Healthcare Inspectorate Wales

Maternity Services in Wales - Findings and Themes from the All Wales Review

August 2007

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G/281/07-08
ISBN 0 7504 4369 2

August
CMK-22-04-030(143)

Typeset in 12pt
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Chapter 1: Executive Summary

1.1 Over 30,000 babies are born in Wales each year and maternity services need to provide safe and effective care and respond to the needs of every woman/mother and their babies in a variety of settings (provided by NHS Trusts and Powys Local Health Board).

1.2 Thirteen organisations provide maternity services in Wales and women can choose to have their babies in a consultant unit, midwifery led unit (not available in all areas) or at home.

1.3 Healthcare Inspectorate Wales's (HIW) review of maternity services indicates that on the whole maternity services are being delivered in a safe and effective way. Staff feel comfortable with the support that organisations provide to them to enable an acceptable standard of care to be delivered to women and their families and in the main the different professions that care for women are working together effectively.

1.4 Maternity services need to be responsive to the changing needs of women but in some cases changes to the provision of care are currently being delayed due to potential reconfiguration and restructuring of services across the country that were being considered when the review first took place.

1.5 There were some issues raised by the review which could affect the quality of care that is being delivered to women, but where these were present, organisations were aware of these issues and in the main they were being addressed, indicating that maternity services in Wales are risk aware.

Chapter 2: Maternity Services in Wales

2.1 The birth rate in Wales is on the increase and the total number of deliveries in 2005, as indicated by the organisations that provide maternity services, was 31,776. Thirteen NHS organisations provide maternity services in Wales and the number of deliveries in each organisations area is detailed in the following table.

Pembrokeshire & Derwen	Carmarthenshire	Swansea	Conwy & Denbighshire	North East Wales	North West Wales	Pontypridd & Rhondda	Bro Morgannwg	North Glamorgan	Cardiff & Vale	Gwent Healthcare	Ceredigion & Mid Wales	Powys Local Health Board	Total Deliveries in Wales
1288	1519	3618	2288	2366	1924	2396	2491	1482	5655	5911	552	286	**31,776**

2.2 Births are planned to take place in three different settings:

- **At Home –** a homebirth is usually a planned event where the woman gives birth at home, with care provided by a midwife.

- **In a Midwifery Led Unit/Birth Centre** - these units (within a community hospital or general hospital maternity unit) are staffed by midwives and provide care for women who want to give birth with little or no medical intervention. They tend to be suitable for women expected to have a good chance of having a straightforward birth ("low-risk" women).

- **In a Consultant Unit** - which is usually part of a general hospital and consists of a labour ward/delivery suite, antenatal and postnatal in patient wards and is staffed by obstetricians (specialists in birth where there are complications) and midwives (specialists in normal birth). A woman is usually booked under the care of a particular consultant, but may only see

him/her rarely throughout her pregnancy. Most of her care will be given by midwives. If complications arise during pregnancy or labour, the doctors will become more involved. Interventions such as epidurals and caesarean operations are usually available in the unit. Details of the number of deliveries in each setting are indicated in the following table.

Trust / LHB	Births in Consultant Unit		Births in Midwifery Led Unit		Homebirths	
Pembrokeshire & Derwen	1217	94.5%	-	-	71	5.5%
Carmarthenshire	1423	93.7%	-	-	96	6.3%
Swansea	3208	88.7%	326*	9.0%	84	2.3%
Conwy & Denbighshire	2245	98.1%	-	-	43	1.9%
North East Wales	2333	98.6%	-	-	33	1.4%
North West Wales	1803	93.7%	55	2.9%	66	3.4%
Pontypridd & Rhondda	2336	97.5%	-	-	60	2.5%
North Glamorgan	1310	88.4%	156	10.5%	16	1.1%
Bro Morgannwg	1960	78.7%	329	13.2%	202	8.1%
Cardiff & Vale	5036	89.1%	476**	8.4%	143	2.5%
Gwent Healthcare	4450	75.3%	1267	21.4%	194	3.3%
Ceredigion & Mid Wales	526	95.3%	-	-	26	4.7%
Powys Local Health Board	851***	0.0%	174	90.1%	112	9.9%
Totals for Wales	**27,847**	**87.6%**	**2783**	**8.8%**	**1146**	**3.6%**

* Opened in May 2005
** Midwifery Led Units opened in July 2005
*** Women cared for by Midwives in Powys but delivered in a General Hospital not included in the overall totals

2.3 The All Wales Home Birth Reference Group was set up in September 2002 to encourage an increase the number of homebirths in Wales. The overall homebirth rate in Wales in 2005 was 3.6%, (this varies between 1.1% and 9.9% across the country). In comparison, the homebirth rate in England

for 2005 was 2.53% and in Scotland 1.28%. Women also have the choice to deliver in midwifery led units if they are “low-risk” (please refer to the organisation specific reports for names of the various units) or have midwifery led care in general hospital maternity units.

2.4 Consultant led maternity units still account for the largest number of deliveries. The number of caesarean sections, instrumental deliveries (forceps and ventouse) and inductions of labour is set out in the following table.

Trust / LHB	*Elective Caesarean Section		*Emergency Caesarean Section		*Instrumental Deliveries		*Induction	
Pembrokeshire & Derwen	140	10.9%	134	10.4%	118	9.2%	309	24%
Carmarthenshire	158	10.4%	217	14.3%	144	9.5%	351	23.1%
Swansea	464	12.8%	542	15%	375	10.4%	593	16.4%
Conwy & Denbighshire	191	8.3%	371	16.2%	270	11.8%	617	27%
North East Wales	168	7.1%	394	16.7%	262	11.1%	518	21.9%
North West Wales	147	7.6%	294	15.3%	233	12.1%	416	21.6%
Pontypridd & Rhondda	390	16.3%	306	12.8%	155	6.5%	551	23%
North Glamorgan	185	12.5%	249	16.8%	143	9.6%	306	20.6%
Bro Morgannwg	170	6.8%	337	13.5%	151	6.1%	366	14.7%
Cardiff & Vale	558	9.9%	831	14.7%	598	10.6%	943	16.7%
Gwent Healthcare	572	9.7%	761	12.9%	616	10.4%	1175	19.9%
Ceredigion & Mid Wales	59	10.7%	94	17%	40	7.2%	118	21.4%
Powys Local Health Board	Powys only carries out midwifery led care and so they do not undertake caesarean sections, instrumental deliveries and inductions							
Totals	**3202**	**10.1%**	**4530**	**14.3%**	**3105**	**9.8%**	**6263**	**19.7%**

*Percentages are calculated on the total number of each occurrence from the total number of deliveries and therefore may not add up to 100%.

2.5 The caesarean section rate across Wales varies from organisation to organisation and there are a number of reasons why the rate might be higher in certain organisations, such as the organisation being the main referral centre for “high-risk” women and therefore having a higher chance of having a caesarean section. The overall elective caesarean section rate in Wales in

2005 was 10.2%. This compares to 9.5% in England and 10.2% in Scotland. The overall emergency caesarean section rate was 14.1% and this compares to 13.6% in England and 15.4% in Scotland. The overall induction rate in Wales was 19.7% and varies quite considerably across the country from 14.7% to 27%. The reasons for this can be similar to the above or if there are different criteria for induction, such as the organisation's policy for how far over due women go before induction is started. In comparison, the induction rate in England is 19.6% and 24.1% in Scotland.

Chapter 3: Why did Healthcare Inspectorate Wales undertake a Review of Maternity Services?

3.1 In England the Healthcare Commission has conducted investigations into maternity services at Northwick Park Hospital in London and New Cross Hospital in Wolverhampton, following concerns about the clinical governance arrangements and the quality of care in these units. The overarching themes from these reviews were:

- weak risk management with poor reporting of incidents;
- poor working relationships and working in multidisciplinary teams;
- inadequate training and supervision of clinical staff;
- shortages of staff.

3.2 In response to the concerns about maternity services in England, HIW decided to carry out a national review in Wales in order to provide the Welsh Assembly Government and the Welsh public with assurance that similar issues were not present in Welsh Maternity Units. HIW has worked with a number of organisations and individuals in developing the review in Wales.

3.3 In addition to this overview report, individual reports have been produced on each NHS organisation (12 Trusts and one Local Health Board) in Wales providing maternity services.

Chapter 4: What did we look at and how did we go about it?

4.1 The All Wales Maternity Review considered six areas: -

- Clinical leadership and accountability for the quality of Maternity Services;
- Management of Maternity Services;
- Teamwork and communication;
- Clinical care;
- Women and their families experience and involvement;
- Documentation and information.

4.2 There were several elements to this review, including the examination of data about maternity services (including National Service Framework for Children, Young People and Maternity Services Self Assessment Audit Tool Data), and documentary evidence supplied by NHS Trusts and Powys LHB, seeking the views of patients, the public and other stakeholders and an on site visit to each provider. The review was carried out by HIW staff and a team of appointed reviewers (details about the team appear at the end of this report).

A more detailed description of the review process is included at Annex 1.

Chapter 5: Findings and Themes

5.1 Individual reports have been written and published for each of the thirteen organisations that provide maternity services in Wales. These detail the specific findings and recommendations that each organisation should address. Copies of these reports are available from the HIW website (www.hiw.org.uk - Publications Section, NHS Wales Publications, Theme, Maternity Services Review) or by phoning HIW on 02920 928850.

5.2 The following section outlines the overall themes identified during the All Wales Maternity Services Review, including areas of strength and areas for further improvement.

5.1 Clinical Leadership & Accountability for the Quality of Maternity Services

Background

5.1.1 The Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM) document "Towards Safer Childbirth", published in 1999, set out to establish guidelines for staffing, equipment and general facilities on maternity wards necessary to provide a safe and effective service and makes a number of recommendations in this respect. Those pertinent to this area of HIW's review are:

- There should be a lead consultant obstetrician and a clinical midwife manager for labour ward to provide clinical leadership, training and support to staff.
- The consultant on-call for the labour ward should conduct a labour ward round during the day and midwives and medical staff should be able to communicate and consult freely.
- As a minimum a consultant or equivalent should be available in a supervisory capacity for 40 hours during the working week (ten sessions), unless the unit is small and where the majority of women who give birth have a normal pregnancy.
- Midwifery staffing levels should be 1 midwife per 1.15 women in labour.
- There should be a "multidisciplinary labour ward forum comprising, at a minimum, the lead obstetrician, the clinical midwife manager, an obstetric anaesthetist, a neonatal paediatrician, a risk manager, representatives from junior medical and midwifery staff and a consumer representative from the Maternity Services Liaison Committee to review labour ward activity and develop guidelines".

The document is in the process of being updated and the revised version is due to be released in late summer 2007 and organisations will need to consider any updated recommendations.

Is there Clinical Leadership (Medical and Midwifery) for the Labour Ward, Midwifery Led Unit (where applicable) and for Homebirths?

5.1.2 The review established that there is an identified medical and midwifery lead or leads in almost every unit that undertakes deliveries in Wales. However, there are a few units where a lead is yet to be identified or where there needs to be clarification about who takes this responsibility. In addition, the review identified that the job descriptions of about half of the leads needed to be updated to reflect their responsibility.

5.1.3 Part of the role of the medical and midwifery leads, along with other senior colleagues, is to support junior staff. This was tested by HIW during the site visits and there was evidence that staff generally felt supported by senior colleagues and that they were available and approachable should they need assistance and advice. Staff also identified that there were various opportunities for training events for staff to keep their skills up to date.

> *"I feel very well supported, there is always a senior midwife available and I can go to skills drills and other courses".*

5.1.4 Effective communication between staff is a key issue in ensuring safe and effective care. A number of units undertake joint ward rounds and have links between midwifery and medical staff handover but some units need to improve these arrangements to ensure effective communication between the professions.

5.1.5 The availability of a consultant or equivalent in a supervisory capacity for 40 hours (ten sessions) during the working week is important to ensure that clinical expertise is on hand to deal with complicated cases and to support and train junior staff. The review found that six of the maternity units in Wales had all ten sessions covered with the remaining six units having between five and nine sessions covered. It was noted that some units experience difficulty covering all ten sessions as consultants may have other commitments and so are not present on the labour ward for the full ten

sessions. A number of these units are aiming to cover all ten sessions with recently appointed staff. Of the other two units that provide maternity services in Wales, one provides midwifery led services and so this requirement does not apply and the other is small and so provides three fixed consultant sessions per week as guided by the RCOG/RCM document.

5.1.6 Recommendations to address these shortfalls have been made in the organisation specific reports. With “Towards Safer Childbirth” about to be updated it is likely that the requirement for consultant presence on the labour ward will be increased and organisations will need to take any new recommendations from the RCM and RCOG into consideration.

5.1.7 Effective workforce planning to provide a safe level of care for women is important and all thirteen organisations in Wales have made use of Birthrate Plus (an established framework for workforce planning and strategic decision making in maternity services) between 2002 and 2006 to identify their staffing requirements. The Birthrate Plus audits showed that in approximately two thirds of the organisations the staffing was about adequate for the services being provided but that it would be beneficial to change some working patterns to better utilise the workforce, e.g. reconfiguration of community midwifery teams and the opening of day assessment units. A few units had more significant staff shortages that need to be addressed and recommendations to this effect have been made in the relevant organisation specific reports.

Is there a named obstetric anaesthetist available at all times to provide advice and cover for the Labour Ward?

5.1.8 Twenty-four hour on call consultant or senior anaesthetic cover is available for the consultant led maternity units in Wales with consultant anaesthetists also present on the labour wards for a number of sessions each week. In some of the smaller units, on call anaesthetists are also responsible for covering the rest of the hospital but the review did not identify any specific

issues with regard to their availability for the labour ward should they be needed.

Is there a multi-disciplinary labour ward (midwifery led unit) forum to review labour ward activity?

5.1.9 All units have groups in place that consider labour ward matters. Just over half of these are labour ward forums that consider all aspects of labour ward activity, such as the development of guidelines. The other units have different groups in place that only consider certain aspects of labour ward activity. These groups need to be reviewed to ensure that there is a general labour ward forum for each unit.

5.1.10 All organisations need to review the membership of the labour ward forum to ensure that it is in line with the recommendation of the RCM and RCOG. At the present time no unit has a forum with the full membership or attendance on a regular basis.

5.2 Management of Maternity Services

Background

5.2.1 Communication and sound management arrangements are key to the safe running of maternity services.

Do Maternity Unit Managers, Heads of Midwifery (HOM) and the Clinical Director for Maternity Services, have clearly defined roles and responsibilities, protected time to fulfil their management roles and effective support from the organisation to carry out their roles?

5.2.2 Job descriptions were reviewed and interviews with senior staff were carried out in each unit. It was found that generally staff were clear on their role and responsibilities within maternity services and the wider organisation, most felt that they had adequate time to carry out their role and were well supported by the organisation, through their peers, other colleagues and various training courses. Whilst most organisations had effective communication channels in place, some staff felt that communication to and from senior managers could be improved.

> *"Yes I am confident that senior staff are aware of issues and then take action".*
>
> *"There is not enough consultation, senior staff should listen more".*

Is there an appropriate flow of information from/to the Trust Board and the maternity services?

5.2.3 Senior staff reported that there was an appropriate flow of information to the Trust/LHB Board and that they were adequately briefed on issues in maternity services. This information flowed through committee structures, direct reports from key staff or via informal routes. There were a few units

where staff felt that communication to the Trust Board could be improved and recommendations have been made in the organisation specific reports to address this.

Is there an escalation policy during periods of increased activity to ensure the safe management of the maternity services which includes clear criteria for staffing levels?

5.2.4 Having an escalation policy in place ensures the safe management of maternity services and the processes to be followed by staff should there be an increase in activity in the unit or reduced staffing. In some instances this may mean that a unit has to close, however this is rare and if it does occur it is usually only for a short period of time. The review found that all organisations have an escalation policy in place; however, a few of these were in draft and need to be approved, some need expansion to cover all aspects and in some units staff awareness of the policies needed to be strengthened. Very few organisations had undertaken any audit of the effectiveness of the escalation policy and arrangements for this to happen need to be put in place.

5.3 Teamwork and Communications

Background

5.3.1 Good teamwork and communication is essential in ensuring safe and effective care.

5.3.2 The review took into account the following key publications in considering teamwork and communication:

- The RCOG/RCM report "Towards Safer Childbirth" referred to earlier in the report also makes recommendations in relation to effective teamwork and communications:
    - There should be a set of referenced, evidenced-based guidelines which should be dated, signed and reviewed on a regular basis, every one to three years. Past guidelines and protocols should be dated and archived;
    - Midwives and medical staff should be able to communicate and consult freely and at an appropriate level.
- The National Service Framework (NSF) for Children, Young People and Maternity Services in Wales, which is part of the Welsh Assembly Government's strategy for children and young people in Wales. It includes key actions that apply to all children and young people as well as specific actions for maternity services under three headings:
    - children and family centred services;
    - access to services;
    - the quality of services.
- The All Wales Clinical Pathway for Normal Labour which provides support for midwives who wish to practice evidence-based clinical care with minimal unnecessary intervention.

How does the maternity unit encourage effective team working and communication?

5.3.3 In addition to the formal and informal interviews with staff, HIW reviewed staff surveys, minutes of multidisciplinary meetings and training programmes in order to identify how staff felt they worked and communicated both in teams and across the professions.

5.3.4 It was found that there is generally good team working and communication across the different teams and also the different professions.

> *"Brilliant here, teamwork definitely, always feel supported".*

5.3.5 Practical systems such as newsletters, communication files and regular meetings were mentioned by some staff as effective ways of disseminating information and keeping up-to-date. In a number of organisations, the multidisciplinary groups held across the clinical directorates were evidence of how communication, discussion and working across the professions can successfully take place.

5.3.6 In relation to staff surveys, there was evidence that most organisations had taken part in the NHS Staff Survey and, although this was more relevant to the directorates than to maternity services, some organisations demonstrated a commitment in taking the results forward, setting out recommendations in the form of an action plan. Unfortunately, there was little to indicate that in-house staff surveys specific to individual services such as maternity had been undertaken.

5.3.7 While it is evident that communication and team working is actively promoted and works well for most organisations and staff, some of the interview evidence indicated that further improvements could be made to strengthen communication especially between teams working in the community and main hospital site and across the professions. Multidisciplinary training was also an area where evidence was inconsistent

and, although there were good examples of this, more needs to be done in this respect.

Do all women receive an agreed plan of care throughout pregnancy, labour and the postnatal period in line with current professional standards with their risk assessment and their chosen place of birth and is there a mechanism for referral from one professional to another at all stages of care, including a written evidence based transfer policy where applicable?

5.3.8 An agreed Care Plan is key to identifying the appropriate level of care for pregnant women. To this end, guidelines and procedures need to be in place to ensure adequate risk assessment and criteria for homebirth, "low-risk" and "high-risk" care and transfer and referral.

5.3.9 The majority of organisations have care plans that are completed in partnership with women and where appropriate women have a named midwife.

5.3.10 HIW found that all organisations had the relevant guidelines in place, covering areas such as the booking process, inclusion and exclusion criteria for the pattern of care to be offered, guidance on referral and transfer and the regular assessments to be undertaken or observed. However, there were a few instances where policies, including those specific to the labour ward, did not cover in enough detail the more practical steps to be taken and these will need to be reviewed and amended in order that best practice is followed and where possible unnecessary risks reduced.

> *"Community midwives put the plan of care in place, and decide if a woman is "low-risk" or requires consultant input, however, if there is a problem the woman can easily be referred in to the consultant led unit".*

5.3.11 The aim of the Clinical Pathway for Normal Labour (implemented in all organisations that undertake deliveries during 2004) is to reduce unnecessary intervention in labour. The focus is on promoting normality and in supporting midwives to use evidence based practice.

5.3.12 HIW observed during the site visits that organisations are committed to implementing the all-Wales Clinical Pathway for Normal Labour, when appropriate. The Pathway is a useful tool for promoting normality, with 90% of eligible women achieving a normal birth. However, more work needs to be done in ensuring that all healthy women with normal pregnancies are cared for using the Pathway's principles. Given the criteria for including women on the Pathway, we should expect that around 60% of all women giving birth in Wales would be deemed as suitable to be started on the pathway, the average currently is around 30%.

5.3.13 HIW also reviewed labour ward policies. These should be developed in line with the Trust/LHB processes and reviewed on a regular basis. Overall, the labour ward policies were appropriately set out and contained sufficient detail; however, not all organisations had a systematic approach to their development. Staff were aware how to locate these policies and were conscious of ensuring they were referring to the latest versions.

> *"There are paper copies of the policies on the labour ward and also on the intranet".*

> *"I can access them on the computer or in the file and they have review dates on them".*

5.4 Clinical Care

Background

5.4.1 Good clinical care is underpinned by good training.

5.4.2 The RCOG/RCM report "Towards Safer Childbirth" referred to earlier also makes recommendations in relation to clinical care. The following is pertinent to this area of HIW's review:

- Six monthly multidisciplinary education/training sessions on the management of 'high risk' labours and CTG interpretation should be attended by all clinicians.

Is there a system to ensure that all critical incidents are reported through the appropriate channels, have immediate action taken to prevent reoccurrence, are investigated, analysed and patterns and trends are identified and that these are reviewed by a multidisciplinary group and any changes in practice are made?

5.4.3 All organisations in Wales have incident reporting policies in place that describe the reporting process staff should follow. During the site visits, HIW reviewed the last two months completed incident forms and established that staff are reporting a wide range of incidents in all units. On the whole, midwifery and medical staff are reporting incidents, however in approximately one third of organisations there were no or only limited examples of incident forms being completed by medical staff. This should be addressed to ensure that all staff are reporting incidents. HIW also spoke to a number of staff and were assured that they generally recognised the importance of reporting incidents and believed that organisations aimed to learn from incident reporting rather than apportion blame.

"I think that incident reporting is regarded as a learning experience, we get good feedback".

"I have never reported an incident, I am not sure what incidents should be reported".

5.4.4 Organisations have arrangements in place generally to review incidents and to ensure that action is taken to prevent reoccurrence and changes in practice as a result of incident reporting was evident in a number of organisations. However, there was limited evidence to suggest that incident trends are being collated, discussed and acted on. Recommendations have been made in the organisation specific reports to address this.

Are all healthcare professionals directly involved in childbirth competent in basic adult obstetric resuscitation, neonatal resuscitation and immediate care and cardiotocograph (CTG) interpretation training and are updates undertaken on a regular basis?

5.4.5 All organisations should ensure that resuscitation training is available for all staff either through the statutory arrangements in the organisation, external courses or specifically organised in house training. HIW found that on the whole staff are receiving resuscitation training; however, there are some organisations that need to improve the uptake of this training.

"I have resuscitation training every year, we are reminded but I usually remember".

"Training is available but it is difficult to get time and the cover to be able to go".

"I have not had training since I started here".

5.4.6 CTG interpretation training is also provided in all organisations through a variety of ways; a computer based training system, study days and in house

meetings where cases and CTGs are discussed in a multidisciplinary forum. HIW found that for the most part staff had attended this training in the last six months.

> *"I attend CTG meetings regularly".*

> *"I have ongoing access to the computer based training package".*

> *"I learn on the job, I can attend meetings but time is short".*

5.4.7 Various methods, from electronic databases to paper records, are used by organisations to record and monitor staff attendance at various training events. HIW found that generally there were good training records evident for all grades of midwifery staff but were poorly addressed for attendance and monitoring of grades of medical staff. Specific recommendations have been made in the organisational specific reports to ensure that training records capture all professional staff, so that attendance can be monitored and staff reminded when they are due for update training.

5.5 Women and Families

Background

5.5.1 Women and their families should be given good information and be involved in their own care.

Are the views of women and their families sought routinely and changes made as a result?

5.5.2 All organisations demonstrated how they obtain the views of women and their families. Examples included the National Childbirth Trust (NCT) Birth Environment Survey, exit questionnaires, Women's Forums and Focus Groups. Overall, HIW found evidence that points and suggestions made by patients are discussed and reviewed and recommendations made as a consequence. There is also evidence that changes have been made to areas within the units as a result of the NCT Birth Environment Survey.

5.5.3 It was difficult to conclude how effective some of the in-house patient surveys had been as in some cases the uptake and response rate was poor. Generally, more needs to be done by organisations to effectively obtain the views of women and their families.

Are women and their families provided with evidence based information to enable them to make informed decisions about their care throughout pregnancy, labour and the postnatal period?

5.5.4 The information provided to women and their families should cover all aspects of pregnancy and labour and specifically what is available to them locally. It was evident that the vast majority of organisations are providing women with the Welsh Assembly Government Pregnancy Book, which provides advice on the relevant areas, specific local information and any other relevant national guidance such as the NICE 'Fetal Monitoring in Labour'

leaflet, as appropriate. All organisations should ensure that local information about the services they provide is routinely made available and is kept up-to-date in order that informed choices can be made by women and their families.

> *"During booking women are given as much information as possible".*

> *"The pregnancy book is given and other information leaflets, it is very good".*

Is there a named healthcare professional identified for each woman, who leads and plans her contact with maternity services?

5.5.5 Organisations are reporting that care plans are completed in partnership with women and, where appropriate, women have a named midwife. It was also clear from the health records HIW reviewed that the named healthcare professional was identified and named at the front of each of the hand held records. In addition, interview evidence identified that staff were confident and happy with the process of referring and transferring pregnant women and felt the system worked well.

> *"Midwives are the first point of contact and work together to keep the caseload even, there is a named midwife."*

5.6 Documents and Information

Background

5.6.1 Good care depends on good record keeping and information.

"Towards Safer Childbirth" referred to earlier makes recommendations in relation to documentation and information:

- The documentation and storage of data should be rigorous and precise. The use of computerised documentation, using recognised and acceptable programmes, should be encouraged.

Does the maternity unit seek to continuously improve the quality of medical records through ongoing audit and review?

5.6.2 There should be a multidisciplinary audit of medical records and record keeping. HIW found that the majority of maternity units are undertaking annual record keeping audits and case note review audits in order to continually improve how medical records are maintained. These audits identify areas for improvement and recommendations are communicated and discussed within the Trust/LHB audit systems. A systematic approach to regular audit and review was apparent for the majority of organisations but others will need to consider how they should be incorporating this as part of their annual audit programme. It was also clear that in the main multidisciplinary audits are not taking place and this needs to be addressed.

What data on maternity services is routinely collected and what changes have occurred as a result of collecting this information?

5.6.3 HIW found that organisations are collecting data about maternity services, either electronically or manually, on a monthly or sometimes daily basis. The data being collated includes the information from the initial

booking of women, projected deliveries, type of delivery, place of birth and information about the all Wales Clinical Pathway for Normal Labour. The processes of data collection are resource intensive. It was therefore disappointing to note that there were only a few instances identified where the information being collected was explicitly being acted upon and used, whether in planning services and predicting busy periods or sharing information and learning lessons.

5.6.4 There is currently no standard All Wales maternity data set being collected, nor is it clear in many cases what the information currently being collected is being used for either locally or centrally. Therefore HIW is making a recommendation that does not appear in the organisation specific reports for all organisations to collectively address and take forward.

Recommendation

The Welsh Assembly Government in consultation with maternity providers in Wales should develop a coherent and integrated national data set for maternity services, taking into consideration what the data needs to be used for, the various organisations that this information is submitted to and benchmarking with other organisations across the UK.

Is a structured and accurate record of all events during antenatal, childbirth and postnatal periods maintained for every woman and child?

5.6.5 HIW sampled and reviewed 20 sets of health records during each of the site visits. The records, overall, were found to be robust with information securely stored and maintained. However, there were cases where the pocket located to the front or back of the record did contain some patient information which had the potential to fall out. There was also evidence that CTG traces

were being stored on a mount sheet usually used for blood results and had the potential to unravel. Certain storage methods are known to increase the speed with which records fade and for this reason the simplest storage method is to use a re-sealable, clearly labeled envelope secured within the main body of the health record as maternity records need to be kept for 25 years, so it is important that they are maintained appropriately and the information contained within them safely secured and appropriately filled.

5.6.6 Some issues were identified with the recording of information, such as staff names, dates and times. These should be addressed by all organisations and it was noted that some were already dealing with these issues through regular audit and review.

Chapter 6: Next Steps

6.1 Each organisation is now required to produce an action plan to address the specific recommendations from each of the organisation specific reports, these will be submitted to HIW and approved in conjunction with the Department of Health and Social Services Regional Offices and monitored through the routine performance management arrangements for the NHS in Wales. In addition, the Welsh Assembly Government should address the national recommendations included in the report.

6.2 Organisations should also consider other Maternity services reviews and audits that are undertaken such as the Welsh Risk Pool Assessments, Wales Audit Office Maternity Service Review and a review of neonatal services when drawing up their action plans and ensure that links between all of this work is drawn together.

Annex 1

Stages of the HIW review of maternity services

Activity	Date
Analysis of documentary evidence that was submitted from each organisation that provides maternity services in Wales.	Sept-Nov 2006
Consideration of stakeholder and public comments in relation to the provision of maternity services.	Sept-Nov 2006
Consideration and comparison of National Service Framework (NSF) for Children, Young People and Maternity Services Self Assessment Audit Tool Data (SAAT Data) against information submitted from each organisation. The 17 key core actions for maternity services where relevant to the HIW maternity review, which organisations have self assessed themselves against and submitted to the Welsh Assembly Government (WAG).	Sept-Nov 2006
Five weeks of site visits incorporating all of the thirteen organisations that provide maternity services in Wales with a team consisting of HIW staff, Peer and Lay reviewers. Undertaking: - • Formal interviews with key staff and lay members where applicable; • Informal discussions with staff and observational visits to all units undertaking deliveries; • Review of additional sensitive information and specific polices.	Nov 2006–Feb 2007
Final analysis of all information obtained from the site visits.	Feb–Mar 2007
Drafting of thirteen organisation specific reports and submission to each organisation for checking of factual accuracy.	Mar–May 2007
Drafting, checking and publication of the Maternity Services in Wales – Findings and Themes from the All Wales Review.	Jun–Aug 2007

Annex 2

Healthcare Inspectorate Wales

Healthcare Inspectorate Wales (HIW) carries out the functions conferred upon the National Assembly for Wales in Chapter 4 of Part 2 of the Health and Social Care (Community Health and Standards) Act 2003. HIW has been established as a Unit within the Assembly with a formal independence provided through delegations made under the 2003 Act under section 63 of the Government of Wales Act 1998. In turn the functions of the National Assembly for Wales have now been transferred under the new constitutional arrangements brought into effect by the Government of Wales Act 2006 to the Welsh Ministers. HIW now performs these functions on behalf of the Welsh Ministers.

HIW's core responsibility is to undertake reviews and investigations into the provision of NHS funded care either by or for Welsh NHS organisations in order to provide independent assurance about and to support the continuous improvement in the quality and safety of Welsh NHS funded care. In doing so, HIW must play particular regard to:

- the availability of and access to healthcare;
- the quality and effectiveness of healthcare;
- the management of healthcare and the economy and efficiency of its provision;
- the information provided to the public and patients about healthcare and;
- the rights and welfare of children.

The frameworks of Clinical Governance and Healthcare Standards set by the Welsh Assembly Government are central to the way in which HIW assesses Welsh NHS organisations and Welsh NHS funded care.

In this respect, HIW is committed to:

- strengthening the voice of patients and the public in the way health services are reviewed;
- working with others to improve services across sectors and agencies;
- working with other regulators/inspectorates to ensure that the public, NHS organisations and the Assembly receive useful, accessible and relevant information about the quality and safety of Welsh NHS funded care and;
- developing more effective and co-ordinated approaches to the review and regulation of the NHS in Wales.

On 1 April 2006, the responsibility for the regulation of independent healthcare transferred to HIW from the Care Standards Inspectorate for Wales under the remit of the Care Standards Act 2000. Independent healthcare settings include acute hospitals, mental health establishments, dental anaesthesia settings, hospices, private medical practices, and clinics where prescribed techniques include class 3b and 4 lasers.

In addition on 1 April 2006, following the abolition of Health Professions Wales, HIW assumed responsibility for the statutory supervision of midwives and also entered an agreement with the Nursing & Midwifery Council (NMC) to conduct annual monitoring of higher education institutions in Wales which offer approved NMC programmes.

Annex 3

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Investigation into 10 maternal deaths at, or following delivery at, Northwick Park Hospital, North West London Hospitals NHS Trust, between April 2002 and April 2005 by the Healthcare Commission August 2006.

National Service Framework for Children, Young People and Maternity Services in Wales by the Welsh Assembly Government February 2006.

Review of Maternity Services Provided by North West London Hospital NHS Trust by the Healthcare Commission July 2005.

Towards Safer Childbirth Minimum Standards for the Organisation of Labour Wards by the Royal College of Obstetricians and Gynaecologist and the Royal College of Midwives February 1999.

Annex 4

Glossary

accountability – liability to answer for conduct / performance.

action plan – a timetable of agreed tasks designed to address a specific set of problems; in the context of an inspection, designed to respond to its recommendations.

antenatal care – care of women during pregnancy by professionals in order to detect, predict, prevent and manage problems with the women or their unborn babies. This care also includes education, advice and support.

audit – originally applied to assessment of the accuracy and probity of financial accounting; now extended to cover any assessment activity which sets out to assess the extent to which a product / outcome matches the criteria set.

benchmarking – comparison of practice or performance with that of others, with the purpose of identifying and emulating best practice.

Birthrate Plus – is a framework for workforce planning and strategic decision making in maternity services. It aims to match midwifery staffing levels to the appropriate requirements of care needed for women and their babies throughout pregnancy, labour, birth and the post-natal period.

cardiotocograph - the pattern on a strip of paper or "trace" that is produced by a machine electronically monitoring a baby's heartbeat.

caesarean section – an operation where the baby is delivered through an incision in the abdominal and uterine wall.

clinical audit – evaluation and measurement by health professionals of how far they are meeting standards that have been set for their service. Standards may be set by health professionals themselves or others.

clinical pathway – a clinical pathway is a template or blueprint for a plan of care. It is a guide to usual treatment patterns, but does not compromise the need for clinical judgement.

clinical governance – a "framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish" (Welsh Office: 'Quality Care and Clinical Excellence').

clinical incident – an event which occurs in a hospital or in community health service from which actual or potential harm may have been experienced by patients or the public.

data - a collection of information or facts.

evidence based practice – practices and disciplines in clinical fields based upon the best available evidence of what works. Practices should include asking the most apposite question for a particular patient, searching for evidence to answer the question, critically appraising the evidence to make sure that it applies to the patient in question, applying it and auditing success.

guidelines – systematically developed statements which help in deciding how to treat particular conditions.

Healthcare Commission – is the health watchdog in England which was created under the Health and Social Care (Community Health and Standards) Act 2003 and exists to promote improvements in the quality of healthcare and public health in England.

healthcare professional – a person qualified in a health discipline.

incident reporting – arrangements through which critical incidents are recorded and brought to the attention of managers responsible for their elimination or reduction.

induction of labour – the process of artificially bringing on labour using drugs or surgical interventions with a view to achieving vaginal delivery.

instrumental delivery –

> **forceps delivery** – specially designed instruments in two halves which lock together and has a blunt spoon-shaped curve which cradles the baby's head and a handle held by the person doing the delivery.
> **ventouse delivery** – is also known as a vacuum extractor or a suction cup. It consists of a round cup which is placed on the baby's head and a handle which is held by the person doing the delivery.

lead professional – the professional who will give a substantial part of the women's care and who is responsible for ensuring the woman has access to care from other professionals as appropriate.

maternity – related to the state of being pregnant.

midwifery – the profession which leads on normal pregnancy and birth and provides expert care to mother and baby during pregnancy, childbirth and the postnatal period within a family centred environment.

multidisciplinary team – a group of people from different disciplines (both healthcare and non-healthcare) who work together to provide care for patients with a particular condition. The composition of multidisciplinary teams will

vary according to many factors, these can include the specific condition; the scale of the service being provided; and geographical / socio-economic factors in the local area.

National Institute for Health and Clinical Excellence (NICE) – a special health authority producing guidance for the NHS and patients on medicines, medical equipment and clinical procedures.

National Service Framework (NSF) – guidelines for the health service on how to manage and treat specific types of disease and illness.

obstetrician - a doctor specialising in pregnancy and childbirth.

paediatrician – a doctor who specialises in medicine specifically related to children normally up to age 16.

performance management – the use of a review process, focusing on standards and objectives, to assess how well a person, team or service is working.

performance monitoring – a system which routinely collects and analyses how well a particular service or procedure meets targets or standards.

pregnancy - the period during which a woman carries a developing foetus, normally in the uterus.

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

resuscitation – cardio pulmonary resuscitation is a life saving procedure that is performed when a person's breathing or heartbeat has stopped.

Royal College of Midwives (RCM) - the professional organisation and trade union run by midwives for midwives. It is committed to developing a service that meets the needs of women and their babies throughout pregnancy, labour and the postnatal period.

Royal College of Obstetricians and Gynaecologists – an organisation which improves, maintains and promotes standards of care in obstetrics and gynaecology. It also supports other organisations that have similar objectives to those of the college.

trust board – a group of people who are by statute responsible for major strategy and policy decisions in each NHS Trust. Typically comprises a lay chairman, five lay members, the Trust Chief Executive and Executive Directors.

Wales Audit Office - undertakes comprehensive audit and inspection services across a wide range of public services in Wales.

Welsh Risk Pool (WRP) - is a mutual self assurance scheme for all health bodies in Wales. It also supports patient and staff safety by encouraging and supporting good risk management performance and assessment by measuring against set standards.

Annex 5

Appreciation

HIW would like to thank the thirteen organisations that provide maternity services in Wales for their co-operation and assistance in undertaking the All Wales Maternity Services Review and all of those staff and lay members that we spoke to as part of the review.

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