

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

Findings for Pembrokeshire and Derwin NHS Trust

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Maternity Services in Wales

Over 30,000 babies are born in Wales each year. Just over 2% of births take place at home or elsewhere but the majority (98%) are born in a hospital setting. These settings are Midwifery Led Units/Birth Centres or Consultant Units.

Midwifery Led Units/Birth Centres - These units are staffed by midwives and provide care for women who want to give birth with little or no medical intervention, they tend to be suitable for women expected to have a good chance of having a straightforward birth ("low-risk" women).

Consultant Units - A consultant unit is usually part of a general hospital and consists of a labour ward/delivery suite, antenatal and postnatal inpatient wards and is staffed by obstetricians (specialists in birth where there are complications) and midwives (specialists in normal birth). A woman is usually booked under the care of a particular consultant, but may only see them rarely throughout her pregnancy. Most of her care will be given by midwives. If complications arise during pregnancy or labour, the doctors will become more involved. Interventions such as epidurals and Caesarean operations are usually available in the unit.

Background to the HIW All Wales Maternity Review.

Reviews undertaken by the Healthcare Commission in England into maternity services have given rise to concerns in relation to the clinical governance arrangements in these units and in Wales we needed to be assured that similar issues were not present in Welsh Maternity Units. Therefore a review of maternity services has been undertaken, the review considered the following six areas: -

- Clinical leadership and accountability for the quality of Maternity Services;
- Management of Maternity Services;
- Teamwork and Communication;
- Clinical Care;
- Women and their families experience and involvement;
- Documentation and information;

The All Wales Maternity Review considered and analysed the following information: -

- Documentary evidence that was submitted from each organisation that provides maternity services in Wales;
- National Service Framework (NSF) for Children, Young People and Maternity Services Self Assessment Audit Tool Data (SAAT Data). The 17 key core actions for maternity services where relevant to the HIW maternity review, which organisations have self assessed themselves against and submitted to the Welsh Assembly Government (WAG);
- Formal and informal interviews;
- Observation visits to every unit undertaking deliveries were made with a team consisting of HIW staff, Peer and Lay reviewers.

Background to Maternity Services at Pembrokeshire and Derwin NHS Trust

The Trust provides acute, community and mental health services throughout Pembrokeshire and the surrounding area. Maternity deliveries take place at the Consultant Unit at Withybush General Hospital in Haverfordwest. A total of 1288 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	140	10.9%
Emergency Caesarean Sections	134	10.4%
Instrumental deliveries (forceps and ventouse)	118	9.2%
All other deliveries in the Consultant Unit	825	64.1%
Homebirths	71	5.5%
Total number of births (Includes Consultant Unit, Birth Centre and Homebirths)	1288	100%
Number of Inductions of Labour in 2005 (% of the total number of deliveries in the Trust)	309	24%

HIW visited Pembrokeshire and Derwin NHS Trust maternity services on the 21st November 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)	No job descriptions were provided in the documentation submission from Pembrokeshire and Derwen NHS Trust identifying the Clinical Lead (Medical) for the Labour Ward. A document entitled Introduction to Guidelines (2006) identified one Consultant as the Clinical Lead in Obstetrics and Gynaecology, but this was for the Obstetrics and Gynaecology Department and not specifically for the Labour Ward. HIW found that a Consultant was identified as the Clinical Lead (Medical) for the Labour Ward.	1. A Clinical Lead (Medical) should be identified for the labour ward and their job description should clearly identify this responsibility.
		Activities of Clinical Lead(s) (Medical)	Staff (Medical, Midwifery and Support Staff) in maternity services felt that senior colleagues were helpful, approachable and supportive, they were available in the unit or easily contactable for advice. Training and education sessions were available such as skills drills and weekly education sessions.	
		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). No rota was provided in the documentation submission from Pembrokeshire and Derwen NHS Trust. A document entitled Handover Process for Medical Staff (2005) indicates that there are currently 5 sessions out of a possible 10 (40 hours) per week where a named consultant is available to cover the labour ward. As part of the site visit we established that the Trust has recently appointed a number of new consultants and has now almost covered all of the 10 sessions with 9 out of the 10 sessions (40 hours) of Consultant cover available on the labour ward.	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 Handover Process for Medical Staff (2005) and the Midwifery Handover Policy (2005) outlines the process for handover of care when shifts change. Midwifery handovers occur three times a day when staff change shift, there is a general handover with all midwifery staff and then one to one with the person taking over that particular woman's care. Medical staff handovers also occur at the change of shift. Midwifery and medical staff handovers occur separately.	3. 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 Senior Clinical Midwife Job Description (undated), identifies she should demonstrate effective leadership skills and the Acting Head of Midwifery Job Description (undated), also identifies the leadership of staff. In addition the Senior Midwives Objectives (2006) identified her as the Clinical Lead (Midwifery) for Labour Ward and this was confirmed by HIW during the site visit.	
		Activities of Clinical Lead(s) (Midwifery)	Activities discussed in L1	
		Birth-rate plus and actions/progress from audit	Birthrate Plus, is a framework for workforce planning and decision making for maternity services. The Birthrate plus audit was not submitted as part of this review. It was unclear from the evidence reviewed if this has been undertaken in maternity services, or if it has, if any changes have been made as a result of this audit. Although no staff identified any issues in caring for women in labour, maternity should ensure that it has a robust way of auditing whether the workforce in place is adequate for the work being undertaken.	4. Workforce planning should be undertaken to ensure the workforce is adequate for the work being undertaken.
		Handover procedures for change of Medical/Midwifery staff	Handover discussed in L1	

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L3	There is a named obstetric anaesthetist available at all times to provide advice and cover for the Labour Ward.	Obstetric anaesthetist rota detailing cover for the labour ward	24 hour on call consultant or senior anaesthetic cover is available for the maternity unit. On call anaesthetists are also responsible for covering the rest of the hospital but they work flexibly to ensure that they are available for labour ward should they be required. There is also a written rota so labour ward staff know whom to contact. An elective caesarean section list is carried out on a regular basis each week. There is a named Consultant Lead for the labour ward who works 1 flexible session per week on the unit.	
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>While the following groups are in place: -</p> <ul style="list-style-type: none"> • The Perinatal Group, the remit of which is to review incidents, review policies and guidelines in relation to incidents and identify good practice. • The Risk Assessment Group, the remit of which is to identify trends from incidents and learn lessons from investigation. • A Forum on a Thursday afternoon which all staff (Midwives and Medical staff) can attend, the meetings considers interesting cases that have occurred. <p>While these groups consider certain aspects of labour ward activity they do not carry out the functions of a Labour Ward Forum as defined by the RCOG and the RCM and this should be addressed.</p>	5. 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	Job descriptions were submitted for the Acting Head of Midwifery (undated), Senior Clinical Midwife (2004) and the Lead Clinician in Obstetrics and Gynaecology (2004) outlining their roles and responsibilities within maternity services. We found that there was no conflict or negative overlap of roles and responsibilities and that on the whole the postholders had time to carry out their role and they were well supported by the organisation.	
		Terms of Reference and minutes for Directorate meetings	A number of different meetings take place in maternity services such as the Womens and Childrens Directorate Clinical Governance and Risk Managment Group, Obstetric and Gynaecology Services Meetings and the Women's and Children's Directorate Business Meetings. Areas discussed at these meetings include Clinical Governance and Risk, Performance, Staffing and Policies. We found that senior colleagues and managers meet on a regular basis, formally and informally to discuss key issues in maternity and to allow effective communication to take place. Staff indicated that they felt that senior colleagues listened to them and they were aware of issues in maternity services.	
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)	Regular Board reports from the Director of Nursing, which include maternity issues are submitted to the Trust Board. Minutes of the Trust Board were not submitted as part of the documentation submission so HIW could not establish what discussion takes place around these reports. Senior staff felt that there were good links with the Trust Board and they were adequately briefed on issues in maternity services especially since the maternity services review in the Trust.	

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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.	There is an Escalation Policy (February 2006) which includes a contingency plan and sets out the procedures and steps to be taken in the event that the unit would need to close. The policy has not been audited and this is planned for later this year. Staff were aware of various contingencies that could be taken in the event of the unit becoming busy, such as the calling in of additional staff, however not all staff were aware of the escalation policy.	6. All staff should be aware of the escalation policy and it should be audited on a regular basis.

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T1	How does the maternity unit encourage effective team working and communications	Staff Surveys	The NHS Wales Staff Survey 2005 results for the Women's and Children's Services Directorate suggest, that, overall staff felt they worked effectively as part of a team. Interview evidence verified this within the maternity services and in addition supported that there were channels and systems in place, such as the meetings that take place and a newsletter, which promoted wider communication.	
		Multi disciplinary meetings	Minutes of meetings such as the Obstetrics and Gynaecology Service Meetings were reviewed. The minutes demonstrate multidisciplinary working and the variety of topics discussed indicate team working and communication across the professions.	
		Multi disciplinary training	There are various examples of multidisciplinary training events such as the Friday afternoon teaching sessions and obstetric training days.	
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.	Obstetrics and Gynaecology Homebirth Guidelines (2005) and Midwifery Led Care Guidelines (2006) are in place. Both documents were comprehensively set out and detail the assessment and booking process for either homebirth or midwifery led care and includes the inclusion / exclusion criteria to be followed and guidance for referral to consultant care. The guidelines are evidence based and are referenced accordingly. SAAT data indicates that all women have a named midwife within a named team and that the care plan is completed in partnership with the woman.	

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		Labour ward policies	The labour ward policies were reviewed during the site visit. Generally, the documents were brief but covered the specific management of the condition, as appropriate. Where applicable, the majority were ratified by the Clinical Governance Group and referenced accordingly. During the site visit staff indicated that they knew how to locate the policies via the Labour Ward Office and were alerted to updates by the Training Manager.	
		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 followed, when appropriate.	
T3	There is a mechanism for referral from one professional to another at all stages of care, including a written evidence based transfer policy where applicable.	Transfer policy and referral mechanism.	<p>Along with the guidelines above which include indications for transfer and referral, a Cause for Concern form (2006), Maternity Bed Booking Form (no date) and a Transfer of Recently Delivered or Pregnant Women and Neonatal Patients to other Units policy (June 2005) are in place.</p> <p>The Transfer of Recently Delivered or Pregnant Women and Neonatal Patients to other Units policy gives guidance on if, when and how transfers should take place for the different groups of patients and the necessary arrangements to be carried out.</p> <p>We found that staff were clear about referral mechanisms and confident that the system worked well.</p>	

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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 Recognition, Reporting and Review of Serious/Adverse Incidents, Dangerous Occurrences and Near Misses Policy (May 2006) clearly sets out the incident reporting process in the Trust.	
		Completed incident forms	Completed incident forms for the last two months were reviewed during the site visit. This included incident forms (IR1 and PACER forms are currently being used in maternity services) and information from the DATIX system, which is in the process of being introduced in the Trust. This review identified that all disciplines of staff (Midwifery and Medical) are reporting a wide range of incidents, such as protocol issues, transfers into the unit and communication issues. Discussions with staff identified that they feel that the culture of the organisation in relation to incident reporting is better than it was and staff on the whole feel supported reporting incidents in that the organisation wants to learn from these incidents rather than apportion blame.	
		Minutes of meetings and reports where incidents and trends are reviewed	Minutes of the Obstetrics and Gynaecology Directorate Meeting indicate that incidents are discussed, but it is unclear if trends are discussed and identified at this meeting. However a Clinical Governance Report for 2006 sets out the themes identified from the review of PACER forms.	7. All incidents (including trends information) should be collated, reviewed and action taken by a group on a regular basis.
		Examples of changes made.	We found that changes have been made as a result of incident reporting, such as the introduction of the integrated care pathway for postnatal care.	

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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	<p>Adult and neonatal resuscitation training is undertaken for all staff and the Trust has reported through its submission as part of the SAAT data that a policy is in place to meet this criterion. HIW found that on the whole most staff had received resuscitation training in the last year.</p> <p>The Trust has access to the K2 Fetal Monitoring Training System, which is a computer, based training system that can be accessed via the internet at home or in the hospital. We found that on the whole most staff had received some type of CTG interpretation training in the last 6 months. Either through the K2 package, obstetric emergency training, meetings where CTGs are discussed or a combination of these.</p>	
C3	CTG (cardiotocograph) interpretation training and updates should be undertaken on a 6 monthly basis.	Records of attendance and a system to ensure all staff attend	<p>A training log is kept of midwifery staff by one of the senior midwives, which identifies all training undertaken including adult and neonatal resuscitation and CTG training. Midwifery staff are reminded when an update is due. Although medical staff indicated they had received training It is unclear what systems are in place to record and monitor their attendance.</p> <p>Some staff identified that there can occasionally be problems releasing staff for training activities if the unit is busy.</p>	8. There should be a system in place to record and monitor medical staffs attendance at resuscitation and CTG training.

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P1	The views of women and their families are sought routinely and changes are made as a result.	Examples of recent surveys.	A Better Birth Environment survey was carried out in September 2006 based on the questionnaire formulated by the National Childbirth Trust. Findings from the survey suggest that the majority of women were generally satisfied with the care they received and the environment in which they gave birth.	
		Examples of changes made.	We found evidence within the minutes of the Maternity Service Liaison Group that reflected commitment to recruit lay representation to the group and that the website being established would include a link for patient and public involvement. It was also noted that the Better Birth Environment questionnaires were reaching its 2 nd stage of audit.	
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 MIDIRS leaflets; Welsh Assembly Government Pregnancy book and Bounty packs whether specific local information on the maternity unit and place of birth is supplied to women and their families.	9. Adequate information should be made available to women and their families, including local information about the unit and choice of place of birth.

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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	

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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>A presentation giving the findings of a records and record keeping case notes audit was submitted for November / December 2005 along with the blank audit tool form used. Findings show that there is a satisfactory standard of record keeping and the Action Plan appropriately addresses the areas of weakness and in particular the future benefits of medical staff involvement. It was evident that the Trust is working towards implementing a systematic process of regular audits.</p> <p>The Trust submitted their Postnatal Care Pathway as evidence of changes made, but it is unclear as to when this will be audited.</p>	

HIW No	Criteria	Key Areas Considered	Findings including areas of strength and areas for further improvement	Recommendations
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"> • Monthly delivery figures incorporating the different delivery units / areas; projected deliveries and home births; • Daily activity sheet covering categories such as antenatal / highdependency / postnatal / babies / labour / homebirths / identified problems etc • Community midwife statistics book which gives information of midwifery led care / shared care / transfer of care / bloods / delivery / discharge notes etc. • Information submitted as part of the Dr Foster Birth Guide publication; • RCM Staffing Survey; • Maternity Normal Pathway reports. <p>While some of the information is being used to inform audit, it is unclear how the remaining 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	<p>20 completed sets of health records were requested and reviewed during the site visit. Generally, the records were found to be robust and the information securely stored and maintained.</p> <p>It was noted, however, that in approximately half of the records the CTG traces did have the potential to unravel as they were secured on a mount sheet. Certain storage methods are known to increase the speed with which records fade, for this reason the simplest storage method is to use a re-sealable, clearly labelled envelope secured within the main body of the health record.</p> <p>In over half of the health records reviewed the named professional was not clearly identified on the front of the notes.</p>	<p>10. CTG traces should be securely stored in a re-sealable envelope that is hole-punched and filed within the main body of the records.</p> <p>11. The named healthcare professional should be clearly identifiable on the front of the health record.</p>