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M.R.H.A
RCVD 13 OCT 1988
FOR ACTION: DR J EPS
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FT9.

To General Managers of:

Regional Health Authorities
District Health Authorities
Special Health Authorities

Your reference

Our reference
MDD3/19

Date
11th October 1988

Dear Sir

ADVISORY COMMITTEE ON DISTINCTION AWARDS
ADVANCE NOTIFICATIONS - 1988 REVIEW

The Advisory Committee on Distinction Awards will be meeting in January 1989 to consider new and higher awards for 1988. In granting these awards it is necessary to take into account the number of vacancies arising from retirements, resignations and death during the year.

In order that an accurate statement of vacancies may be available to the Committee I shall be glad if you will let me have the names of all Consultants and, if applicable, Community Phsycians (both paid and honorary) who have retired or are due to retire between 1 October and 31 December inclusive. Any award holders who are on an extended period of unpaid leave at 31 December must also be included. I should also be grateful if you would advise me of the names of any <u>award holders</u> who are to be appointed during this period. Please let me have this information <u>not later than 1 November</u> - even if yours is a "nil" return.

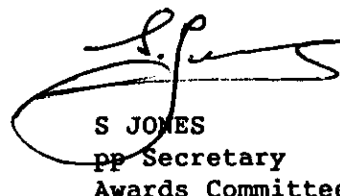
Any further retirements or deaths which occur after you reply should be notified by telephone and confirmed in writing without delay to Mr C Padwick at the above address.

I regret the necessity for having to ask for information at this time, but hope that you will appreciate that as the meeting of the central Advisory Committe is being held in January the necessary details will not be available from the quarterly returns in time for this meeting.

I should mention that this request is in addition to the return which is required every quarter. If not already sent I shall be pleased to receive your letter for the quarter ended 30 September as soon as possible and that for 31 December by 11 January 1989.

This letter will be cancelled and deleted from the current communications index on 31 December 1988.

Yours faithfully



S JONES
~~pp~~ Secretary
Awards Committee

2406S/EMC/2

ANNEX 1

MSAC REVIEW QUESTIONS

1. Maternity Services Liaison Committee (MSLCs)

Each MSLC should include representatives of all the professions involved in maternity and neonatal services in the DHA, to ensure integration between the hospital and community services. MSLCs should have two functions: the agreement of generally applicable procedures and the monitoring of effectiveness of these procedures as they apply to the individual woman.

a) What is the membership of each MSLC (by professional position or other capacity)?

b) How frequently does each MSLC meet?

c) Please give examples of recent activities of MSLCs in the areas of antenatal care, intra-partum care, postnatal care, and neonatal care.

2. Antenatal Care

A high percentage of antenatal care has been taking place in hospitals. This places excessive demands on the consultants' teams and can create unsatisfactory conditions and long waiting times for women in clinics. Difficult or expensive journeys to hospitals may also deter women from attending clinics.

a) What is the policy on shared antenatal care for

i. low-risk pregnancies

ii. other pregnancies in each District? Has it been agreed with the Family Practitioner Committees?

b) Does each DHA have midwives' clinics?

c) Please give examples of steps taken to improve the conditions and organisation of hospital antenatal clinics?

3. Health Education & smoking

Numerous studies have demonstrated a link between smoking during pregnancy and low birthweight. There is also an increase of about 28 per cent in perinatal mortality where the mother smoked during pregnancy. Both the reduction in birthweight and increase in perinatal mortality increase with the average number of cigarettes smoked.

a) What provision does each DHA make for health education during pregnancy, especially in relation to the dangers of smoking and the importance of a healthy diet? Does the

provision take account of the diversity of cultures, languages and social and economic circumstances in the District and are there classes provided at times to suit working women and partners?

b) In each maternity unit, what steps have been taken to protect non-smokers from tobacco smoke and to encourage those who smoke to give up?

4. Written operational policies

All staff working in a maternity unit should be aware of the unit's operational policies for normal births as well as for complications in labour and birth. Written information should be available covering how and where paediatric, anaesthetic and laboratory services can be obtained in emergencies. This should be readily up-dated and easily accessible at all times.

a) Do all maternity units have agreed written operational policies, covering care during labour and childbirth?

b) If not, please state which do not and what percentage this represents of total units. When do these units plan to introduce them?

c) Do the written policies cover medical procedures in crisis situations?

d) What steps are taken to ensure that every member of staff working in the unit is aware of the policies?

5. Medical cover in the delivery suite

In every consultant unit there should be a doctor immediately available for the delivery suite who should have no conflicting commitments. A consultant obstetrician or his deputy should be available to take over from junior staff when necessary.

a) Do all consultant units have arrangements for a doctor to be immediately available for the delivery suite at all times, without other conflicting commitments?

b) In each consultant unit, what is the highest grade of doctor i) obstetric ii) anaesthetic, iii) paediatric, who is commonly immediately available for emergencies in the delivery suite:

i. during the day (9am - 5pm)

ii. during the evening (5pm - midnight)

iii. at night (midnight - 9am)

iv. at weekends (5pm Friday - 8am Monday).

c) Where problems with availability of medical staff are identified, when plans are there to improve the situation?

6. Postnatal and community care

As the trend towards shorter postnatal stay in hospital continues, much postnatal care must be carried out by the GP, community midwife and health visitor. Without adequate co-ordination between the services, there is a risk that conflicting advice given by different health professionals would confuse rather than help the new mother. Also, all community health professionals need to be on the alert for babies at risk of Sudden Infant Death Syndrome.

a) What steps are taken in each DHA to ensure postnatal care and advice provided to mothers by both hospital and community services are co-ordinated?

b) Are there special procedures agreed locally for monitoring the progress of babies who may be at risk of unexpected infant death?

7. Inquiries into perinatal and neonatal deaths and Perinatal reviews

Both local confidential inquiries and Regional Perinatal Review are necessary for a full understanding of the causes and trends of mortality and to enable appropriate steps to be taken to prevent avoidable deaths. Local inquiries into the circumstances surrounding each death should be undertaken promptly while staff still have a ready recall of events. As a result of MSAC recommendations and Korner requirements, DHAs should by now be collecting a comprehensive range of statistical management information including incidence and outcome of births involving complications, obstetric procedures, nature and outcome of neonatal care as well as demographic and epidemiological characteristics of the population.

a) How many perinatal pathologists does the Region have? If not an adequate number, what steps are being taken to improve the situation?

b) In each consultant unit, what investigations are undertaken into each perinatal and neonatal death? How soon after the death do the investigations take place? Are near-misses also investigated?

c) Does the RHA collate District statistics on the incidence of stillbirths nd neonatal deaths in relation to a range of contributing factors (Regional Perinatal Reviews), in order to identify any Regional trends and general problems? If not, what plans are there to begin doing so and when?

d) If the Region does undertake Regional Perinatal Reviews, what use is made of the results? Do DHAs and their relevant professional staff receive them?

8. Neonatal care

A baby should not be separated from his mother unless absolutely necessary for the care of either: contact between the small or ill baby and his mother and father is as important for his development and well-being as for any other baby. Every maternity unit should be prepared to meet the immediate needs of all babies delivered in it but because not all maternity units and associated neonatal units have the necessary facilities or staff expertise to meet the continuing needs of all small or seriously ill babies, some may have to be transferred to units which have such facilities. Each Region should have a strategy for the development of neonatal care.

a) Do all consultant units have arrangements for 'Transitional care', allowing babies with limited special care needs to be looked after on the postnatal wards? If not are there plans to introduce Transitional care?