students in training have adequate mentorship and support for the remaining years of their training
- Ensure that RGU and UWS have recruitment plans in place that encourage recruitment from our Board area in order to sustain future services
- Ensure that midwifery mentors in NHS Highland have adequate hours of mentorship to continue in the role
- Ensure that RGU and UWS students on placement have access to their university web-based programmes and information
- Develop strong working relationships with RGU midwifery teaching staff

11. RESEARCH

Research plays a vital role in the future development of maternity services in NHS Highland. It is important that more midwives become research active in order that the service provision becomes evidence-based. Specific topics that should be considered for further research include:

- What do we need to change in order to reduce the c/s rate?
- What do we need to change in order to increase local birth?
- How can NHS Highland support homebirth?

Service Improvement Measure

- Identify research training needs for professionals within maternity services and develop a research framework for research careers within maternity services
- Ensure that this is part of PDP and eKSF
- Identify specific research topics for maternity services research
- Collaborate with HEIs and NES to ensure that training needs are met and that multi-disciplinary research groups are established

12. INFORMATION AND COMMUNICATION

This section of the Strategy workplan endorses the requirements of maternity services to address how we gather and use information for the service and for women.

The main areas are:

- The development and implementation of the Highland wide maternity Dashboard
- The implementation of the updated SWHMR and e-health maternity system - there should be a national, unified and standardised woman-held maternity record that is electronically available and accessible
- NHS Highland Maternity Services Web-page

Service Improvement Measures

- The appropriate use of ISD data - planning and provision of maternity services at national and local level must be underpinned by an appropriate and comprehensive database.
- Implement the maternity Dashboard across NHS Highland maternity service
NHS Highland Maternity Services Strategy and Strategy Workplan

- Implement the updated SWHMR when available
- Develop a NHS Highland webpage available to women of reproductive age in order to provide easy access to evidence based information
- Translation services should be available and used when required 24/7
- Video conferencing already takes place where appropriate, as does telemedicine, and these should be further developed.
- Use of shared drives to access information across maternity service localities should be encouraged

Core information, which is provided to women within Highland, is available from the Public Health Department, Local Midwives and Maternity Units. There is a comprehensive Highland Information Trail that allows women and practitioners to be aware of all the relevant documents and leaflets they should receive. The Ready Steady Baby book provides a wealth of information and helps to inform decision-making. It is given to all women who are pregnant.

CONCLUSION

The Strategy aims to ensure a safe, effective and high quality maternity service, delivered in local communities as far as possible. It aims to deliver maternity care of the highest standard through the efficient use of a well trained workforce and to invest in the maintenance of staff skills.

The Strategy Workplan outlines in more detail the Vision and Principles in order to provide the operational units with details on each area of service provision and to provide auditable service improvement measures. Each operational unit and area will require to set up means by which this Workplan can be implemented and audited. This work will be monitored through the MSSCG on a regular basis.

The implementation of the Strategy and Workplan poses challenges to staff in maternity and related services and to the wider communities within the Highlands. It demands intra- and inter-professional as well as intra agency working to make it happen. We recognise these challenges and acknowledge that the implementation will require strong leadership and drive from these different areas. MSSCG will have a pivotal role in the implementation and monitoring to support the process.

Through the implementation of the Maternity Services Strategy and Workplan outlined in this document, NHS Highland can be assured that maternity services are up to date, safe, effective and women and family centred and fit for purpose for the duration of the Strategy.