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Healthcare Inspectorate Wales
All Wales Maternity Services Review

Findings for Conwy & Denbighshire 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 in patient wards and is staffed by obstetricians (specialists in birth where there are complications) and midwives (specialists in normal birth). A woman is usually booked under the care of a particular consultant, but may only see 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 Conwy and Denbighshire NHS Trust

Conwy & Denbighshire NHS Trust provides Acute, Community, Mental Health and Learning Disabilities Healthcare services to central North Wales through a network of Hospitals, Health Centres and Clinics. Maternity deliveries take place at the Consultant led Unit at Glan Clwyd Hospital in Rhyl, Denbighshire. Deliveries also take place in the home-from-home unit (midwifery led birthing room) in Denbigh Infirmary. A total of 2288 births took place in 2005, further details of the type of delivery are set out in the following table.

Data for January – December 2005	**Total Number**	**Percentage**
Caesarean Sections – Elective	191	8.3%
Emergency	371	16.2%
Instrumental deliveries (forceps and ventouse)	270	11.8%
All other deliveries in the Consultant Unit	1413	61.8%
Homebirths	43	1.9%
Total number of births (Includes Consultant Unit and Homebirths but not the Home-from-Home unit because this only opened in 2006)	2288	100%

Number of Inductions of Labour in 2005 (% of the total number of deliveries in the Trust)	617	27%

During HIWs maternity review the Trust was in the process of reviewing its maternity services, following a clinical governance review undertaken by the Clinical Governance Support and Development Unit of the Welsh Assembly Governments Department of Health and Social Services.

HIW visited Conwy and Denbighshire NHS Trust maternity services on the 5th December 2006 and interviewed staff and visited the Consultant Unit and the Home-from-home 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)	No job descriptions were provided in the documentation submission from Conwy and Denbighshire NHS Trust identifying the Clinical Lead (Medical) for the Labour Ward. Minutes of the Consultants meeting that took place in August 2006 indicate that a lead had been identified at this meeting but this does not appear to have been formalised. During the site visit HIW established that there was not an identified Clinical Lead (Medical) for the Labour Ward but the review team were advised that a job description is being developed for the post.	1. A Clinical Lead (Medical) for the labour ward should be identified and their job description should clearly identify this responsibility.
		Activities of Clinical Lead(s) (Medical)	HIW found that staff (Medical, Midwifery and Support Staff) in maternity services felt that senior colleagues were available in the clinical areas and offer support to staff. Staff also identified that there were opportunities for training in maternity.	
		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). There are currently 5 out of 10 dedicated sessions per week where a named consultant is available to cover the labour ward. Cover for the other 5 sessions also requires the consultant to cover gynaecology emergencies. The Trust is aiming to cover all 10 sessions, but the timescales for this are unclear.	2. 40 hours Consultant Cover should be made available for the labour ward and rotas detailing consultant labour ward cover should be available for staff to refer to.

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		Handover procedures for change of Medical/Midwifery staff	The Trusts Handover Policy – Hospital at Night (May 2005) outlines the overarching principles of good handover and why it should be done. A letter was also submitted which outlined the arrangements for handover in the maternity department, but no formal policy/procedure setting out the arrangements for maternity was submitted. 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 presence when possible. Midwifery and medical staff are now linking and interacting more during handovers.	3. The maternity service should develop a handover policy/procedure to ensure that all staff are aware of what is expected of them when handing over care.
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 Clinical Leader Job Description – Temporary Lead Midwife (undated) identifies that she should provide dynamic professional and strategic leadership to all clinical staff, be visible, accessible and authoritative by presence in the clinical setting. HIW identified and confirmed during the site visit that there is a Clinical Lead (Midwifery) for the Labour Ward. The Home from Home unit at Denbigh Infirmary opened in the summer of 2006, a Clinical Lead (Midwifery) should be in place if this had not already been established.	4. A Clinical Lead (Midwifery) should be in place for the Home from Home unit.
		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 Plus Audit Report (July 2004) identified that the Trust had about the right number of Midwives, but needed more support workers, some have been appointed, but recruitment has been difficult. Staff expressed some concerns that the audit did not demonstrate a true picture of the workforce in maternity services and interviewees indicated that there is a high level of sickness in maternity services. The Birthrate Plus audit is being undertaken again internally and once completed action should be taken to	5. Workforce planning should be undertaken to ensure that the workforce is adequate for the work being undertaken.

HIW No	Criteria	Key Areas Considered	Findings including areas of strength and areas for further improvement	Recommendations
			address any workforce issues it shows.	
		Handover procedures for change of Medical/Midwifery staff	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 department. On call anaesthetists are also responsible for covering the intensive care unit at night but this has not caused a problem in obtaining anaesthetic support. There is also a written rota and a dedicated bleep so labour ward staff know whom to contact. There are dedicated consultant sessions and presence in the maternity unit on a regular basis.	
L4	There is a multidisciplinary 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". While the following groups are in place: - • Obstetric and Gynaecology Consultants Meeting, later entitled Consultants and Management meeting. • Interesting case discussions. • A number of groups that have been established as part of the maternity review. 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.	6. 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	There have been a number of changes in roles and responsibilities in maternity services recently, due to the review of maternity services in the Trust. Job descriptions were submitted for the Community and In-services Midwifery Manager (undated), Divisional Clinical Director (2005) and Acting Head of Midwifery and Gynaecology Nursing (undated) outlining their roles and responsibilities within maternity services. Staff interviewed were clear about their role and did not feel there was any overlap of responsibility. The postholders work flexibly to ensure they are able to carry out their roles and they had good support from the organisation. When HIW visited maternity services they found on the whole that staff felt that senior colleagues were aware of issues in maternity, but some staff felt that communication could be improved.	7. Maternity services should ensure that appropriate communication channels are in place for staff to raise issues with senior staff and that these are acted upon.
		Terms of Reference and minutes for Directorate meetings	A number of different meetings take place in the Family Services Division and recent changes have been made to the structure and there is now an Obstetric and Gynaecology Programme Team meeting which feeds into the Family Services Division Meetings. The aims of these meetings are to ensure that there is a quality and seamless service underpinned by performance management utilising the domains of clinical governance. Senior colleagues and managers meet on a regular basis, formally and informally to ensure effective communication in maternity and to the rest of the Trust.	

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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)	Minutes from the Family Services Divisional Meetings demonstrate that there is communication to and from the Trust Management Team. Minutes of the Trust Board were not submitted as part of the documentation for the maternity review so HIW could not establish what discussion takes place around maternity issues. During the site visit HIW established that senior staff felt there were good links to and from the Trust Board, through formal and informal routes. This is demonstrated through the Clinical Governance review of maternity services, which was requested by the Trust, and progress and action plans from this are closely monitored.	
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	The Trusts Policy and Procedures to be Followed When Nurse Staffing Levels are Below the Minimum Agreed for each Nursing Area (Oct 2004) sets out the general principles to be followed when staffing levels are below the agreed minimum. There is also a policy specific to the Obstetric and Gynaecology Directorate (May 2005) which gives further details for maternity services.	8. An escalation policy, which includes contingency plans and trigger mechanisms to alert staff to capacity issues, should be developed. This policy should be communicated to all staff and audited on a regular basis.
		Contingency Plans	An Example of a specific contingency plan, which pertained to a weekend in 2006, was reviewed, but there is no detailed contingency plan in place, which would cover unexpected increased activity. It is understood through documentary and interview evidence that the various elements of maternity services escalation policy and contingency plans are being draw together, along with trigger mechanisms to alert staff. During discussions with staff 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 and alerting senior colleagues, however not all staff were aware of all of the different policies in place.	

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T1	How does the maternity unit encourage effective team working and communications	Staff Surveys	The Trust did not submit any information in respect of Staff Surveys but HIW did note from the Midwifery Action Plan that a staff survey was carried out in 2006 and although there was a poor response to this, the results are going to be audited and the findings of this discussed at the senior managers meeting.	9. Maternity services should ensure that they capture the views of staff.
		Multidisciplinary meetings	Minutes of meetings such as the Obstetrics and Gynaecology Programme Team Meeting demonstrate a commitment to moving towards multidisciplinary working and it is evident that communication across professions is occurring. During the site visit HIW found that the systems and structures in place are starting to have a positive effect on team working and that staff are reporting good communication across the teams.	
		Multidisciplinary training	There was limited evidence submitted of multidisciplinary training events.	10. The maternity service should develop a programme of multidisciplinary training events.
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 Family Services Division Guidelines for Antenatal Care (2006) sets out the process of care and assessment that should be followed for woman to be booked appropriately, either to receive midwifery care or consultant care including the criteria for inclusion/exclusion and the protocol for referral from low to high risk and vice versa. The Best Practice Guidelines for Home Birth and Home from Home Birth (2005) sets out the standards and level of care to be met, including managing the risks in relation to home birth or home from home birth. Each document is referenced and evidence based. Information submitted as part of the SAAT data states that women have a care plan given to them when they are booked by their community midwife and this is updated as the pregnancy progresses. Interview evidence also confirmed that staff were aware of the procedures to be followed.	

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		Labour ward policies	Labour ward policies were reviewed during the site visit. The majority were developed by the Obstetric Policy Group and others by the Clinical Director. The policies were clearly identifiable, appropriately set out, referenced, dated and the majority recently reviewed. Although staff were aware of how to locate policies and protocols, they were unclear as to how the policies were updated, who updated them or how staff were alerted to new policies that may come into effect.	11. A system should be in place for staff to access the most up to date policies.
		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 being followed.	
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.	The Family Services Division Guidelines for Antenatal Care (2006) and the Best Practice Guidelines for Home Birth and Home from Home Birth (2005) were reviewed. The procedures set out for referral in the Antenatal Care Guidelines were clear and interview evidence verified that staff were comfortable with the system in place and reported no problems. The Home Birth and Home from Home Birth Guidelines states that transfer is required for all women whose condition results in the discontinuation of the all Wales Care Pathway for Normal Labour, again there were no reported problems with this system. Both documents were found to be referenced appropriately.	

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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	The Trusts Policy for Incident Reporting (Nov 2004) outlines the trust wide procedure for incident reporting and the Directorate Risk Strategy – Managing Risk is Everyone's Responsibility (2004 – 2006) sets out the process and priorities for risk management including clinical incident reporting in obstetrics.	
		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 and Medical) are reporting a wide range of incidents, such as staff shortages, shoulder dystocia and communication issues. Discussions with staff confirmed that on the whole they are reporting incidents and 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	The Obstetric and Gynaecology Risk Meeting minutes indicate that significant issues and incidents are discussed however it is not clear what is seen and discussed at these meetings and if trends are identified.	12. 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 interview and documentary evidence.	

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C2 C3	All healthcare professionals directly involved in childbirth are competent in basic adult obstetric, neonatal resuscitation and immediate care. CTG (cardiotocograph) interpretation training and updates should be undertaken on a 6 monthly basis.	Training programmes	Resuscitation training, including neonatal and adult resuscitation for Midwives takes place on a regular basis. Information from the SAAT data indicates that resuscitation training is mandatory for all midwives on an annual basis and attendance is audited. Training for medical staff is undertaken through the postgraduate obstetric and gynaecology teaching programme, which covers obstetric emergency drills, although the exact detail of the content of these drills is unclear from the evidence submitted. HIW found that on the whole staff spoken to had received resuscitation training in the last year. 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 are also available. The CTG Training Report (2003 – June 2006), identifies that CTG interpretation training should be undertaken on a 6 monthly basis. HIW found that on the whole staff had received CTG interpretation updates in the last 6 months.	
		Records of attendance and a system to ensure all staff attend	A database has recently been established to record and monitor attendance of midwives at training sessions. While examples of records of training sessions were seen for all staff, it is unclear from the evidence reviewed how attendance by medical staff is monitored.	13. There should be a system in place to record and monitor medical staffs attendance at resuscitation and CTG training.

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 survey to explore the views of women who live in the area regarding the provision of a midwifery led birthing room at Denbigh Infirmary was undertaken in 2005. The Trust has acted upon these findings and opened the Home from Home unit (midwifery led birthing room) at Denbigh Infirmary in summer 2006. There are plans to evaluate the service after the first 12 months. It would also seem that the survey motivated the team to look at maximising choice and normalising birth in the community.	
		Examples of changes made.	The Better Birth Environment survey was undertaken in 2006 and the results are currently being collated. The Trust is also taking forward a Mystery Patient Project for Maternity with the final report and recommendations expected in 2007.	
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.	• 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.	The patient information leaflets submitted as evidence included: Placenta Praevia produced by the Royal College of Obstetricians and Gynaecologists 2005; Pain Relief in Labour produced by the Obstetricians Anaesthetics Association 2005; Vaginal Birth after Caesarean Section produced by the Trust 2006; NICE guidance on Monitoring your Baby's Heartbeat in Labour and the Welsh Assembly Government Pregnancy Book.	14. Adequate information should be made available to women and their families, including local information about the unit and choice of place of birth.

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.	Audits of Administration of Antenatal Corticosteroids in Preterm Labour (2006); Twin Pregnancy Chorionicity and Scanning Policy (2005) and Documentation of Instrumental Vaginal Delivery (2006) have been undertaken. The results indicate areas for improvement including updating guidance; improvements in certain procedures performed; training and the use of a proforma to capture information. All are to be re-audited to assess the improvement of practice. While these audits include elements of record keeping they are not multidisciplinary record keeping audits designed to improve the quality of medical records.	15. The maternity service should ensure that there is a systematic process in place for regular multidisciplinary record keeping audits.
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 data in a number of ways including: - Obstetric Performance Management Data which includes information on different types of deliveries; - Information in relation to studies undertaken as part of the UK Obstetric Surveillance System which is requested by the North Wales Central Research Ethics Committee. The reports and newsletters provided as a result of the above data being collected would suggest that the information is being acted upon and findings disseminated to staff. A recommendation relating to data collection and data sets will be discussed in the All Wales Thematic Report.	

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 requested and reviewed during the site visit. Overall the records were found to be robust and of an appropriate standard, for example, all blood results were secure, all staff names were recognisable and when they took over care, dates and times were duly noted on the labour pages and key procedures identifiable. It was noted however that the older records did have information contained within the pocket at the back of the file and there were some loose CTGs or they were stored in un-fastened envelopes.	16. CTG traces should be securely stored in a re-sealable envelope that is hole-punched and filed within the main body of the records. 17. Patient information should be securely stored in the health record and not left loose in any pockets in the folder.