

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

Findings for Carmarthenshire 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 Carmarthenshire NHS Trust

Carmarthenshire NHS Trust provides a wide range of acute and community healthcare services to a population of 170,000 across Carmarthenshire and neighbouring counties. Maternity deliveries take place at the Consultant Unit at West Wales General Hospital in Carmarthen. A total of 1519 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	158	10.4%
Emergency Caesarean Sections	217	14.3%
Instrumental deliveries (forceps and ventouse)	144	9.5%
Unassisted	904	59.5%
Homebirths	96	6.3%
Total number of births (Includes Consultant Unit, Birth Centre and Homebirths)	1519	100%

Number of Inductions of Labour in 2005 (% of the total number of deliveries in the Trust)	351	23.1%
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HIW visited Carmarthenshire NHS Trust maternity services on the 22nd November 2006 and interviewed staff and visited the Consultant Unit. 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 descriptions (dated 2000 and 2001) and a letter (dated 1998) for the three Consultants in Obstetrics and Gynaecology at Carmarthenshire NHS Trust were reviewed. They outline the roles and responsibilities in Obstetrics and Gynaecology including those for training and supervision of junior medical staff on a regular basis. None of the documents specifically detail who is the Clinical Lead (Medical) for the labour ward, however interview evidence indicates that there is a dedicated clinical lead (Medical) for the Labour Ward.	1.The job description for the Clinical Lead (Medical) for the labour ward should be updated to reflect this responsibility.
		Activities of Clinical Lead(s) (Medical)	Multidisciplinary teaching is undertaken and staff are supported by senior colleagues in the clinical area by being visible and available to staff and this was evidenced when HIW spoke to staff in the unit.	
		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). Documentary evidence indicates that there are currently eight sessions per week where a named consultant is available to cover the labour ward, with the other 2 sessions being covered by the on call consultant. Interview evidence indicates that the Trust has covered all 10 sessions (40 hours) of Consultant cover on the labour ward.	

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		Handover procedures for change of Medical/Midwifery staff	The Trust has guidelines (2006) which set out the underlying principles of handover of care when staff change shifts. In maternity there is a document entitled 'Introduction to obstetric and midwifery care' (2005) which identifies that formal handover of care must exist between midwifery and medical staff at all shift changes and this should be recorded in the notes. Midwifery handovers occur three times a day when staff change shift, there is a general handover with all midwifery staff and then one to one with the person taking over that particular woman's care. Medical staff handovers also occur at the change of shift, with Consultant attendance or a phone call from Consultant to Consultant. Midwifery and medical staff handovers, on the whole occur separately. There is a book on the Labour Ward for recording handovers.	2. Midwifery and Medical staff should, where appropriate, undertake handovers together to ensure the sharing of relevant information.
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 Practice Development Midwife's Job Description (undated) identifies that she should "provide clinical leadership to the Midwifery Department, co-ordinate the clinical areas and provide highly specialised knowledge and support to other colleagues". During the interviews the Department Head of Midwifery and the Practice Development Midwife were identified as the Clinical Leads (Midwifery) for labour ward.	
		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 (April 2003) identified a shortfall of 2.74 Midwives and 6 support workers. The audit report was presented to the Trust Board and the day assessment unit, which helps to avoid admission as an impatient, has been opened as a result of the audit, but it is unclear if any further action has been taken as a result of this work.	

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		Handover procedures for change of Medical/Midwifery staff discussed in L1.	Handover 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 registrar cover is available for the maternity unit and a baton bleep is handed between medical staff to ensure they can be contacted. There is also a written rota so staff on labour ward know who to contact. Elective caesarean section lists are carried out on a regular basis each week. The named Consultant Lead for labour ward is unfortunately off sick at present.	
L4	There is a multi-disciplinary labour ward (midwifery led unit) forum to review labour ward activity.	Terms of reference and minutes of meetings.	<p>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".</p> <p>While the following groups are in place: -</p> <ul style="list-style-type: none"> • The Working Policy Group, the remit of which is policy development. • The Clinical Risk Monitoring Group Obstetrics, the remit of which is risk submissions and action plans. <p>While these groups consider certain aspects of labour ward activity they do not carry out the functions of a Labour Ward Forum as defined by the RCOG and the RCM and this should be addressed.</p>	3. A Labour Ward Forum that meets on a regular basis and includes the membership and carries out the functions set out by the RCOG/RCM should be established.

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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 Head of Midwifery (undated), Consultant in Obstetrics and Gynaecology (2001) and the Director for Family Health Services Directorate (2000) outlining their roles and responsibilities within the maternity services. HIW found there was no overlap in their roles, the responsibilities of each post were clearly defined and that on the whole the postholders had time to carry out their role and they were well supported by the organisation.	
		Terms of Reference and minutes for Directorate meetings	A number of different meetings take place in maternity to discuss key issues with senior colleagues and managers and allow effective communication to take place. Minutes were reviewed and the areas discussed include Clinical Governance, Performance and Clinical issues. The minutes of these meetings record the names of individuals and not their job title so it is difficult to establish attendance. 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 issues.	4. Minutes of meetings should clearly detail the job title as well as the name of those attending.
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)	Minutes of the Trust Board and the Trust Management Team meetings indicate that maternity issues are brought to the attention of the Trust Board. HIW found that there were good links with the Trust Board and staff felt they were kept adequately briefed on issues within the maternity services. There is also a flow of information from the Trust into the Directorate and to staff through the team brief.	

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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	The Birthrate audit report (April 2003) identified the appropriate staffing levels for the unit (this is discussed further in L2).	
		Escalation Policy and Audit, Contingency Plans.	There is an Escalation Policy for the closure of the maternity unit (October 2005). This includes two procedures, one for in hours and one for out of hours, it uses a traffic light system for the various stages of contingency before the unit would need to close. The policy was audited in July 2006. There is also a Policy for the Closure of the Special Care Baby Unit (SCBU) (July 2006), which outlines the steps that would need to be taken if the SCBU became full and needed to close. This would only occur following a clinical risk assessment and after consultation with senior staff. An incident form is completed if the escalation policy is used. We found that staff were aware of the traffic light system in place for the various stages of contingency identified in these policies and what action they should take.	

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T1	How does the maternity unit encourage effective team working and communications	Staff Surveys	The NHS Wales Staff Survey (2005) for the Trust was submitted along with the Investors in People Action Plan for the Family Health Directorate which supports team working and communication.	
		Multidisciplinary meetings	Minutes of meetings such as the Joint Consultant Group were submitted as evidence. The minutes demonstrate multidisciplinary working and the variety of topics discussed indicate team working and communication across the professions. HIW found that staff felt they worked well as a team with a good relationship between colleagues.	
		Multi disciplinary training	Evidence suggests that multidisciplinary training is undertaken in maternity.	
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.	The Homebirth Guidelines (2003) and Midwifery Led Care Guidelines (2003) clearly set out the assessment process and inclusion/exclusion criteria to be followed in order for women to book a homebirth or receive midwifery led care, and when referral for consultant care should be made. Each document is referenced and evidence based. Information submitted from the SAAT data indicates that the individual care plan is formulated at the booking appointment and reviewed at each visit and HIW found that staff were aware of the process and the guidelines in place.	
		Labour ward policies	Labour ward policies were reviewed during the site visit, these are developed and approved by the Working Policy Group. They were clearly identifiable and appropriately set out, with dates of development and when they are due to be reviewed (every 3 years). It was noted that not all policies were referenced. HIW found that staff knew how to locate the policies either on the labour ward or website and that they were clearly dated and updated so they knew they were referring to the most up to date version.	5. All policies should be evidenced based and clearly referenced.

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		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.	Along with the guidelines above, which include indications for transfer and referral, the Policy for Routes of Referral within Maternity Services Multidisciplinary Team (not dated) and the Transfer of Women in Labour (2003) to a Consultant Unit was reviewed. HIW found that there is a clear process in place for referral and transfer with all levels of staff able to, and comfortable to, contact all other professionals when appropriate.	

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C1	There is a system to ensure that all critical incidents: - a) Are reported through the appropriate channels. b) Have immediate action taken to prevent re occurrence. c) Are investigated and analysed. d) Identify patterns and trends. e) Result in changes in practice. f) Are reviewed by a multi disciplinary group.	Incident reporting policy	A number of documents were submitted which set out the incident reporting process in the Trust and maternity services, including the Risk Management Strategy and Policy (2006) and the Obstetric Trigger List (2003).	
		Completed incident forms	Completed incident forms for the last two months were reviewed during the site visit. These identified that all disciplines of staff (Midwifery, Medical and others) are reporting a wide range of incidents, such as closure of the unit, postpartum haemorrhage and emergency caesarean section. Discussions with staff identify that staff feel comfortable with the culture of the organisation in that it wants to learn from incidents.	
		Minutes of meetings and reports where incidents and trends are reviewed	Minutes for the Clinical Risk Meeting were reviewed. An overview of clinical incidents is undertaken and any problems are identified and subsequent actions agreed. The minutes of the meetings do not include any dates or the individual who is responsible for any actions and this makes it difficult to follow up on actions at subsequent meetings. The minutes do not indicate who attends the meetings.	6. Minutes of the Clinical Risk Meeting should detail dates by which actions should be completed and by whom and the names and job titles of those present.
		Examples of changes made.	We found through documentation and in discussion with staff that changes and improvements have been made in maternity as a result of incident reporting.	

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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	A number of training programmes were submitted as part of the review, including the Obstetrics Emergency Study Day Course Programme (undated) which covers maternal and newborn resuscitation and is a multidisciplinary training day. The Trust has reported through its submission as part of the SAAT data that all staff are trained in neonatal and adult resuscitation, records are kept and it is recorded in the annual staff appraisal. All but one member of staff interviewed indicated that they 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	Staff have access to and were found to be using the K2 Fetal Monitoring Training System which is a computer based training system that can be accessed via the internet at home or in the hospital. There is also the opportunity to discuss cases including CTG traces at teaching sessions. A training needs analysis (2006/07) is completed to identify which staff need training, this includes resuscitation and CTG training. A Database is kept of training sessions attended by midwives and medical staff. The Database for midwives includes the types of sessions attended such as CTG training or obstetric emergency study day. The medical database just includes dates of training and should be updated to include details of the training attended to enable monitoring of attendance to take place.	7. Full details of training sessions should be included on the database to enable monitoring of attendance of all staff to take place.

HIW No	Criteria	Key Areas Considered	Findings including areas of strength and areas for further improvement	Recommendations
P1	The views of women and their families are sought routinely and changes are made as a result.	Examples of recent surveys.	A maternity user survey was carried out in August 2004 which collected information such as antenatal class attendance, type of care and length of stay in hospital most women reported they were satisfied with the care they had received.	8. 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.	The Maternity Service Liaison Group, terms of reference indicate that it will actively involve patients and collect their views and feed changes into the Directorate. It was evident from the Maternity Service Liaison Group Minutes that there is lay representation and involvement and that this input is valued and acted upon.	
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>The Patient Information Leaflets that were submitted as evidence included: Antenatal Screening Tests; Smoking and Pregnancy; Pain Relief in Labour; Statutory Supervision of Midwives; Home Sweet Home; Breastfeeding; Maternity Unit Guide; Induction of Labour; Caesarean Section and Sleep Safe. A link to the Welsh Assembly Government Pregnancy Book was also provided.</p> <p>There was evidence from the informal interviews that relevant information is available to women during their pregnancy.</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	<p>Documentary evidence such as the Responsibility of Care document (2005), Home Birth Guidelines (2003) and Midwifery Led Care Guidelines (2003) identified the different types of care available to women and the criteria to be followed in relation to risk assessment to ensure that women have appropriate care and informed choice.</p> <p>Information from the SAAT data indicates that the named consultant or midwife should be recorded on the front of the pregnancy held record. HIW found from reviewing a sample of health records and from talking to staff that the majority had the named health care professional easily identifiable on the front of the handheld record.</p>	

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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 copy of the Notes Audit (Nov 2004) and the Labour Ward Audit presentation (Jan 2006) generally identified good standards of record keeping, but it is unclear if these are multi disciplinary or if there is a systematic process of regular audit in place.	9. The maternity service should ensure that there is a systematic process in place for regular multi disciplinary 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"> • Team statistics, which includes information on births, caseloads and homebirths. • Family Health Directorate Balanced Scorecard Indicators, which includes information on waiting times, lengths of stay etc. • Monthly Statistics Report, which includes statistics by consultant or midwifery led care such as births, mortality and home deliveries. <p>While some of the information is being used to inform audit and planning of services, it was unclear what happened to the other information collected and there appears to be considerable overlap in the information being collected and collated.</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	<p>The Record Keeping Policy (2005) that was submitted as evidence was clearly defined for nursing, midwifery and health visiting staff.</p> <p>20 completed sets of health records were requested and reviewed during the site visit. On the whole the records were robust, securely stored and confidentially maintained. Decisions and actions taken during the care of women were clearly identifiable within the record. Approximately a quarter of the records reviewed did not have the CTGs securely stored; some of the traces were stored in the pocket at the back of the record or stapled onto a mount sheet. Certain storage methods are known to increase the speed with which records fade, for this reason the simplest storage method is to use a re-sealable, clearly labelled envelope secured within the main body of the health record.</p> <p>In some of the health records reviewed the names of staff and when they took over care, and dates and times on the labour pages were not always included or clear.</p>	<p>10. CTG traces should be securely stored in a re-sealable envelope that is hole-punched and filed within the main body of the records.</p> <p>11. Staff should clearly record their names in the health record and the dates and times they took over care.</p>