

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

Findings for Ceredigion and Mid Wales 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 Ceredigion and Mid Wales NHS Trust

The Trust provides an integrated acute and community health care service at Bronglais District General Hospital in Aberystwyth supported by community hospitals in Aberaeron, Cardigan and Tregaron. The main area served by the Trust's hospital and community services is Ceredigion, which incorporates a population of approximately 70,000 with areas of South Gwynedd, North Powys and North Pembrokeshire also falling into the Trust's catchment area. Maternity deliveries take place at the Consultant led Unit at Bronglais District General Hospital in Aberystwyth. A total of 577 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	59	10.7%
Emergency Caesarean Sections	94	17%
Instrumental deliveries (forceps and ventouse)	40	7.2%
All other deliveries in the Consultant Unit	333	60.3%
Homebirths	26	4.7%
Total number of births (Includes Consultant Unit, Birth Centre and Homebirths)	552	100%

Number of Inductions of Labour in 2005 (% of the total number of deliveries in the Trust)	118	21.4%
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HIW visited Ceredigion and Mid Wales NHS Trust maternity services on the 6th February 2007 and interviewed staff and visited the Consultant led 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)	The document entitled the Activities of the Clinical Lead for Labour Ward (undated) indicates that the role will oversee all activity and issues relating to obstetrics. The job description for the Obstetrician and Gynaecologist, Lead Clinician in Obstetric Scanning, Early Pregnancy Assessment Unit and Teaching (2003) states that the service is midwifery led but they will be in charge of the obstetric service. HIW established that there is a Clinical Lead (Medical) for the Labour Ward.	
		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 staff need advice. A variety of training opportunities are available for staff to attend.	
		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 for units delivering less than a 1000 deliveries per year, as a minimum a consultant should be available within the hospital, but may have other commitments. There should be at least two set consultant sessions on the labour ward a week. HIW established that there are currently three sessions when a consultant is present on the labour ward.	
		Handover procedures for change of Medical/Midwifery staff	The Handover of Care Between Shifts for Doctors (2004) and the Guidelines for Midwifery Handover of Care (undated) details handover procedures for junior medical staff and midwives respectively. 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. Midwifery and medical staff handovers occur separately.	1. Midwifery and Medical staff should, where appropriate, undertake handovers together to ensure the sharing of relevant information.

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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 Hospital Based Midwife/Ward Manager (undated) identifies that she will be responsible for the day to day management of the maternity unit and delivery suite. An additional document entitled the activities of the Clinical Lead (Midwifery) for the Labour Ward, which includes that the lead midwives are responsible for overseeing all activity on a day to day basis. Neither document clearly identifies who the Clinical Lead (Midwifery) for the labour ward is. HIW established that there are potentially two Lead Managers but it was unclear which if one or both are the Clinical Lead (Midwifery) for the Labour Ward and this should be addressed.	2. The Clinical Lead(s) (Midwifery) for the labour ward should be clearly identified and their job description should identify this responsibility.
		Activities of Clinical Lead(s) (Midwifery)	Activities discussed in L1.	
		Birth-rate plus and actions/progress from audit	Birthrate Plus, is a framework for workforce planning and decision making for maternity services. The Birthrate plus audit was not submitted as part of this review. Interview evidence indicated that Birthrate Plus has been undertaken some years ago and it identified at the time that the staffing establishment was sufficient. Although no staff identified any issues in caring for women in labour, maternity should ensure that it has a robust way of auditing whether the workforce in place is adequate for the work being undertaken.	3. Workforce planning should be undertaken to ensure the workforce is adequate for the work being undertaken.
		Handover procedures for change of Medical/Midwifery staff	Handover procedures discussed in L1.	

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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. On call anaesthetists are also responsible for covering the rest of the hospital but to date there has not been a problem being available for labour ward should they be needed. There is also a written rota and a dedicated bleep so labour ward staff know whom to contact.	
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>The following groups are in place: -</p> <ul style="list-style-type: none"> • Case Review Meetings, the remit of which is to discuss incidents and policies. • The Risk Management Committee, the remit of which is risk issues in maternity. <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>	4. 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	<p>The job description for the Head of Maternity and Gynaecology Services, Statutory Supervisor of Midwives (2004) was submitted outlining the post holders role and responsibility within maternity services and the Trust. Staff interviewed indicated they were clear about their roles and responsibilities and there was no overlap of roles. Staff felt that they were well supported by the organisation and there was good communication between them.</p> <p>HIW found that staff felt that senior colleagues were made aware of any issues in maternity services and that there were effective communication channels in place.</p>	
		Terms of Reference and minutes for Directorate meetings	<p>The Family Health Directorate Meeting, whose membership includes the Directorate Manager, Head of Maternity Services and Consultant Obstetrician and Gynaecologist meet on a monthly basis, items discussed include NSF, trainee staff and the Welsh Risk Pool standards.</p> <p>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.</p>	
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)	<p>Information on maternity services is fed up to the Trust Board through the Trusts committee structure. The minutes of the Trust Board meeting indicate that maternity issues are discussed. Senior staff felt that there were good links to the Trust Board and that they were adequately briefed on issues in maternity services.</p>	

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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 Guidelines, Escalation Policy for the Closure of the Maternity Unit and Special Care Baby Unit (undated) sets out the appropriate steps that should be taken to prevent closure. It includes contingencies that can be taken and the escalation policy that should be followed if the contingencies do not resolve the situation. Information relating to maternity unit activity was submitted as evidence but there has been no audit of the escalation policy. HIW established that staff were aware of various contingencies that could be taken in the event of the unit becoming busy, such as the calling in of additional staff, however no staff interviewed mentioned that there was an escalation policy in place.	5. An operational escalation policy should be in place and all staff should be made aware of it and it 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	<p>The Trust did not submit evidence in relation to any recent staff surveys being undertaken.</p> <p>Interview evidence suggests that staff surveys are undertaken and action plans drawn up as a result. Staff also reported good team working and communication across the maternity service.</p>	6. Maternity services should ensure they capture the views of all staff.
		Multidisciplinary training	While the Case Review meetings did provide some evidence of a multidisciplinary event, overall, there was very little information to support this.	
		Multidisciplinary meetings	Minutes of the meetings such as the Family Health Directorate were reviewed. A variety of topics is discussed at the meetings which demonstrates 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>The Trust is currently providing midwifery led care in shadow form only.</p> <p>A blank copy of the Pregnancy Health Record (Antenatal / Postnatal) was submitted as evidence of the guidance followed for booking women. Information regarding medical history, preferred place of delivery and agreed care management plan is recorded. The inclusion / exclusion criteria against which a judgement can be made regarding homebirth or referral was not contained within the document.</p> <p>SAAT data indicates that there is a named midwife for each patient.</p>	

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		Labour ward policies	The labour ward policies were reviewed during the site visit. It was evident that the Lead Obstetrician and Supervisor of Midwives approved the policies but it was unclear who developed them. The documents were clearly set out with dates of development and review (every 3 years). All documents were referenced. HIW found that staff knew how to access the policies within the main office and were conscious of the dates for review.	
		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, and other supporting evidence submitted, 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.	<p>The Maternity Guidelines – Maternal Transfer to Another Hospital (2004) and Jump Call Procedure (2006) are in place. The guidelines are very brief covering the process to be followed but little information on when, or if, a transfer should take place. There was no information to indicate the referral mechanism in place.</p> <p>Interview evidence suggests that there are both written and verbal referral mechanisms in place and there are no perceived problems with the system.</p>	7. The Maternal Transfer to Another Unit Guidelines should be updated to detail the safe management of the transfer of mother and baby.

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> <ul style="list-style-type: none"> 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	The Trust Adverse Incident, Near Miss and Hazard Reporting Policy and Investigation Procedure (2005) sets out the incident reporting procedure to be followed in the organisation.	
		Completed incident forms	<p>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 drug errors, protocol issues and equipment matters 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.</p> <p>During the site visit HIW were made aware of concerns over the distance between the Labour Ward and the Theatre used for caesarean sections as they are on different floors and the potential impact this could have on ensuring caesarean sections are undertaken within the appropriate timescales.</p>	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 Committee indicate that a report on incidents is reviewed on a quarterly basis. This reports includes all incidents in the Trust and does not specifically breakdown maternity incidents. Maternity incidents are also discussed at the Case Review Meetings. It is unclear if maternity incidents (including trends) are collated and reviewed by a group on a regular basis.	9. All incidents (including trends information) should be collated, reviewed and action taken by a group on a regular basis.
		Examples of changes made	No documentary evidence was provided to demonstrate changes made as a result of incident reporting.	10. Follow up procedures should be improved to ensure that changes as a result of incident reporting are actioned.

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	Neonatal and adult resuscitation training is provided on an annual basis to all staff. Information from the SAAT data indicates that resuscitation training is in place but that time for this training is not reflected in the service establishments. HIW found that not all staff had received resuscitation training in the last year and this should be addressed. 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 case review meetings are also available for staff to attend where CTGs are discussed. HIW found that staff had received CTG updates in the last 6 months.	11. All appropriate staff should receive resuscitation training on a regular basis as defined by the Trust.
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 Statutory Training Record captures maternity services training for CTG, Case Review Meetings, Neonatal and Adult Resuscitation. A print out of registrations for the K2 system was also provided.	

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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.	A blank copy of the questionnaire used to collate women's experiences of the maternity services was submitted. The survey was undertaken in 2006 and an action plan is to be produced. The results of the survey demonstrate varying satisfaction levels with the types of care received although it is unclear how many women responded to the survey.	
		Examples of changes made.	The Trust did not submit any evidence.	12. Follow up procedures should be improved to ensure that changes as a result of women and their families views actioned.
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. 	Due to no patient information leaflets being submitted, it is unclear whether in addition to the Welsh Assembly Government book specific local information on the maternity unit and place of birth is supplied to women and their families.	13. Adequate information should be made available to women and their families, including local information about the choice of place of birth.

HIW No	Criteria	Key Areas Considered	Findings including areas of strength and areas for further improvement	Recommendations
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.	

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.	The Trust submitted a blank copy of the Supervisors of Midwives record keeping audit tool and Case Review minutes where audit is touched upon. It is unclear if the trust has a systematic approach to audit, or if actions and recommendations are made as a result of the midwives undertaking audit. There was also no indication whether multidisciplinary audits are planned for the future.	14. 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.	The Trust collates Midwifery Statistics that includes activity regarding total births, deliveries by type, healthcare professional involved and transfers etc. Although some information may be being used to improve practice etc., it is unclear how the remaining data is being used. A recommendation relating to data collection and data sets will be discussed in the All Wales Thematic Report.	
D3	A structured and accurate record of all events during the antenatal, childbirth and postnatal periods is maintained for every woman and child (unified record)	Review of Health Records	20 completed sets of health records were reviewed and requested during the site visit. Generally, the records were found to be robust although there were some instances where information could have been better secured. The pocket located within the cover of the record also contained loose patient information. CTG and blood results were securely stored and all key procedures along with the named healthcare professional were clearly identifiable.	15. Patient information should be securely stored in the health record and not left loose in any pockets in the folder.