

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

Findings for Powys Local Health Board

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 Powys Local Health Board (LHB)

Powys LHB provides a range of hospital, community, mental health and learning disability services and is responsible for commissioning secondary health care and hospital services and co-ordinating the delivery of primary care services for the people of Powys. Maternity deliveries take place at the following Midwifery Led Units: Brecon War Memorial Hospital, Llandrindod Wells County War Memorial Hospital, Llanidloes War Memorial Hospital, Victoria Memorial Hospital, Knighton Hospital and Montgomery County Infirmary. A total of 286 births took place in 2005, further details of the type of delivery is set out in the following table.

Data for January – December 2005	Total Number	Percentage
Deliveries at the Birth Centre, Brecon War Memorial Hospital	34	11.9
Deliveries at the Birth Centre, Llandrindod Wells County War Memorial Hospital	16	5.6
Deliveries at the Birth Centre, Llanidloes War Memorial Hospital	12	4.2
Deliveries at the Birth Centre, Victoria Memorial Hospital	48	16.8
Deliveries at the Birth Centre, Knighton Hospital	21	7.3
Deliveries at the Birth Centre, Montgomery County Infirmary	43	15
Homebirths	112	9.9*
Number of women cared for in District General Hospitals outside of Powys (not included in the total)	851	29.3**
Total number of births in Powys	286	100%
*Percentage takes into account the 851 District General Hospital Births outside of Powys. **Percentage of births outside of Powys		

HIW visited Powys Local Healthboard NHS Trust maternity services on the 6th, 7th, 27th and 28th February 2007 and interviewed staff and visited the six 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.		Powys provides midwifery led services only and therefore this criterion is not applicable.	
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 Midwifery Team Leader Job Descriptions (2004) identifies that the postholder will be responsible for the management of midwifery staff in a defined geographical area and they will be a proactive leader giving advice and support to staff. The leadership structure identifies that there is a Clinical Lead (Midwifery) for North and South Powys. HIW confirmed this during the site visits.	
		Activities of Clinical Lead(s) (Midwifery)	During the site visit HIW established that staff feel very well supported by senior colleagues and identified that they were approachable and could easily contact them to ask for help and advice. The mandatory training days enable staff to update their skills on a regular basis.	
		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 LHB. The Birthrate audit report (2003) identified that there was adequate staffing in maternity services. Interview evidence indicates that due to changes in work patterns the audit may need to be undertaken again.	
		Handover procedures for change of Medical/Midwifery staff	Guidelines for Midwives Working Hours and Handover of Care set out the handover procedures for midwives. HIW established that if handovers do need to occur that these are done on a one to one basis with the person taking over the care.	

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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	Powys provides midwifery led services only and therefore this criterion is not applicable.	
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". Powys LHB provides midwifery led services and therefore the full membership as defined by the RCOG and RCM is not appropriate. There are two forums in Powys, the South Shire and the North Shire Meetings, which discuss guidelines, safety issues and reports from the Birth Centres. Minutes of the meetings only record the names of individuals and not their job title so it is difficult to establish attendance. HIW established that although there is lay representation on other groups in the LHB there should be lay representation at the Shire Meetings to fulfil the recommendations set out by the RCOG and RCM.	<ol style="list-style-type: none"> 1. The membership of the Labour Ward Forum should include the membership based on the RCOG/RCM guidance but appropriate for midwifery led services. 2. Minutes of the Labour Ward Forum should clearly detail the job title/role as well as the name of those attending.

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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 Midwifery Team Leader (January 2004) and the Head of Women and Children's Services (2005) outlining their roles and responsibilities within the maternity services. Staff interviewed identified that they were clear about their roles and responsibilities and there was no negative overlap of roles. Staff felt that there was good communication and links with each other and they were supported by the organisation to carry out their role. HIW found that 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.	
		Terms of Reference and minutes for Directorate meetings	The Women and Children's Health Directorate Meeting, whose membership includes the Head of Women and Children's Services and Head of Midwifery meet on a monthly basis the purpose of the meeting is to identify the service and support needs of Women and Children in Powys. HIW found that senior colleagues and managers meet on a regular basis, formally and informally to discuss key issues in maternity 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)	Information on maternity services is fed up to the LHB Board through the Clinical Governance and Risk Management Committee and direct reports. Minutes of the Clinical Governance and Risk Management Committee indicate that maternity issues are discussed. No minutes of the LHB Board were provided in the submission from Powys LHB so HIW could not establish what information on maternity services is discussed at the Board. Senior staff felt there were good links to the LHB Board 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.	The Operational Policy for Powys Maternity Services (2006) includes the escalation procedures to ensure the safety of mothers and babies and that maternity services will only close after a clinical risk assessment. A maternity unit closure form and an escalation letter are included. The policy does not detail the practical steps that could be taken in the event of there being pressure on maternity service and this should be included. The policy has not been audited and is still in draft. HIW established that staff were aware of the various contingencies that could be undertaken such as the calling in of additional staff and centralising deliveries at one Birthing Centre. The escalation policy needs to reflect the arrangements that are currently undertaken.	3. The Escalation Policy should be updated to include practical steps to be taken, be formally approved, disseminated to all staff and audited on a regular basis.

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T1	How does the maternity unit encourage effective team working and communications	Staff Surveys	<p>Feedback from the Powys Midwives on statutory supervision was submitted as evidence. The feedback was the result of a suggestion box on display at Midwifery Update Days during 2005/06. The comments, where appropriate have been acted upon and target dates for completion have been set.</p> <p>Interview evidence suggests that there is good communication and teamworking across all areas of Powys and some reported that the Shire Monthly Meetings and ToolBox were very useful.</p>	
		Meetings	Minutes of meetings, such as the Women and Children's Directorate Meeting and Team Leader Meetings were reviewed. The topics discussed indicate communication and teamworking across maternity services in Powys.	
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>Guidelines for the Pattern and Content of Antenatal Care (2006), Referral for Additional Care (2006) and Home or Birth Centre against Medical / Midwifery Advice (2006) are in place. Each of the documents were clearly set out and each made reference to the other and any addition guidance to be adhered to. The recommendations and patterns of care for high and low risk women; inclusion / exclusion criteria; guidance for referral to consultant care and back to midwifery care are included. The documents were referenced and evidence based as appropriate. Interview evidence verified that staff were clear about the guidelines to be followed.</p> <p>The SAAT data indicates that the pregnancy records promote holistic assessment and joint planning of care along with the hand held pregnancy record, and is audited annually for the Welsh Risk Pool Standard.</p>	

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		Labour ward policies	Birth Centre policies were reviewed during the site visit. It was evident that the documents were developed by the responsible officer and approved by Women and Children's Directorate, Clinical Governance and Risk Management Committee and Senior Nurses. All documents were clearly identifiable and appropriately set out with dates of development and review dates (every 3 years). All documents were referenced appropriately. HIW found that staff knew how to access the policies, whether in offices or on the intranet and were especially aware of the dates for review.	
		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 all-Wales Clinical Pathway is followed as 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 documents above which give guidance on referral procedure, the Policy for the Emergency Transfer of Women during Antenatal, Intrapartum or Post Natal Period (2005) and Policy for In-Utero Transfer and Newborn Infants to Consultant Care (2005) are in place. Both documents give clear advice on what action is to followed when a deviation from the normal has been recognised, and what type of care should be implemented for the different groups. There is also a list of other policies to be referred to. It was noted however that only the Policy for the Emergency Transfer of Women during Antenatal, Intrapartum or Post Natal Period was referenced.</p> <p>We found that staff were clear about the referral mechanism and the processes to be followed.</p>	4. All policies should be clearly referenced and evidenced based.

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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 Powys LHB Midwifery Risk Management Procedure (2006) sets out the incident reporting and investigation process in maternity services, including a trigger list to identify what incidents should be reported.	
		Completed incident forms	Completed incident forms for the last two months were reviewed during the site visit. These identified that midwives are reporting a wide range of incidents, such as transfers, communication issues and baby death. Discussions with staff identify that staff feel comfortable to report incidents in that the organisation wants to learn from incidents rather than apportion blame.	
		Minutes of meetings and reports where incidents and trends are reviewed	Minutes from the Supervisor of Midwives Meeting and other meetings indicates that incidents are discussed and actioned. However it is not clear if maternity incidents (including trends) are collated and reviewed by a group on a regular basis.	5. All incidents (including trends information) should be collated, reviewed and action taken by a group on a regular basis.
		Examples of changes made	Examples of changes to be made as a result of incident reporting are evident from documentary evidence.	

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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	The Maternity Services Midwifery Practice Development Strategy 2005/2006 outlines the framework to help direct the investment in training and development in the maternity services in the LHB. The Midwifery Update Training Days include maternal and neonatal resuscitation and CTG Training. Staff also attend the local District General Hospital for updates on a regular basis. HIW found that 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.		Powys does not use CTGs as the service is midwifery led and if there are any concerns then women are transferred to the nearest consultant unit. But staff do have 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 to maintain their skills in interpreting CTGs. HIW found that staff had received CTG updates in the last 6 months.	
		Records of attendance and a system to ensure all staff attend	The Powys Midwives Training Database captures all midwives and the training they have undertaken and this is monitored and updated.	

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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 result of the second audit of the Better Birth Environment (2006) was submitted as evidence. The results confirm the findings of the National Childbirth Trust surveys (2003 and 2005) covering issues around the room in which women give birth.	
		Examples of changes made.	<p>Various examples submitted to demonstrate a commitment in involving user representatives on Groups - including the MUMs of Powys group and the Regional Maternity Services Committee. The MUMs of Powys is a group of parents and health professionals set up to monitor and help improve the provision of maternity care and the Regional Maternity Service Committee has a third of its members as users of the service and meets quarterly.</p> <p>Interview evidence demonstrated the staff were aware of user involvement across the different groups.</p>	
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>The LHB submitted patient information leaflets in relation to – Welcome to Powys Midwifery Service and Vitamin K.</p> <p>The Welsh Assembly Pregnancy Book and MIDIRS leaflets are also provided to pregnant women as appropriate.</p>	

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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>Audits of Record Keeping (Jan 2006), Welsh Risk Pool standard 15 (June 2006) and all-Wales Clinical Pathway for Normal Labour (2006) have been undertaken. Results of the audits are set out so that good practice and areas for improvement are identified. Actions and recommendations are also specified.</p> <p>The LHB submitted their Audit and Effectiveness Report 2005/06 that demonstrates a systematic process of regular audits. It also highlights how findings will be shared and acted upon in order that change is implemented.</p>	
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 LHB collects data in relation to:</p> <ul style="list-style-type: none"> - initial booking of women including the risk assessment and category of care to be given, place of booking, gestation at booking, referral and preferred place of birth. Information is then completed on postnatal discharge. - All Wales Clinical Pathway for Normal Labour. <p>Some of the changes reported as a result of this routine data collection includes reviewing the team caseloads and a change to guidelines.</p> <p>A recommendation relating to data collection and data sets will be discussed in the All Wales Thematic Report.</p>	

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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. We found that in general, the records were robust and the information securely stored and maintained.</p> <p>It was noted, however, that the healthcare professional could not be easily identified in over half of those reviewed.</p>	6. The health record should clearly indicate the lead professional.