

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

Findings for Cardiff and Vale Trust 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 Cardiff and Vale Trust NHS Trust

Cardiff and Vale NHS Trust is the largest NHS Trust in Wales and one of the largest in the UK. It provides day to day health services to a population of around 500,000 people living in Cardiff, the Vale of Glamorgan and surrounding areas. Maternity deliveries take place at the Consultant led Unit and Midwifery Led Unit at the University Hospital of Wales in Cardiff and at the Midwifery Led Unit at Llandough Hospital. A total of 5655 births took place in 2005, further details of the type of delivery is set out in the following table.

Data for January – December 2005	Total Number	Percentage
Elective Caesarean Sections	558	9.9%
Emergency Caesarean Sections	831	14.7%
Instrumental deliveries (forceps and ventouse)	598	10.6%
All other deliveries in the Consultant Unit	3049	53.9%
Deliveries at the Midwifery Led Unit, University of Wales Hospital	317	5.6%
Deliveries at the Midwifery Led Unit, Llandough Hospital	159	2.8%
Homebirths	143	2.5%
Total number of births (Includes Consultant Unit, Birth Centre and Homebirths)	5655	100%
Number of Inductions of Labour in 2005 (% of the total number of deliveries in the Trust)	943	16.7%

HIW visited Cardiff and Vale NHS Trust maternity services on the 22nd and 23rd January 2007 and interviewed staff and visited the Consultant Led Unit and Midwifery Led Unit at University of Wales Hospital and the Midwifery Led Unit in Llandough. 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)	Job plans were submitted which detail individual Consultants activities during the week, they do not specifically detail who is the Clinical Lead (Medical) for the Labour Ward. During the site visit HIW did not establish who was the Clinical Lead (Medical) for the labour ward and this should be clarified.	1. Clarification should be made as to who is the Clinical Lead (Medical) for the labour ward and their job description should clearly identify this responsibility.
		Activities of Clinical Lead(s) (Medical)	During the site visit HIW established that staff feel well supported by senior colleagues and identified that they are available to consult with if advice or help is needed. There are a number of regular training opportunities and meetings available to 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 maternity service has 40 hours named consultant cover on the labour ward and this is clearly detailed in the Consultants timetable.	
		Handover procedures for change of Medical/Midwifery staff	The Maternity Guidelines for Handover of Care at Shift Change (2005) details handover between midwifery staff. The job description for the Consultant Team Delivery Suite Sessions/Acute Service Day (2005) details the medical staff ward rounds. Handovers occur at the change of shift for all staff in maternity services. In the Consultant Unit, there is a general handover and then staff are allocated to care for specific women for the shift, at 8.30am there is a multidisciplinary team handover to ensure effective communication across all professions. In the midwifery led units handover occurs on a one to one.	

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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 of the Midwifery Manager of Consultant Led Care (2005) identifies that she will provide professional leadership ensuring that clinical and midwifery governance is delivered within the service to the highest level. The job description for the Community and In-services Midwifery Manager (2005) identifies that she will provide strong clinical leadership and management support to the midwifery led units and community teams. HIW identified and confirmed during the site visit that there is a Clinical Lead (Midwifery) for the Labour Ward and for the Midwifery Led Units.	
		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 for Dec 2003 was submitted as evidence, but during the site visit HIW established that the audit had been undertaken again in Dec 2006. It identified that a number of midwives were needed but this had not as yet been actioned at the time of the site visit.	2. The Trust should ensure that the actions identified from the most recent Birthrate Plus audit are implemented.
		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. There are dedicated bleeps 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 services has a Labour Ward Forum that meets on a monthly basis, items discussed include guidelines, patient surveys and the Birthrate plus audit. It is a multidisciplinary group whose membership includes Consultant Obstetrician, User Representative, Midwives, Managers, a representative from the midwifery led unit. Attendance is variable with sometimes over half of attendees sending apologies and there is no representation from junior medical staff, anaesthetist or paediatrician and this should be addressed.	3. 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 Directorate Clinical Director, three Assistant Clinical Directors one of which is the Head of Midwifery and Nursing (2004) and the Directorate Manager – Obstetric and Gynaecology Directorate (2004) outlining their roles and responsibilities in maternity services and the Trust. There has been a change in the management structure in maternity recently and some staff are new in post. Staff interviewed identified that on the whole they were clear about their roles and responsibilities, even though in some cases these were still evolving and there was no negative overlap of roles. Staff felt that communication was good and they were 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 in maternity services such as the Women, Children and Community Service Group Meeting and the Service Group Clinical Governance Meeting. These meetings enable key issues to be discussed with senior colleagues and managers and allow effective communication to take place. Items discussed include Guidelines, Clinical Governance Reports and Health and Safety Report.	
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 Committee and direct reports from the Director of Nursing and the Medical Director and this is evidence from the Trust Board minutes. Senior staff felt there were adequate links to the Trust Board and that they were well briefed on issues in maternity services.	

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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 Maternity Escalation and Closure Protocols (2006) sets out the triggers to alert staff to the possible need to take action and implementation of the closure procedures of the maternity unit and who to communicate with. It also includes contact details and a template letter to send to women apologising for having to be referred to another unit. An incident form is completed if the policy is used. The policy has not been audited. During discussions HIW established that staff were aware than 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.	4. The Maternity Escalation and Closure Protocols 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 Trust took part in the NHS Wales Staff Survey (2005) and submitted the Technical Report and results of the Organisational Review. Over half of those who responded across the Trust felt they worked well as part of a team but reported that communication was ineffective. Interview evidence indicated that staff felt they worked well as a team and that the communications file "Hot File" system was a practical tool that helped to improve communication in maternity.	
		Multidisciplinary training	The Labour Ward Review sessions indicates multidisciplinary training takes place.	
		Multidisciplinary meetings	Minutes of meetings such as the Labour Ward Forum meetings were reviewed. The minutes demonstrate multidisciplinary discussion 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>Midwifery Led Care Guidelines (2005) are in place. The document is clearly set out and details the assessment and booking process for either midwifery led care and homebirth or consultant care, including the exclusion / inclusion criteria to be followed and guidance for referral and transfer. The document is referenced and evidence based.</p> <p>The SAAT data indicates that all women are booked at home by a community midwife and given contact details of their named midwife. Risk assessment is undertaken to determine the package of care (high or low risk) at booking and the named lead professional either for midwifery led care or consultant led care is given, and women are offered an appropriate model of care.</p>	

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		Labour ward policies	Labour ward policies were reviewed during the site visit. There are different processes in place for the development of policies for example, some were developed through the Labour Ward Forum and others through the Midwifery Policy Group. All were dated but two lacked appropriate references and there was no specific Fetal Monitoring Policy provided. HIW found that staff knew how to access the policies, whether in hard copy or intranet but it was unclear if there was a specific in-house fetal monitoring policy in place or if the NICE guidelines were being followed. This should be addressed to ensure that staff know what policy to follow.	5. All policies should be clearly referenced and evidenced based. 6. A Fetal Monitoring Policy should be developed or the formal adoption of the NICE Policy to ensure all staff follow the same guidelines.
		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.	HIW found that as part of the policy mentioned above the indications for transfer and referral were clearly set out. Other documentation submitted, such as the Guideline for The Request to Change Lead Professional (2005) and the Pathway for Referral of Midwifery Led Care women for Consultant Review of any Woman for Assessment Unit Review (2005) further supports this. There were no perceived problems with the referral and transfer system and staff interviewed were aware of the criteria to be followed.	

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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 Risk Management Policy and Strategic Framework (2006) sets out the incident reporting process and a flow chart identifies how clinical risk forms are processed and reviewed in Obstetrics and Gynaecology Directorate.	
		Completed incident forms	Completed incident forms for the last two months were reviewed during the site visit. This review identified that all disciplines of staff (Midwifery, Medical and other staff) are reporting a wide range of incidents, such as shortage of staff, post partum haemorrhage and security issues. Discussions with staff identify that staff are reporting incidents and feel comfortable with the culture of the organisation in that it wants to learn from incidents rather than apportion blame.	
		Minutes of meetings and reports where incidents and trends are reviewed	Minutes of the Directorate Obstetric Clinical Risk Meeting indicate that individual clinical cases are discussed and actioned. A presentation on monthly themes in clinical incidents and the Directorate Report, which includes all incidents was also submitted. However It is not clear if these reports are discussed at the above meeting or any other meeting and if any group has an overview of all incidents (including trends) in maternity. The Directorate Obstetric Clinical Risk Meeting minutes only records the names of individuals and not their job title so it is difficult to established attendance.	<p>7. Incident trends information should be collated, reviewed and action taken by a group on a regular basis.</p> <p>8. Minutes of the meetings should clearly detail the job title as well as the name of those attending.</p>
		Examples of changes made	Examples of changes to be made as a result of incident reporting are evident from documentary evidence.	

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C2	All healthcare professionals directly involved in childbirth are competent in basic adult obstetric, neonatal resuscitation and immediate care.	Training programmes	<p>The Obstetric Emergency training days include adult and neonatal resuscitation and are run on a regular basis. Information from the SAAT data indicates that all staff have been trained but monitoring of annual updates for staff needs to be carried out. HIW found that on the whole staff had received resuscitation training in the last year.</p> <p>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. There is also in house CTG training and Labour Ward Review meetings where CTGs are discussed. HIW found that on the whole staff had received CTG updates in the last 6 months.</p>	
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	A database captures attendance at the Obstetric Emergency training days and if the K2 package has been completed for midwives. The database does not detail if anyone has completed the K2 package although examples of some staff completions of the K2 package were seen. There is also a database for medical staff but it is under development as it does not record any information and does not include Consultants.	9. There should be a system in place to record and monitor staffs' attendance at resuscitation and CTG training, including all medical staff.

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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.	The Trust carried out a Women's Service Review during 2003. Women and the public were engaged and consulted with as part of the process. A phased approach to implementing the recommendations has been introduced. It is unclear if any surveys have been carried out since 2003.	10. A process should be in place to obtain the views of women and their families on the care they have received on a regular basis.
		Examples of changes made.	<p>Following the National Childbirth Trust survey in 2003, the Trust invited representatives from the NCT to undertake an audit of the birth environment in May 2005 and January 2006. Evidence from the audit undertaken in 2006 verified that there had been an improvement in the birth environment following changes made during 2005.</p> <p>The matrix setting out the Groups within the Obstetrics and Gynaecology Directorate and the activity and engagement of the user involvement demonstrate a commitment to gaining views of women and their families.</p>	
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"> • Place of birth. • Pain relief. • Induction of labour. • Mode of delivery. • Vaginal birth after caesarean section (VBAC). • Fetal monitoring in labour. • Vitamin K. • Post natal depression. 	<p>In addition to the Welsh Assembly Government Pregnancy Book, the Trust submitted leaflets in relation to:</p> <ul style="list-style-type: none"> - Midwifery- Led Unit - Homebirth - Induction of Labour - A Guide to Planned Caesarean Section - Vitamin K <p>The information is given to women at booking.</p>	

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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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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.	A presentation giving the findings of a Audit of Maternity Records (March 2006) was submitted. Findings reflect varying compliance against the overall standards used for the purpose of the audit, and the recommendations address the areas highlighted for improvement. It was not clear whether an action plan would be prepared as a result of this audit or whether the Trust had a systematic process of regular audits. It was also unclear whether this audit was 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 routinely collates data in a number of ways:-</p> <ul style="list-style-type: none"> - All Wales Antenatal Screening Wales Standards - Home Births / Transfer Rates - Midwifery Led Care - Patient Management System - Protos Statistical Data - Data Warehouse <p>While some of the information is being used to inform service reform and performance, it is unclear how much 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>	

HIW No	Criteria	Key Areas Considered	Findings including areas of strength and areas for further improvement	Recommendations
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 reviewed during the site visit. We found that in general the records were robust with CTG traces securely stored and confidentiality maintained. It was noted, however, that all records had a pocket in the back which contained loose patient information.	12. Patient information should be securely stored in the health record and not left loose in any pockets in the folder.