

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

Findings for Gwent Healthcare 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 Gwent Healthcare NHS Trust

Gwent Healthcare NHS Trust provides healthcare to more than 600,000 people living in South East Wales, through its three acute hospitals, community hospitals, health centres and clinics. Maternity deliveries take place at the Consultant and Midwifery Led unit Royal Gwent Hospital, Consultant and Midwifery Led Unit Nevill Hall Hospital and the Midwifery Led Unit at Caerphilly District Miners Hospital. A total of 5943 births took place in 2005, further details of the type of delivery is set out in the following table.

Data for January – December 2005	Royal Gwent Hospital, Newport		Nevill Hall Hospital, Abergavenny	
	Total Number	Percentage	Total Number	Percentage
Elective Caesarean Sections	357	10.3%	215	11.5%
Emergency Caesarean Sections	513	14.9%	248	13.2%
Instrumental deliveries (forceps and ventouse)	378	10.9%	238	12.7%
All other deliveries in the Consultant Unit	1327	38.4%	1174	62.6%
Deliveries in the midwifery led unit	879	25.4%	0	0%
Total number of births (Includes Consultant Unit and Midwifery Led unit at each site)	3454	100%	1875	100%
Number of Inductions of Labour in 2005 (% of the total number of deliveries in the Trust)	741	21.5%	434	12.6%
Deliveries at Midwifery Led Unit at Caerphilly District Miners in Caerphilly	388 / 6.6%			
Homebirths	194 / 3.3%			
Total number of births (Includes Royal Gwent, Nevill Hall, Caerphilly Minors and Homebirths)	5911			

HIW visited Gwent Healthcare NHS Trust maternity services on the 24th, 25th, and 26th of January 2007 and interviewed staff and visited two consultant units and three midwifery led units. 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 job descriptions provided in Gwent Healthcare NHS Trusts submission did not identify who the Clinical Leads (Medical) were for the Labour Wards at Royal Gwent and Nevill Hall Hospitals. HIW established that there is a Clinical Lead (Medical) for the Labour Ward at the Royal Gwent Hospital but there is no specific Clinical Lead (Medical) for Nevill Hall Hospital and this should be addressed.	1. A Clinical Lead (Medical) should be identified for the Labour Ward at Nevill Hall Hospital. 2. The job descriptions for the Clinical Lead (Medical) for the labour wards should clearly identify this responsibility.
		Activities of Clinical Lead(s) (Medical)	During the site visit HIW established that staff on the whole feel supported by senior colleagues and identified that they are available to consult with if staff need advice. There are a number of training opportunities available. Staff at Nevill Hall identified that Consultants are not always present on the Labour Ward for staff to consult with.	3. Consultants should be available on the Labour Ward at Nevill Hall to support junior staff.
		40 hours consultant cover (rota and work undertaken)	The Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM) document "Towards Safer Childbirth" (1999), which is in the process of being updated, recommends that as a minimum a consultant or equivalent should be available in a supervisory capacity for 40 hours during the working week (10 sessions). The rota for the Royal Gwent Hospital indicates that there are 10 sessions (40 hours) of Consultant cover on the labour ward and this was confirmed during the site visit. The rota for Nevill Hall Hospital indicates that there are 9 sessions of consultant cover on the labour ward, and this was confirmed during the site visit.	4. 40 hours Consultant Cover should be made available for the labour ward at Nevill Hall Hospital.

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		Handover procedures for change of Medical/Midwifery staff	The Guidelines for Handing-Over a Woman's Care During the Intrapartum Period (2005) details handover for midwives and medical staff. Midwifery handovers occur when staff change shift, there is a general handover with all midwifery staff and then more detailed handover for each woman in labour. Medical staff handovers also occur at the change of shift. It is unclear if there is a link between midwifery and medical staff handovers and this should be reviewed to ensure that where relevant there is sharing of information.	5. 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 job description for the Clinical Midwifery Manager – Caerphilly Birth Centre (2004) identifies that she will act as a leader and support to those midwives working in the unit. The job description for the Clinical Midwifery Manager – Main Delivery Unit, Royal Gwent Hospital (2004) identifies that she will be responsible for the operational management of the Main Delivery Unit at the Royal Gwent Hospital. A job description for the Labour Ward Manager at Nevill Hall Hospital was not submitted. HIW established that there is a Clinical Lead (Midwifery) for the Caerphilly Birth Centre, the Labour Ward at Nevill Hall Hospital and the Labour Ward at Royal Gwent Hospital. It is unclear who the leads are for the Midwifery Led Units at Nevill Hall Hospital and the Royal Gwent Hospital and this should be clarified and the job descriptions should reflect this responsibility.	6. The Clinical Lead (Midwifery) for the Labour Ward at Nevill Hall Hospital should have this responsibility clearly identified in their job description. 7. Clinical Leads (Midwifery) for the Midwifery Led Units at Nevill Hall and Royal Gwent Hospitals should be identified and this responsibility should be clearly identified in their job description.
		Activities of Clinical Lead(s) (Midwifery)	Activities discussed in L1.	

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		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 (2005) identified that the Trust has approximately 30 midwives less than is required for the activity in the Trust. Four options have been suggested as a way to address the current deficit but no decision had been made at the time of the site visit. A number of staff expressed concern as to the current staffing levels in the organisation and this should be addressed by the Trust.	8. The Trust should ensure that the actions identified from the recent Birthrate Plus audit is implemented and monitored.
		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 units at Royal Gwent and Nevill Hall Hospitals, 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 is also a written rota and a dedicated bleep so labour ward staff know who 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.	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". There is a Labour Ward Forum at Nevill Hall Hospital and the Labour Ward Forum at Royal Gwent has only just been established. It is unclear exactly who attends these meetings and what is discussed as no minutes were submitted as part of the document submission from	9. The membership and remit of the Labour Ward Forum should reflect what is set out by the RCOG/RCM and minutes should be taken.

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			Gwent Healthcare NHS Trust. The Trust should ensure that it follows the guidance as set out by the RCOG and RCM and that there are links between the three sites.	

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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>Job descriptions were submitted for the South Gwent Midwifery Manager, the Midwifery Manager, Nevill Hall Hospital, the Head of Midwifery/Directorate Manager for Obstetrics Divisional Lead for Midwifery and Gynaecology Nursing (2003). Staff interviewed identified that they were clear about their roles and responsibilities and there was no negative overlap of roles. Staff felt there was good communication between them and on the whole they were supported by the organisation to carry out their role.</p> <p>HIW found that on the whole 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, but some staff felt that communication and the cascading of information could be improved.</p>	10. Maternity services should ensure that appropriate communication channels are in place to cascade and communicate information to staff.
		Terms of Reference and minutes for Directorate meetings	A number of meetings take place across the Trust such as the Women, Children and Family Divisions Clinical Directorate of Obstetrics and Gynaecology meeting which enables key issues to be discussed with senior colleagues and managers and allow effective communication to take place. Items discussed at these meetings include consultant expansion, guidelines and training.	
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 cascaded to the Trust Board through a number of different routes, such as the performance reviews and the Executive Management Group. Trust Board papers indicate that progress against the balanced scorecard for the directorate is presented to the Trust Board. No minutes of the Trust Board were provided in the submission from Gwent Healthcare NHS Trust so HIW could not confirm what information on maternity services is discussed at Trust Board. Senior staff felt there were good links to the Trust Board, both formally and informally, and that they were adequately 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.	Gwent Healthcare NHS Trust Maternity Unit Escalation and Unit Closure Policy (2006) sets out the process to be followed if the ward is over stretched, including informing senior colleagues, assessing the situation, the decision to close and liaison with other units. There is a flow chart and forms that should be completed. An incident form is completed if the escalation policy is used. The policy has not been audited. HIW found that on the whole staff were aware of the escalation policy and the various contingencies that should be taken in the event of the units becoming busy, such as the calling in of additional staff.	11. The Escalation and Unit Closure Policy should be audited on a regular basis.

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T1	How does the maternity unit encourage effective team working and communications	Staff Surveys	<p>There were nine focus groups for midwives across the Trust which provide an opportunity for staff to contribute their ideas on services and discuss their experiences. No information was submitted indicating how opinions from medical staff are captured or neither was there any evidence of a staff survey.</p> <p>Interview evidence suggested that team working and communication is actively promoted and there are some areas where it works well, but there were also reports where this could be improved especially across the professions.</p>	<p>12. Maternity services should ensure they capture the views of all staff.</p> <p>13. The Trust should continue to encourage multi professional teamworking.</p>
		Multidisciplinary training	There are various examples of multidisciplinary training events such as the Obstetric Emergency Reflection sessions and Labour Ward Training days.	
		Multidisciplinary meetings	Minutes of meetings such as the Clinical Directorate of Obstetrics and Gynaecology meeting, Guidelines Development Group and Audit Meetings were reviewed. The minutes demonstrate multidisciplinary working and indicate 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 Midwifery Care Guidelines (2005) and Home Birth Policy (2003) are in place. Each of the documents were clearly set out and referenced and included the booking criteria to be followed, the risk / score and the appropriate management of care to be offered. The guidance for referral was also set out. As part of the interview process HIW found that staff were aware of the guidelines and processes to be followed.</p> <p>SAAT data indicates that every woman has a named midwife who will discuss their care in the early antenatal assessment.</p>	

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		Labour ward policies	The labour ward policies were reviewed during the site visit, these are approved by the Obstetrics Directorate. They were clearly identifiable and appropriately set out, with dates of development and when they are due to be reviewed (every 3 years). All the policies were referenced. HIW found that staff knew how to access the policies, whether in hard copy or electronically.	
		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 and it was evident from the minutes and presentation submitted that this has also been audited. HIW found evidence of the pathway being used within the health records reviewed.	
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>Along with the guidelines above which include indications for transfer and referral the Draft Guideline for the transfer of women and babies within the Maternity Services and Transfer for additional care in labour (no date) was submitted.</p> <p>The Draft Guideline for the transfer of women and babies within the Maternity Services which is based on the labour ward guideline gives guidance on how transfers should take place for different patients and the necessary arrangements to be carried out.</p> <p>We found that staff were clear about referral mechanisms and procedures to be followed.</p>	14. The draft guideline should be formally approved and cascaded to all staff.

HIW No	Criteria	Key Areas Considered	Findings including areas of strength and areas for further improvement	Recommendations
C1	<p>There is a system to ensure that all critical incidents: -</p> <p>a) Are reported through the appropriate channels.</p> <p>b) Have immediate action taken to prevent re occurrence.</p> <p>c) Are investigated and analysed.</p> <p>d) Identify patterns and trends.</p> <p>e) Result in changes in practice.</p> <p>f) Are reviewed by a multi disciplinary group.</p>	Incident reporting policy	The Trusts Incident Reporting Policy and Procedure (2004) sets out the incident reporting process in the Trust and the Risk Management Process for Clinical Incident Reporting and Investigation Flow Chart for the Obstetric Department (2006).	
		Completed incident forms	Completed incident forms for the last two months were reviewed during the site visit. These identified that midwives and medical staff are reporting a wider range of incidents, such as maternal death, emergency caesarean and transfer to another unit. Discussions with staff identify that they 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	Transfer meeting minutes for the Caerphilly Birth Centre shows the discussion and action around incidents. The Risk Management Minutes for Nevill Hall and Royal Gwent Hospitals indicate that incidents are discussed and actioned. The Clinical Risk Trends Statistics Report covers all three sites and sets out the clinical risk management trends for each site and the directorate. However it is unclear if this report is discussed at any of the above meetings or if an overview of all incidents is reviewed.	15. All incidents (including trends information) should be collated, reviewed and action taken by a group on a regular basis.
		Examples of changes made	Interview evidence indicated that changes have been made 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	Neonatal and maternal resuscitation training takes place on a regular basis. Information from the SAAT data indicates that a framework for appropriate levels of training is offered via the resuscitation service. 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. There are also in-house CTG updates and reviews that all staff can attend. HIW found that on the whole staff had received CTG updates in the last 6 months.	
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 number of databases are kept to record staff training which includes maternal and neonatal resuscitation and CTG training and K2 completion. Attendance of midwives is monitored and followed up if staff do not attend. Reports are produced for Managers detailing attendance at training sessions.	

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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 regularly undertakes audits and discharge interviews to establish women's opinions regarding midwifery care received across all locations. From responses received, results indicated that women were satisfied with the care. Recommendations addressing areas for improvement are made as a result of each audit and also following the analysis of the exit interview questionnaires.	
		Examples of changes made.	<p>There are Women's Focus Groups across all locations which provide an opportunity for users of the services to comment on the care they received. We found evidence within the minutes submitted that both positive feedback and areas for improvement are discussed and furthermore, that recommendations are made to address the points raised.</p> <p>It is evident from the examples of flyers, posters and newsletters submitted that the Trust is committed to gaining the views of patients and the public.</p>	

HIW No	Criteria	Key Areas Considered	Findings including areas of strength and areas for further improvement	Recommendations
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"> - Anaesthesia for Caesarean Section - All Wales Clinical Pathway for Normal Labour - Monitoring your Baby's Heartbeat in Labour - Elective Caesarean Section - Maternity Services Guide - Thinking About Homebirth - About Induction of Labour - Midwifery Led Care - Pain Relief in Labour with an Epidural - Post Operative Support Ward - Information about Next Birth for Women who have experienced a Previous Caesarean Section - Vitamin K advice to parents. <p>Leaflets are given out at booking and as the need is identified.</p>	
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.	Case Notes Audits were undertaken in 2005, 2004 and 2003 by supervisors of midwives and midwives from each of the units. The audits identified areas for improvement, and the recommendations were made to address the quality of record keeping. HIW also noted that although medical staff had been invited to participate in the audit (2005) no notes audits were completed by medical staff.	16. The maternity services should ensure that there is a systematic process in place for regular multidisciplinary audit.
D2	What data on Maternity Services is routinely collected and what changes have occurred as a result of collecting this information.	List of data that is collected routinely, where this is sent and changes made as a result of collecting.	<p>The Trust collates data in a number of ways:-</p> <ul style="list-style-type: none"> - Obstetric and Midwifery Statistics incorporating hospital and community deliveries, section rates and induction rates. - Trust statistics provided to the Maternity Services Liaison Committee including total number of births, deliveries by midwife / doctor, place of birth, type of delivery. <p>While it is clear from the evidence that some of the information is being used to inform audit, it is unclear how much of the 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 requested and reviewed during the site visit. Overall the records were found to be robust and of an appropriate standard. 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. In was noted, however, that some CTG traces did have the potential to unravel, as they were stored on a mount sheet and there was some patient information loose in the back pocket of the folder.	<p>17. CTG traces should be stored in a re-sealable envelope that is hole-punched and filed within the main body of the records.</p> <p>18. Patient information should be securely stored in the health record and not left loose in any pockets in the folder.</p>