

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

Findings for North West 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 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 North West Wales NHS Trust

The North West Wales NHS Trust provides services for the counties of Gwynedd, Ynys Môn and parts of Conwy. It serves a population of about 225,000 people as well as large numbers of holidaymakers who are attracted to the area every year. Maternity deliveries take place at the Consultant Unit at Ysbyty Gwynedd and at the three midwifery led units at Bryn Beryl Hospital, Dolgellau Hospital and Tywyn Hospital. A total of 1924 births took place across the Trust 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	147	7.6%
Emergency Caesarean Sections	294	15.3%
Instrumental deliveries (forceps and ventouse)	233	12.1%
All other deliveries in the Consultant Unit	1129	58.7%
Deliveries in Midwifery Led Unit at Bryn Beryl Hospital	30	1.6%
Deliveries in Midwifery Led Unit at Dolgellau Hospital	16	0.8%
Deliveries in Midwifery Led Unit at Tywyn Hospital	9	0.5%
Homebirths	66	3.4%
Total number of births (Includes Consultant Unit and Homebirths but not the Midwifery Led Units)	1924	100%
Number of Inductions of Labour in 2005 (% of the total number of deliveries in the Trust)	416	21.6%

HIW visited North West Wales NHS Trust maternity services on the 7th of December 2006 and interviewed staff and visited the Consultant Unit and the midwifery led unit at Bryn Beryl Hospital. The midwifery led units at Dolgellau Hospital and Tywyn Hospital were not undertaking maternity deliveries as the Trust had identified some areas of concern and a review was in progress which was due to finish in January 2007. HIW findings, including areas of strength and areas for further improvement, and recommendations against the six key areas are detailed in the following table.

HIW Review of Maternity Services in Wales – North West Wales NHS Trust

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 description for the Clinical Director (1999) was submitted as part of the maternity review which details that the postholder will take a professional leadership role in the directorate but it does not specifically identify them as the Clinical Lead (Medical) for the Labour Ward. During the site visit HIW established that there was an identified 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)	HIW found that staff (Medical, Midwifery and Support Staff) in maternity services felt that senior colleagues were supportive and available in the clinical areas to assist and advise when needed. Staff also identified that there were a number of different 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). Documentary evidence does not clearly indicate the number of sessions covered by a consultant but HIW established that the maternity service has 40 hours named consultant cover on the labour ward.	2. A Rota detailing the 40 hours consultant labour ward cover should be available for staff to refer to.
		Handover procedures for change of Medical/Midwifery staff	The Arrangements for Handover of Care, Midwifery Staff (2001) indicates that handovers should occur at the beginning and the end of each shift and should be recorded in the notes. Midwifery handovers occur three times a day when staff change shift, there is a general handover with all midwifery staff and then more detailed for each woman in labour. Medical staff handovers also occur at the change of shift and the Consultants do a ward round during the day. The link between midwifery and medical staff handovers is limited and should be improved. In the community handovers occur using diaries to record key information and phones to communicate and handover work to each other.	3. Midwifery and Medical staff should, where appropriate, undertake handovers together to ensure the sharing of relevant information.

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 Senior Midwife Delivery Suite and Practice Development Job Description (2004) and the Community Manager Job Description (undated), which also covers the midwifery led units, identifies that they should be highly skilled in midwifery care and be able to provide leadership through professional and clinical knowledge. HIW identified and confirmed during the site visit that there is a Clinical Lead (Midwifery) for the Labour Ward but the responsibility for community and the midwifery led units was unclear and should be clarified.	4. The Clinical Lead (Midwifery) for the community and/or midwifery led units 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, 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 there was slightly more staff in maternity services than was required but due to sickness some feel that the report is not a true reflection of staffing in maternity services. A number of new midwifery staff have recently been appointed to the Trust which should address some of the staffing issues.	
		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, consultants are present on the labour ward for a couple 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 whom to contact.	

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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 which meets on a monthly basis, it is a multidisciplinary group and all staff are invited to attend, membership includes senior and junior midwives, consultants and manager, with other staff such as paediatricians and anaesthetists attending as required. There is no lay representative. Minutes of the meetings do not always include job titles so it is difficult to establish the roles of the individuals attending.</p> <p>While this group carries out a number of the functions of a labour ward forum its remit should be expanded to include all labour ward activity and include the full membership as defined by the RCOG/RCM. A community forum is also being established and links between the two groups should be in place to ensure affective communication.</p>	5. The membership of the Labour Ward Forum should include the membership and remit as set out by the RCOG/RCM and job titles of staff should be recorded in all minutes.

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M1	<p>Maternity Unit Managers, Heads of Midwifery (HOM) and the Clinical Director for Maternity Services:-</p> <p>a) Have clearly defined roles and responsibilities.</p> <p>b) Have protected time to fulfil their management roles.</p> <p>c) Have effective support from the organisation to carry out their roles.</p>	<p>Job descriptions:- Maternity Unit Manager, Head of Midwifery, Clinical Director for Maternity Services</p>	<p>The Job description for the Deputy Head of Nursing and Maternity Services/Professional Lead for Midwifery (2005) was submitted, it outlines the job role, responsibilities and accountability. No other job descriptions were submitted for this criterion. Staff interviewed indicated that they were clear about their responsibilities and there was no overlap of roles and on the whole they were supported by the organisation. There is not a Head of Midwifery post within the Trust but a Professional Lead for Midwifery and Deputy Head of Nursing. The Trust felt this would allow for better links and benchmarking with other parts of the Women and Families Directorate. However there is the potential for confusion as many documents and minutes of meetings reviewed refer to a Head of Midwifery and not the Professional Lead for Midwifery and Deputy Head of Nursing. There is also the potential for issues in maternity to not be brought forward due to the wide remit of the Professional Lead for Midwifery and Deputy Head of Nursing.</p> <p>HIW found that staff felt that senior colleagues were aware of issues in maternity services but some felt that action was not always escalated upwards to address concerns.</p>	<p>6. The Trust should review the post of Professional Lead for Midwifery and Deputy Head of Nursing to establish if midwifery leadership would be better supported by a Head of Midwifery.</p> <p>7. Maternity services should ensure that appropriate channels are in place for issues raised by staff to be acted upon.</p>

HIW No	Criteria	Key Areas Considered	Findings including areas of strength and areas for further improvement	Recommendations
		Terms of Reference and minutes for Directorate meetings	Terms of reference and minutes for the Women and Families Directorate Management Team meetings were submitted and reviewed. The remit of this meeting is to ensure the effective and efficient running of the directorate in relation to quality, finance and resources. Membership includes the Professional Lead for Midwifery and Deputy Head of Nursing, Directorate General Manager, Service Support Manager and the Clinical Director. The Clinical Director was on sick leave at the time of the HIW visit and had not attended recent meetings of the Directorate Management Team meetings. These meetings enable key issues to be discussed with senior colleagues and managers and allow effective communication to take place.	
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 Public and Committee Trust Board do not specifically indicate that maternity issues are being brought to the attention of the Trust Board, the formal discussion of clinical issues is not reflected in papers and minutes however this is an area that the Trust is hoping to improve. HIW found that some staff feel that there are effective communication channels in place to brief the Trust Board on issues in maternity while others feel that the links and communication to and from the Trust Board could be improved.	8. The Trust should ensure that there is a formal process in place to update the Trust Board, and feedback information to the directorate, on maternity issues.

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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 Escalation Policy/Contingency Plan within the Maternity Unit (draft 2006) sets out a framework for the management of situations where demand for in patient care within the maternity unit outweighs the staffing resources or capacity available. It includes a communication checklist which should be followed and completed. The policy has not been audited and is still in draft. During discussions HIW established that staff on the whole were aware that an escalation policy was in draft and understood various contingencies that could be taken in the event of the unit becoming busy, such as informing senior colleagues and calling in additional staff. (The consultant unit and midwifery led units should be included in one policy or if separate there should be links between the two policies).	9. 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	<p>The Women and Family Services Directorate section of the NHS Wales Staff Survey 2005 was submitted as evidence. Communication across the Directorate is reported as good although it is not clear how much of the information is relative to the Maternity Unit. No Action Plan was submitted as a result of the survey.</p> <p>Interview evidence suggests that staff in maternity services work well together and that there are good working relationships within the teams. There are some concerns with regard to the cascading of information to and from those staff working in the community which has been identified from the Trusts review of the midwifery led units.</p>	10. The Trust should take steps to improve communication across maternity services.
		Multidisciplinary training	Within the minutes of the Labour Ward Forum there is evidence of discussion, planning and practices to be included in the multidisciplinary training programme.	
		Multidisciplinary meetings	Minutes were submitted and reviewed for the Labour Ward Forum and Directorate Meeting. It is clear from the topics discussed and actions that result that these are multidisciplinary and interview evidence verifies this.	

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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 submitted many guidelines as evidence including the policy for Midwifery Led Antenatal Care (2006) and Home Delivery Guidelines (2002).</p> <p>The policy for Midwifery Led Antenatal Care (2006) is concise, covering the assessment criteria to be followed when booking women, including the pattern of care for low risk women and when women should be referred. The Home Delivery Guidelines (2002) are very brief and do not give any detail on the practical steps to be taken when booking and undertaking homebirths. The policy does not include any information on what steps are to be taken should difficulties or complications transpire during labour at home.</p> <p>Interview evidence did reflect that staff were aware of the policies and procedures to be followed.</p>	11. The Home Delivery Guidelines should be updated to include detailed guidance to staff on the conduct of homebirths including when to transfer should difficulties or complications occur.
		Labour ward policies	<p>Labour ward policies were reviewed during the site visit. Overall, there did not seem to be a systematic approach to developing the policies – for example, the majority were dated but only two had review dates, all policies were referenced although not all were current or up-to-date and there was little or no information in relation to who or what group developed or approved them.</p> <p>Interview evidence did suggest that staff knew how to locate policies whether in hard copy or electronically and that there was a system where by a memo is distributed regarding updates and staff have to sign to confirm they have seen the policy.</p>	12. All policies should be developed in line with the Trust system for policy development and should be clearly referenced, evidenced based and reviewed on a regular basis.
		Implementation and audit of All Wales Clinical Pathway for Normal Labour.	HIW found from the health records reviewed that the Pathway is being followed and that its use has been audited, as evidenced in the Draft Report - Clinical Normal Labour Pathway Audit (2005) that was submitted.	

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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>Many policies were submitted as evidence including the Midwives Referral to Consultant Care (2001); Transfer of Mother and Baby from Home or a Midwifery Managed Unit to DGH (2002); Transfer of an Infant to a Sub or Regional Unit (2001) and In Utero Transfer (2005).</p> <p>HIW found that as part of the policies mentioned above that indications for referral were clearly set out however, guidance on transferring women, specifically when in labour was less obvious.</p> <p>There were no perceived problems with the referral or transfer systems and staff interviewed were aware of the systems to be followed.</p>	13. The Transfer of Mother and Baby from Home or a Midwifery Managed Unit to DGH Policy should be updated to detail the safe management of the transfer of mother and baby.

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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 Adverse Incident, Near Miss and Hazard Reporting and Root Cause Analysis Procedure (March 2006) sets out the incident reporting process in the Trust and details that incident summary reports should be reviewed at directorate meetings.	
		Completed incident forms	Completed incident forms for the last two months were reviewed during the site visit. These identified that all midwives are reporting incidents but there was only 1 example of a form being completed by a member of the medical staff. A wide range of incidents are being reported including communication issues, emergency caesarean and protocol issues. Discussions with staff identify that staff feel comfortable with the culture of the organisation in that it wants to learn from incidents and this has improved over the last couple of years.	14. All staff should be encouraged to report incidents.
		Minutes of meetings and reports where incidents and trends are reviewed	Minutes of the Labour Ward Forum indicate that individual incidents are discussed at this meeting. However it is not clear what is seen and discussed and if incidents are collated and trends identified.	15. 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.	16. 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	Resuscitation training, including a 1 day multidisciplinary Neonatal Life Support course, in house Neonatal Training refresher sessions for midwives and Obstetric Emergency training occurs on a regular basis. Information from the SAAT data indicates that all staff undertake mandatory basic life support on an annual basis. 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/meetings are also available. HIW found that on the whole staff had received CTG updates in the last 6 months but community staff occasionally sent CTG traces to the consultant unit for checking and interpretation.	17. The Trust should review the use of CTG traces in the community setting to ensure that they are being used appropriately and staff using them should have regular training and updates.
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 annual mandatory training record for Women and Families Directorate captures adult and neonatal resuscitation training, obstetric emergency days and CTG training for midwives. One of the senior midwives is responsible for monitoring training and e mails are sent to remind staff who have not attended. 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 that they had received training but it is unclear as to what systems are in place to monitor their attendance.	18. There should be a system in place to record and monitor 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.	The results of a survey undertaken to collate views on services / information available to mothers to help them breastfeed (2005) and the Breastfeeding Care Audit results (Jan-Feb 2006) were submitted. It is clear from the operational plan 2006/07 and action plan for the working group that the Trust is working to continuously improve this service in the Gwynedd area.	
		Examples of changes made.	The Trust has Acted upon the views of parents in the North West Wales area by providing a local nurse led tongue tie release service for mother's and babies experiencing breastfeeding difficulties.	
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. 	The Trust submitted leaflets in relation to: Home Sweet Home: Thinking about Home Birth; Babycare TENS – Helping you and your Baby; Induction of Labour; All Wales Clinical Pathway for Normal Labour; Advice for Optimal Foetal Positioning; Vaginal Birth after Caesarean Section (draft); Fetal Heart Monitoring in Labour; Information for Parents: Vitamin K given to all Newborn Babies; Postnatal Depression.	

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	See 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.	<p>The results and actions arising from the Record Keeping by Nurses and Midwives in the Women & Families Directorate Audit (2006) were submitted. Generally, findings show areas for improvement in relation to how entries are written or entered, and the actions appropriately address this via improving access to the Nursing and Midwifery Council guidelines for record keeping; training updates for staff and a review of the standards policy for record keeping. It is also evident that the Trust is working towards implementing a systematic process of regular audits.</p> <p>There was no information to suggest that multidisciplinary audits take place.</p>	19. 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.	<p>The Trust states it collects data on:</p> <ul style="list-style-type: none"> - Complaints - Litigation - DATIX - CARIS - Patient Experiences <p>No actual information was submitted as evidence and a judgement could not be made on how much of this data is being used or 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. One third of the records had torn covers and the majority did not have all information securely stored. CTG traces and blood results were appropriately filed and entries in relation to staff names, key procedures, decisions and actions were easily identifiable.	<p>20. The Trust should ensure that records are stored in strong robust folders that do not easily tear.</p> <p>21. Patient information should be securely stored in the health record and not left loose in the folder or any pockets.</p>