

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

Findings for North East Wales NHS Trust

{Publication Date : 15/10/2007}

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 North East Wales NHS Trust

The Trust manages a range of health services in the Wrexham and Flintshire Local Authority Areas. These include health centres and clinics, hospitals, district nursing and health visiting and mental health services. Maternity deliveries take place at the Consultant Unit at Wrexham Maelor Hospital in Wrexham. A total of 2366 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
Elective Caesarean Sections	168	7.1%
Emergency Caesarean Sections	394	16.7%
Instrumental deliveries (forceps and ventouse)	262	11.1%
All other deliveries in the Consultant Unit	1509	63.8%
Homebirths	33	1.4%
Total number of births (Includes Consultant Unit, Birth Centre and Homebirths)	2366	100%

Number of Inductions of Labour in 2005 (% of the total number of deliveries in the Trust)	518	21.9%
---	-----	-------

In late 2004 the Trust conducted a review of maternity services which resulted in a number of changes and an action plan, progress with the review is monitored regularly.

HIW visited North East Wales NHS Trust maternity services on the 6th December 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)	A copy of a Consultant application pack was submitted, while this indicates that the appointments will enable the Trust to cover the labour ward sessions it does not detail that one of these posts will be the Clinical Lead (Medical) for the labour ward. A number of new consultants have recently been appointed and during the site visit HIW confirmed that one of the consultants is identified as the Clinical Lead (Medical) for the labour ward.	1. The job description for the Clinical Lead (Medical) for the labour ward should clearly identify this responsibility.
		Activities of Clinical Lead(s) (Medical)	During the site visit HIW established that staff felt that senior colleagues were supportive and available to consult with if staff needed advice. A variety of training is available for staff, either through specific training sessions or on the job.	
		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). Due to the recent consultant appointments in March 2006 the maternity service is able to offer 40 hours named consultant cover on the labour ward and the consultants on call rota indicates the cover available for morning and afternoon sessions and on call at night.	
		Handover procedures for change of Medical/Midwifery staff	The Guidelines for Handing Over a Woman's Care During the Intrapartum Period (draft Nov 2005) details what should be handed over and by whom. 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 care. Medical staff handovers also occur at the change of shift. There is a handover book to record relevant information and links between the midwifery co-ordinator and medical staff to ensure relevant information is communicated and disseminated to staff.	2. The Handover Guidelines should be formally approved and disseminated to all staff.

HIW No	Criteria	Key Areas Considered	Findings including areas of strength and areas for further improvement	Recommendations
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 Team Leader job description (2006) identifies that she must be visible within the clinical area to enable the provision of effective midwifery and professional leadership. The Assistant Head of Midwifery (Antenatal, Labour, Gynaecology, GUM and Genetic Services) (Oct 2005), identifies that she should support the Head of Midwifery by providing professional and managerial leadership for the designated area of responsibility. HIW confirmed during the site visit that the Assistant Head of Midwifery is the Clinical Lead (Midwifery) for the 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 (July 2004) identified a shortfall of 11.68 midwives and 13.89 support workers. A briefing paper to address this shortfall was presented to the Maternity Services Review Steering Group in Oct 2005 and the Trust Board approved interim funding to increase the maternity establishment in March 2006, with an agreement that patterns of care would be reviewed as per Birth Rate Plus report.	
		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 anaesthetic cover is available for the maternity unit. There is consultant presence on the labour ward during the day so they are immediately available if required and can support junior staff. There is a written rota and a dedicated bleep so staff know who to contact.	

HIW No	Criteria	Key Areas Considered	Findings including areas of strength and areas for further improvement	Recommendations
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 maternity service has a Labour Ward Forum whose remit is to report back to the Programme Team on issues relating to the labour ward and intrapartum care. It is a multidisciplinary group whose membership includes Senior and Ward Midwives, Clinical Director, Lead Consultant and junior medical staff. The group meets monthly. Minutes of the meetings do not include job titles so it is difficult to establish the roles of the individuals attending. There is no representation from a paediatrician, anaesthetist or lay member.</p> <p>The Trust does have lay representation on other maternity groups, such as the Maternity Services Review Steering Group, but needs to ensure that the Labour Ward Forum has the full membership as outlined by the RCOG and RCM.</p>	3. The membership of the Labour Ward Forum should include the membership as set out by the RCOG/RCM and job titles/role should be recorded in all minutes.

HIW No	Criteria	Key Areas Considered	Findings including areas of strength and areas for further improvement	Recommendations
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 and Reproductive Health Nursing (2004), two Assistant Heads of Midwifery (2005) and the Associate Clinical Director (2003) outlining their roles, responsibilities and lines of accountability within maternity services. Staff interviewed identified that on the whole they were clear about their role and responsibilities and there was no negative overlap of roles. Staff felt that since the maternity review support for these roles from the organisation has improved and they had time to carry out their role. HIW found that staff felt that senior colleagues in maternity services were aware of issues in the service and there are effective communication channels in place.	
		Terms of Reference and minutes for Directorate meetings	Minutes of the Maternity and Reproductive Health Programme Team Meeting were submitted and reviewed, membership includes Head of Midwifery, Directorate Manager and other staff. These meetings enable senior colleagues to meet and discuss issues including training, incidents, policy and procedures.	
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 indicate that they receive reports from the Maternity Review Steering Group on progress with the actions from the maternity services review on a regular basis. The review has led to the Trust Board being better informed about issues in maternity and there is also a flow of information from the Trust into the Directorate and to staff through the team brief and newsletter.	4. The Trust Board should continue to be briefed on issues in maternity services.

HIW No	Criteria	Key Areas Considered	Findings including areas of strength and areas for further improvement	Recommendations
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 Policy for the Management of Staff Shortages or Excessive Workload Within the Maternity Unit (Draft 2005) sets out the framework for the management of situations where demand for in-patient care within the maternity unit outweighs the staffing resources or capacity available. The policy has not been audited and is still in draft. It includes various contingencies set out as action cards and an incident form is completed if the escalation policy is used. During discussions HIW established that staff were aware that an escalation policy was in place and understood the various contingencies that could be taken in the event of the unit becoming busy, such as the calling in of additional staff.	5. The Escalation Policy should be formally approved and disseminated to all staff and audited on a regular basis.

HIW No	Criteria	Key Areas Considered	Findings including areas of strength and areas for further improvement	Recommendations
T1	How does the maternity unit encourage effective team working and communications	Staff Surveys	There were no staff surveys submitted.	6. Maternity services should ensure that they capture the views of staff.
		Multidisciplinary meetings	Minutes such as the Maternity and Reproductive Health Programme Forum were reviewed. The minutes demonstrate multidisciplinary working and the variety of topics discussed indicate team working and communication across the professions. Interviews undertaken during the site visit verified the good working relationships and a mutual respect between the different professions.	
		Multidisciplinary training	The Maternity Services Review Newsletter submitted is an example of how information in relation to training sessions, meeting dates and feedback from focus groups is cascaded and shared with staff. Both documentary and interview evidence suggests that multidisciplinary training is undertaken.	
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 Midwifery Led Care Policy (due for ratification Sept 2006) and Home Birth Policy (updated 2005) were reviewed. Each of the documents identified the criteria to be followed when booking women, in order that the appropriate plan of care is achieved and informed choice for place of birth is made available. Risk factors are considered along with the ongoing risk assessment process and when and how referral for consultant review maybe required. Staff were aware of the guidelines and the assessment process to be followed in relation to booking low and high risk women. SAAT data supports this with all pregnant women being offered an holistic assessment and records kept accordingly.	

HIW No	Criteria	Key Areas Considered	Findings including areas of strength and areas for further improvement	Recommendations
		Labour ward policies	Labour ward policies were reviewed during the site visit. It was unclear as to how some of the policies were developed or approved as they were part of the overall Labour Ward Protocol and two were undated and unreferenced. Staff did report that they knew how to locate the policies whether electronically or in hard copy and were aware if any changes that were planned etc. via the Labour Ward Forum.	7. All policies should be developed in line with the Trust system for policy development and should be clearly referenced and evidenced based.
		Implementation and audit of All Wales Clinical Pathway for Normal Labour.	It was evident from the Health Records reviewed that the Pathway has been implemented. Evidence submitted also confirms that the pathway has been audited.	
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.	Processes for transfer and referral were set out in the policies above. Staff interviewed were clear about the procedures to be followed and reported that there were no problems with the system in place.	

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 Incident and Hazard Reporting Policy (2005) clearly sets out the Trusts incident reporting process. It also details that analysis of data will occur to ensure trends are identified and reports will be available for discussion at the Directorate Risk Management Groups and quarterly at the Trust Risk Management Committee. There is also an Obstetric and Gynaecology Incident Reporting and Serious Incident Review Policy (2005) in draft which localises the Trusts policy specific to the directorate.	8. The Obstetric and Gynaecology Incident Reporting and Serious Incident Policy should be formally approved and disseminated to all staff.
		Completed incident forms	Completed incident forms for the last two months were reviewed during the site visit. This review identified that all disciplines of staff (Midwifery, Medical and other staff) are reporting a wide range of incidents, such as staff shortages, communication issues and drug errors. There are currently two reporting systems in use and maternity is moving towards using just the IR1 form for reporting incidents which will enable consistency in the reporting process. 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 of the Maternity Unit Risk Meeting indicate that incidents are discussed and action taken, it is unclear if incident trends are identified and discussed at any meetings.	9. The process for reviewing incidents should include the identification of incident trends information.
		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	Mandatory training for midwives which includes neonatal and maternal resuscitation and CTG interpretation is run on a regular basis. Information from the SAAT data indicates that all Trust staff who deliver care for mothers and babies are trained to deliver adult and neonatal life support on an annual basis. HIW found that on the whole staff 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	<p>The Trust has access to the K2 Fetal Monitoring Training System, which is a computer based training system that can be accessed at home or in the hospital and there are regular CTG Forums which staff can attend where CTGs are discussed. HIW found that on the whole staff had received an update on CTG interpretation in the last 6 months.</p> <p>The training and development database records midwifery staff attendance at training and development sessions and Midwives are asked to complete a form identifying any additional training they have undertaken so it can be entered into the database.</p> <p>HIW found that all of the documentation submitted as part of the review for C2 and C3 pertained on the whole to Midwives. Medical staff indicated they had received training but it is unclear as to what systems are in place to monitor their attendance.</p>	11. There should be a system in place to record and monitor all staffs' attendance at resuscitation and CTG training, including medical staff.

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. Examples of changes made.	It was clear from the maternity survey results 2005 and information regarding the Focus Groups that the Trust has a commitment to gaining and acting upon the views of women and their families regarding the maternity services they provide. It was also evident from the interviews that staff are aware of this work.	
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 Pregnancy book and information regarding vaginal birth after caesarean section, whether specific local information on the maternity unit and place of birth is supplied to women and their families.	12. 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.	It was clear from the evidence submitted, such as that for the annual Audit of Maternal and Paediatric Notes that there is an ongoing review of medical records and an impetus towards continually improving the quality of record keeping. It was not clear, however, if the audits are multidisciplinary.	
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>Annual statistics 1996 – 2005 were submitted and includes information on birthrates (total deliveries, home births, born before arrival (BBA), planned and unplanned homebirths); delivery methods; perinatal mortality rates; commencement on normal pathway etc. Interview evidence suggests that data collection is very resource intensive at present as it is paper driven and done manually.</p> <p>It was not clear to HIW how much of this 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>	
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 complete sets of health records were requested and reviewed during the site visit. All files were found to be robust and of a good standard. Information was secure and filled appropriately with all details and procedures clearly identifiable. We did find a useful form within the notes which records discussions regarding consent for procedures and decisions and choices of the woman and her family. Unfortunately this was only filled out on two occasions.	