

**Healthcare Inspectorate Wales  
All Wales Maternity Services Review**

**Findings for Bro Morgannwg NHS Trust**

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## **Maternity Services in Wales**

Over 30,000 babies are born in Wales each year. Just over 2% of births take place at home or elsewhere but the majority (98%) are born in a hospital setting. These settings are Midwifery Led Units/Birth Centres or Consultant Units.

**Midwifery Led Units/Birth Centres** - These units 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).

**Consultant Units** - A consultant unit is usually part of a general hospital and consists of a labour ward/delivery suite, antenatal and postnatal inpatient 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 them 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.

## **Background to the HIW All Wales Maternity Review.**

Reviews undertaken by the Healthcare Commission in England into maternity services have given rise to concerns in relation to the clinical governance arrangements in these units and in Wales we needed to be assured that similar issues were not present in Welsh Maternity Units. Therefore a review of maternity services has been undertaken, the review considered the following 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.

The All Wales Maternity Review considered and analysed the following information: -

- Documentary evidence that was submitted from each organisation that provides maternity services in Wales;
- National Service Framework (NSF) for Children, Young People and Maternity Services Self Assessment Audit Tool Data (SAAT Data). 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);
- Formal and informal interviews;
- Observation visits to every unit undertaking deliveries were made with a team consisting of HIW staff, Peer and Lay reviewers.

## Background to Maternity Services at Bro Morgannwg NHS Trust

Bro Morgannwg NHS Trust manages a comprehensive range of integrated hospital and community services for a resident population of around 300,000 people living in the County Boroughs of Neath Port Talbot, Bridgend and the western Vale of Glamorgan. Maternity deliveries take place at the Consultant Unit in Bridgend and the Birth Centre in Neath Port Talbot Hospital. A total of 2491 births took place in 2005, further details of the type of delivery are set out in the following table.

<b>Data for January – December 2005</b>	<b>Total Number</b>	<b>Percentage</b>
Elective Caesarean Sections	170	6.8%
Emergency Caesarean Sections	337	13.5%
Instrumental deliveries (forceps and ventouse)	151	6.1%
All other deliveries in the Consultant Unit	1302	52.3%
Birth Centre	329	13.2%
Homebirths	202	8.1%
<b>Total number of births (Includes Consultant Unit, Birth Centre and Homebirths)</b>	<b>2491</b>	<b>100%</b>
Number of Inductions of Labour in 2005 (% of the total number of deliveries in the Trust)	366	14.7%

**HIW visited Bro Morgannwg NHS Trust maternity services on the 9<sup>th</sup> and 10<sup>th</sup> of January 2007 and interviewed staff and visited both the Consultant led unit and Birth Centre. Our findings, including areas of strength and areas for further improvement, and recommendations against the six key areas are detailed in the following table.**

HIW No	Criteria	Key Areas Considered	Findings including areas of strength and areas for further improvement	Recommendations
L1	There is Clinical Leadership (Medical) for the Labour Ward.	Job description of Clinical Lead(s) (Medical)	A copy of the generic job description for consultants who are appointed to the Trust (undated) was submitted along with a job description for the Consultant Medical Lead for Labour Ward (undated) which identifies that this is an additional responsibility. HIW established that the current responsibility for Clinical Lead (Medical) for the Labour Ward is split between two individuals and job descriptions should be updated to reflect this and should also clearly identify what functions each is responsible for undertaking.	1. The job description for the Clinical Leads (Medical) for the labour ward should clearly identify this responsibility.
		Activities of Clinical Lead(s) (Medical)	During the site visit HIW established that staff feel supported by senior colleagues and identified that they are available to consult with if staff need advice. A variety of training opportunities are available for staff.	
		40 hours consultant cover (rota and work undertaken)	The Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM) document "Towards Safer Childbirth" (1999), which is in the process of being updated, recommends that as a minimum a consultant or equivalent should be available in a supervisory capacity for 40 hours during the working week (10 sessions). The rota provided in the documentary submission identified the on call sessions rather than the fixed consultant sessions for the labour ward. Interview evidence indicates that the Trust has covered all 10 sessions (40 hours) of Consultant cover on the labour ward.	2. A rota detailing the 40 hours Consultant cover for the labour ward should be available for staff to refer to.
		Handover procedures for change of Medical/Midwifery staff	The Guidelines for Multidisciplinary Patient Handover (2005) details what should be handed over, by whom and the times this should occur, it also indicates that handovers should be documented. The Protocol for Handover of Shift for Labour Ward Co-ordinator (2006) details handover for labour ward shift leaders. Handovers occur at the change of shift for all staff across maternity services. There is a 9.00am multidisciplinary meeting at the Consultant Unit that involves all grades of medical staff, Senior Midwife and Paediatric staff to ensure effective communication across all professions, there is also communication to and from the Birth Centre.	

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L2	There is Clinical Leadership (Midwifery) for the Labour Ward, Midwifery Led Unit (where applicable) and for Homebirths	Job description of Clinical Lead(s) (Midwifery)	The job description for the Senior Clinical Midwife – Delivery Suite (undated) identifies that she is to provide clinical leadership and carry continuing responsibility for the management of delivery suite and obstetric theatres. The job description for the Consultant Midwife (undated) identifies that she will provide leadership and consultancy, but it does not specifically indicate that she will be the Clinical Lead (Midwifery) for the Birth Centre. HIW identified and confirmed during the site visit that there is a Clinical Lead (Midwifery) for the Labour Ward and for the Birth Centre.	3. The Clinical Lead responsibility (Midwifery) for the Birth Centre should be clearly identified in the relevant job description.
		Activities of Clinical Lead(s) (Midwifery)	Activities discussed in L1.	
		Birth-rate plus and actions/progress from audit	Birthrate Plus, which is a framework for workforce planning and decision making for maternity services has been carried out in the Trust. The Birthrate audit report (July 2006) identified that the increased volume of work at Princess of Wales Hospital, due to Port Talbot Hospital becoming midwifery led, has been matched with the necessary establishment and there was adequate staffing in maternity services. But the Trust has taken the opportunity to reorganise some of the community teams.	
		Handover procedures for change of Medical/Midwifery staff	Handover procedures discussed in L1.	
L3	There is a named obstetric anaesthetist available at all times to provide advice and cover for the Labour Ward.	Obstetric anaesthetist rota detailing cover for the labour ward	24 hour on call consultant or senior anaesthetic cover is available for the maternity unit, consultants are present on the labour ward for a number of sessions per week so they are immediately available and can support junior staff, they also attend the daily 9.00am multidisciplinary handover. There is also a written rota and a dedicated bleep so labour ward staff know who to contact.	

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L4	There is a multi-disciplinary labour ward (midwifery led unit) forum to review labour ward activity.	Terms of reference and minutes of meetings.	The RCOG and the RCM document "Towards Safer Childbirth" (1999) identifies that 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 maternity service has a Labour Ward Forum whose remit is to provide an opportunity to promote high standards of care through robust clinical governance arrangements for the labour ward environment. It is a multidisciplinary group that meets between 5 and 8 times a year. Membership includes Consultant Obstetrician, Anaesthetist, Paediatrician, Midwife, Labour Ward Manager, Head of Midwifery and representatives from the Birth Centre. Minutes of the meetings indicate that relevant items are discussed and that representatives attendance is good. There is however no representation from junior medical or midwifery staff or a lay representative and this should be addressed.	4. The membership of the Labour Ward Forum should include the membership as set out by the RCOG/RCM.

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M1	Maternity Unit Managers, Heads of Midwifery (HOM) and the Clinical Director for Maternity Services:- a) Have clearly defined roles and responsibilities. b) Have protected time to fulfil their management roles. c) Have effective support from the organisation to carry out their roles.	Job descriptions:- Maternity Unit Manager, Head of Midwifery, Clinical Director for Maternity Services	Job descriptions were submitted for the Clinical Lead: Obstetrics and Gynaecology (undated), the Assistant Directorate Manager for the Women and Children's Directorate (2004) and the Head of Midwifery, Gynaecology and Family Planning Nursing (undated) outlining their roles and responsibilities within the maternity services and the Trust. Staff interviewed identified that they were clear about their roles and responsibilities and there was no negative overlap of roles. Staff felt that there was good communication between them and they were well supported by the organisation to carry out their role.  HIW found that staff felt that senior colleagues were aware of issues in maternity services and that there were effective communication channels in place to raise any concerns.	
		Terms of Reference and minutes for Directorate meetings	A number of different meetings take place such as the Women and Children's Services Directorate Core Team meetings and the Women's Health Speciality meetings. Items discussed include protocols, obstetric capacity, waiting times and feedback from staff and other meetings. The minutes of the meetings submitted record the name of the individuals and not their job title so it is difficult to establish attendance.  HIW found that senior colleagues and managers meet on a regular basis, formally and informally to discuss key issues in maternity and allow effective communication to take place.	5. Minutes of meetings should clearly detail the job title as well as the name of those attending.

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M2	There should be an appropriate flow of information from/to the Trust Board and the maternity services.	Minutes of meetings (Directorate and Trust Board)	Information on maternity services is fed up to the Trust Board through the Clinical Governance Sub Committee, Direct Reports and the Management Executive Meeting. The minutes of the Trust Board demonstrate regular reports from the Clinical Governance Committee and the Director of Nursing. Senior staff felt there were good links to the Trust Board and that they were adequately briefed on issues in maternity services. The Trust newsletter enables the cascade of information and includes maternity issues.	
M3	There is an escalation policy during periods of increased activity to ensure the safe management of the maternity services which includes clear criteria for staffing levels.	Criteria for staffing levels	Birthrate plus audit is discussed further in L2.	
		Escalation Policy and Audit, Contingency Plans.	The Directorate of Women and Children's Services Closure of the Maternity Unit (2003) sets out the trigger factors that would precipitate closure of the unit, it includes informing and discussing with senior colleagues, a checklist and contact details. The Policy for the Maintenance of 1 to 1 Midwifery Care in Labour (2005) includes guidance to ensure 1 to 1 care is maintained. An incident form is completed if the escalation policy is used. The policies have not been audited. During discussions HIW established that staff were aware that an escalation policy was in place and understood the various contingencies that could be undertaken in the event of the unit becoming busy, such as the calling in of additional staff.	6. The Closure of the Maternity Unit Policy should be audited on a regular basis.

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T1	How does the maternity unit encourage effective team working and communications	Staff Surveys	The NHS Wales Staff Survey 2005 results for the Women's & Children's Services Directorate suggest, that overall staff felt they worked effectively as part of a team. Interview evidence verified good team working relations and very open communication between professions.	
		Multidisciplinary training	There are various examples of multidisciplinary training events such as the Directorate of Women & Children's Services Reflections sessions which are also seen referred to as part of the Personal Development Record.	
		Multidisciplinary meetings	Minutes of the meetings such as the Women's Health Speciality Meeting and Labour Ward Forum were reviewed. The minutes demonstrate multidisciplinary working and communication across the professions.	
T2	All women receive an agreed plan of care throughout pregnancy, labour and the post natal period in line with current professional standards consistent with their risk assessment and their chosen place of birth.	Guidelines for Homebirth, Midwifery Led or Consultant Led care.	<p>Directorate of Women and Children's Services Guidelines and Criteria to help Midwives decide on those suitable for Community Based Care regardless of Place of Birth (2006) and Neath Port Talbot Birth Centre Protocols for Birth Centre Management (2004) are in place. Both documents were comprehensively set out and detail the assessments and booking processes to be followed for midwifery led care and consultant led care, including the inclusion / exclusion criteria which is then scored accordingly for the relevant plan of care. Guidance for referral and transfer is also covered and the documents are evidence based and referenced.</p> <p>SAAT data indicates that this is an integral part of the antenatal care pathway.</p>	

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		Labour ward policies	<p>The labour ward policies were reviewed during the site visit. Generally, the documents were very brief but did cover the specifics of the management of the pregnancy related condition. There was no indication of who developed or approved the policies and only two were referenced. All policies were dated.</p> <p>We found that staff were clear on how to locate the policies.</p>	7. All policies should be developed in line with the Trust system and should be clearly reference and evidenced based.
		Implementation and audit of All Wales Clinical Pathway for Normal Labour.	Data relating to the all-Wales Clinical Pathway for Normal Labour is submitted to the Welsh Assembly Government on a regular basis. HIW also found from the health records reviewed that the Pathway is followed, when appropriate.	
T3	There is a mechanism for referral from one professional to another at all stages of care, including a written evidence based transfer policy where applicable.	Transfer policy and referral mechanism.	Discussed in T2.	

HIW No	Criteria	Key Areas Considered	Findings including areas of strength and areas for further improvement	Recommendations
C1	<p>There is a system to ensure that all critical incidents: -</p> <p>a) Are reported through the appropriate channels.</p> <p>b) Have immediate action taken to prevent re occurrence.</p> <p>c) Are investigated and analysed.</p> <p>d) Identify patterns and trends.</p> <p>e) Result in changes in practice.</p> <p>f) Are reviewed by a multi disciplinary group.</p>	Incident reporting policy	The Trusts Adverse Incident Procedure (2005) sets out the procedure to be followed in the event of an adverse incident including investigations, generating recommendations and feedback to those involved. The Directorate of Women and Children's Services: Risk Management Policy and Strategy (2006) sets out the type of incidents that should be reported. There is also a Clinical Trigger List for Obstetrics (undated).	
		Completed incident forms	Completed incident forms for the last two months were reviewed during the site visit. These identified that midwives are reporting incidents but there was no example of a form being completed by a member of the medical staff. A wide range of incidents, such as post partum haemorrhage, transfers and protocol issues are being reported. Discussions with staff identify that staff feel comfortable to report incidents in that the organisation wants to learn from incidents rather than apportion blame.	8. All staff should be encouraged to report incidents.
		Minutes of meetings and reports where incidents and trends are reviewed	Minutes of the Risk Management Sub-Group indicate that serious incidents are being discussed and actioned. A copy of the Directorate of Women and Children's Services Clinical Incident Report includes a summary of incidents with lessons learnt and actions taken. However it is not clear if this report is discussed at the Risk Management Sub-Group meetings or any other meeting and if incidents are collated to ensure that any trends are identified.	9. All incidents (including trends information) should be collated, reviewed and action taken by a group on a regular basis.
		Examples of changes made	Examples of changes to be made as a result of incident reporting are evident from documentary evidence.	

HIW No	Criteria	Key Areas Considered	Findings including areas of strength and areas for further improvement	Recommendations
C2	All healthcare professionals directly involved in childbirth are competent in basic adult obstetric, neonatal resuscitation and immediate care.	Training programmes	The Policy for the Education and Training Requirement of Welsh Risk Pool Standard 15 (2006) includes the training required for CTG interpretation and neonatal and maternal resuscitation. Information from the SAAT data indicates that a policy is in place as part of a mandatory training programme, but resources to pay for training and release staff are very limited. The level of compliance with neonatal resuscitation is improving but not universal. HIW found that on the whole staff had received resuscitation training in the last year.	
C3	CTG (cardio toco graph) interpretation training and updates should be undertaken on a 6 monthly basis.	Records of attendance and a system to ensure all staff attend	The Trust has access to the K2 Fetal Monitoring Training System, which is a computer based training system that can be accessed at home or in the hospital. In-house CTG update sessions/reflection meetings are also available. HIW found that on the whole staff had received CTG updates in the last 6 months.  There is a database to capture midwifery training and examples of personal training summaries from the K2 system were seen for a number of staff. However it was unclear from the documentation reviewed how attendance is monitored at training sessions as a number of staff do not have dates of training entered on to the database.	10. There should be a system in place to record and monitor all staffs' attendance at resuscitation and CTG training.

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P1	The views of women and their families are sought routinely and changes are made as a result.	Examples of recent surveys.	<p>A Local Supervising Authority Client Questionnaire to collect the views of what women in Wales want from Maternity Services was carried out in 2006. There was a flaw in the process, which effected the data but areas for improvement have been highlighted and of the women that did respond, the majority were satisfied with midwifery care and maternity services provided.</p> <p>Findings from the Maternity Client Satisfaction Survey carried out in 2003, 2005 and 2006 suggested that the majority of women were satisfied with the care received, areas for improvement have also been highlighted.</p> <p>There is a Post Natal Support Group which meets frequently and provides an opportunity for women to discuss any concerns etc.</p>	
		Examples of changes made.	As a result of Identified Incidents, Improving Clinical Governance on the Labour Ward and Suggestions received from Patients, action plans are in place, and a number of changes are being implemented.	
P2	Women and their families are provided with evidence based information to enable them to make informed decisions about their care throughout pregnancy, labour and the postnatal period.	<ul style="list-style-type: none"> <li>• Place of birth.</li> <li>• Pain relief.</li> <li>• Induction of labour.</li> <li>• Mode of delivery.</li> <li>• Vaginal birth after caesarean section (VBAC).</li> <li>• Fetal monitoring in labour.</li> <li>• Vitamin K.</li> <li>• Post natal depression.</li> </ul>	<p>The Trust submitted information leaflets in respect of:</p> <ul style="list-style-type: none"> <li>- Birth Centre</li> <li>- Thinking about Homebirth?</li> <li>- Epidurals for pain relief?</li> <li>- Your choice of anaesthesia.</li> <li>- Pain relief in labour.</li> <li>- About induction of labour.</li> <li>- The benefit of Vitamin K for your baby.</li> <li>- Happy &amp; healthy after childbirth.</li> <li>- Post Natal depression.</li> <li>- Welcome to Ward 12 Princess of Wales Hospital.</li> <li>- With your help we can improve our services.</li> </ul>	

P3	There is a named healthcare professional identified for each woman, who leads and plans her contact with maternity services.	Risk Assessment Documentation Guidelines for Homebirth, Midwifery Led or Consultant Led care	Discussed in T2.	
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HIW No	Criteria	Key Areas Considered	Findings including areas of strength and areas for further improvement	Recommendations
D1	The maternity unit should seek to continuously improve the quality of medical records through ongoing audit and review.	Examples of multi disciplinary record keeping audits and changes made as a result.	Copies of the Annual Record Keeping Audit 2006, Audit of Postnatal Records 2006, Review of Postnatal Community Records and NICE Guidelines Audit 2005 identified some areas of good record keeping and areas that needed improvement. Recommendations were made and a systematic process of regular audit set out. It was unclear if any of the audits were multidisciplinary.	11. The maternity service should ensure that there is a systematic process in place for regular multidisciplinary audit.
D2	What data on Maternity Services is routinely collected and what changes have occurred as a result of collecting this information.	List of data that is collected routinely, where this is sent and changes made as a result of collecting.	<p>The Trust collates data in a number of ways:-</p> <ul style="list-style-type: none"> <li>• Midwifery Group Practice Data Review capturing total deliveries, home birth rate, breastfeeding rates, average antenatal and postnatal visits.</li> <li>• Neath Port Talbot Birth Centre statistics for births at the birth centre, births at home, transfers, issues around labour, acute emergency, neonatal, discharges, new bookings, day assessments, telephone calls.</li> <li>• Total Births within Bro Morgannwg NHS Trust including homebirths and caesarean section rates.</li> <li>• Breastfeeding rates</li> <li>• Perinatal Mortality and Morbidity rates.</li> <li>• Cumulative rates of compliance regarding training.</li> </ul> <p>While some of the information is being used to inform audit and improvements in services, it is unclear how the remaining data is being acted upon.</p> <p>A recommendation relating to data collection and data sets will be discussed in the All Wales Thematic Report.</p>	

D3	A structured and accurate record of all events during the antenatal, childbirth and postnatal periods is maintained for every women and child (unified record)	Review of Health Records	20 completed sets of health records were requested and reviewed during the site visit. Generally, the records were found to be robust and the information securely stored and maintained including the CTG traces. The majority had the dates and times included on the labour pages and healthcare professional identifiable. It was noted, however, that the majority of files did have a pocket in the front or back and did contain information such as completed transfer forms, appointment letters and paediatric history sheets.	12. Patient information should be securely stored in the health record and not left loose in any pockets in the folder.
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