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Maternity services: follow-up review

Hywel Dda Health Board

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Contents

Hywel Dda Health Board is making good progress in improving its maternity services; however meeting operational and strategic challenges requires stronger leadership and engagement by obstetricians.

Summary report	4
Detailed report	
Maternity services are a high priority, backed up by greater executive team engagement and clear midwifery leadership, although engagement of obstetricians needs to be strengthened	7
The Health Board is improving the evidence base to support service planning and performance management, but still lacks an effective organisation-wide maternity information system	8
The Health Board faces a number of challenges in deciding the future of its maternity services and although planning is well advanced, the strategic direction of maternity services is not yet clear	11
Safe and effective care is prioritised with staffing standards largely met, improved training and appropriate risk management, although there are particular concerns about neonatal capacity and facilities at Bronllais Hospital	12
The Health Board is improving the maternity care pathway, including better information provision and breast feeding management, although inconsistent practices and high Caesarean Section rates remain an issue	16
Appendices	
Recommendations from our 2009 Maternity Services in Wales report	21
Findings from local audit work in predecessor NHS trusts in 2007-08	22

Summary report

1. In June 2009, the Wales Audit Office published a national report entitled Maternity Services in Wales¹. That report was informed by our 2007-08 review of maternity services across Wales, from which we reported local audit findings to predecessor NHS trusts.
2. Our national report concluded that while maternity services were generally appropriate and women's satisfaction levels were relatively high compared with England, practices varied unacceptably and information was generally not well collected or well used. The report made a number of detailed recommendations; some aimed at the Welsh Government and others at local NHS bodies.
Appendix 1 provides a summary of our recommendations for health boards which addressed the following themes:
 - planning and performance management;
 - user engagement;
 - the provision of safe and effective maternity; and
 - the experience for expectant and new mothers and their babies across the pathway of care.
3. During 2008 we produced local reports on maternity services in the former Carmarthenshire, Pembrokeshire and Derwen, and Ceredigion and Mid Wales NHS Trusts. Overall, we found there were many positive aspects of maternity care and women were largely satisfied, but some aspects of care needed to improve across all of the three predecessor trusts. Many of the areas requiring improvement largely mirrored those identified within our national maternity report. Appendix 2 describes in more detail the conclusions from the three local reports.
4. We presented our national report to the National Assembly's Public Accounts Committee in July 2010 and the Welsh Government gave evidence in response to the report in November 2009. In February 2010, the Committee published its own Interim Report on Maternity Services. Then, in February 2011, the Committee took further evidence from the Welsh Government on the progress that was being made at a national and local level to improve maternity services. That evidence session demonstrated that while action is being taken, challenges still persist in some parts of Wales.

¹ The report can be accessed at:

http://www.wao.gov.uk/assets/englishdocuments/Maternity_services_eng.pdf

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5. Before the Public Accounts Committee returned to the topic in February 2011, we had already decided to undertake further audit work of our own. In April 2011 we undertook some follow-up work to examine whether Hywel Dda Health Board (the Health Board) can demonstrate improvements in the planning and delivery of maternity services in response to the various issues identified in our previous local and national reports.²
 6. We have concluded that Hywel Dda Health Board is making good progress in improving its maternity services; however meeting operational and strategic challenges requires stronger leadership and engagement by obstetricians. The reasons for reaching this conclusion are set out below.
 - Maternity services are a high priority, backed up by greater executive team engagement and clear midwifery leadership, although engagement of obstetricians needs to be strengthened.
 - The Health Board is improving the evidence base to support service planning and performance management, but still lacks an effective organisation-wide maternity information system.
 - The Health Board faces a number of challenges in deciding the future of its maternity services and although planning is well advanced, the strategic direction of maternity services is not yet clear.
 - Safe and effective care is prioritised with staffing standards largely met, improved training and appropriate risk management, although there are particular concerns about neonatal capacity and facilities at Bronglais Hospital.
 - The Health Board is improving the maternity care pathway, including better information provision and breast feeding management, although inconsistent practices and high Caesarean Section rates remain an issue.
 7. Our work has identified a number of areas that still require attention. These are shown below in Exhibit 1.

² Our audit work consisted of interviews with a number of key personnel at the Health Board and document reviews.

Exhibit 1

Key issues for the Health Board

Strategic direction

- Following the detailed maternity service planning discussions, the Health Board needs to quickly agree and widely consult on its future proposals.

Clinical leadership and engagement

- The absence of an overall Health Board-wide lead consultant obstetrician makes it more difficult to unify services, influence practice and drive better engagement within and across counties.

Maternity Information

- The absence of a maternity information system means that senior midwifery staff are using their valuable time to input and generate maternity statistics which is grossly inefficient. The Health Board now needs to quickly secure an effective information system that enables efficient collection and reporting of maternity information to support improved planning and performance management.

Performance management

- The current performance management framework and accountability arrangements are not supporting improved performance and are particularly weak in terms of influencing and changing consultant obstetrician practice.

User engagement

- Although a lot of progress has been made in securing user engagement, sustaining the momentum is key. Further, it will be important for the Health Board to realise the opportunities from this engagement by raising its importance amongst medical staff and ensuring that outputs and results are visibly used as key drivers for change.

Maintaining safe service

- Although a number of mechanisms have been put in place to support safe and effective maternity services, some gaps remain and the Health Board needs to ensure that it uses the findings within this report and this year's Welsh Risk Pool assurance review to strengthen its current arrangements.

Pathway of care

- We acknowledge that the drive to achieve normality of care against a backdrop of increasing complexity will be challenging. However, this report clearly identifies areas of practice that have not improved since our previous review. Inconsistent care management, high levels of ultrasound scanning and high Caesarean Section rates remain an issue.

Detailed report

Maternity services are a high priority, backed up by greater executive team engagement and clear midwifery leadership, although engagement of obstetricians needs to be strengthened

8. Maternity services have become a higher corporate priority for the Health Board than was evident previously for the predecessor NHS trusts. There is greater executive team engagement with the challenges facing maternity services and the Health Board has invested in maternity services against a backdrop of financial constraints. The Board sees maternity as one of its key challenges because of the potential political and public reaction to plans for service reconfiguration.
9. The Annual Operating Framework service improvement plan for maternity services 2010-11 was largely framed around the recommendations from our previous reviews and the monthly Local Delivery Plan progress report provides evidence of progress against our national recommendations. The action plans from the predecessor NHS trusts have also been brought together as one and are being used to track progress in various clinical and strategic fora, including the Health Board's Quality and Safety forum. Other reviews, such as the Welsh Risk Pool's (WRP) assurance work, are also drivers for change with improvement in performance evidenced as part of the 2011 WRP assurance assessment.
10. Senior midwives and some obstetricians were familiar with our reports and recommendations. The midwives in particular saw our reviews as providing a focus for assessing progress and improvement. However, junior midwives were less aware of the context provided by our previous work.
11. The Health Board has implemented an organisational structure which promotes clinical and medical engagement and leadership as key to the successful shift towards community based services. The Health Board has adopted a matrix structure comprising a three county model overlaid by nine clinical programmes and supported by a corporate structure. Within this structure, maternity services are situated within the Women and Children's clinical programme. The matrix model is designed to ensure operational responsibility and accountability to the centre, but local performance and delivery to the populations that each county area serves.
12. The Women and Children clinical director is a paediatrician and although each county has a lead obstetrician, the current structural arrangements mean that there is not an overall lead obstetrician for the Health Board as a whole.
The absence of a Health Board lead obstetrician makes it more difficult to unify services and influence and change consultant obstetrician practice. There is no forum to bring together the county lead obstetricians and there appears to be little dialogue between county obstetricians.

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13. Within each county, consultants attend various clinical fora and while county teams work well together within their own locality and with the rest of the maternity team, each obstetrician operates as an individual with no apparent focus on providing consistent care management
 14. The Health Board has appointed an Assistant Director of Midwifery and Safeguarding Children (ADM) to provide strategic and professional midwifery leadership. The ADM meets the Director of Nursing weekly with a monthly formal one to one meeting and provides the Chief Executive Officer and Director of Nursing with monthly updates. The ADM is supported by three county heads of midwifery services who meet on a regular basis. Although more progress is needed, these arrangements are proving successful in unifying and improving midwifery services across the Health Board and in driving forward a coordinated response to our recommendations from a midwifery perspective.
 15. However, consultant obstetricians are not accountable to the ADM and there is little evidence of mechanisms to ensure that consultant obstetricians are held accountable for their actions in terms of responding to recommendations.
 16. Lead consultant obstetricians appraisals are undertaken by the Associate Medical Directors (AMD) for each county and each lead consultant obstetrician complete their peer appraisals. We found no clear evidence to show that the current structural and performance management arrangements are influencing and changing consultant obstetrician practice.

The Health Board is improving the evidence base to support service planning and performance management, but still lacks an effective organisation-wide maternity information system

Effective information systems are not yet in place to support maternity service planning and performance management

17. The Health Board is in the process of unifying its information systems to the Myrddin system patient information system. This includes the installation of the Myrddin maternity system. The Carmarthen change to the Myrddin maternity system, completed in early 2010, was relatively straightforward. However, the changeover at Withybush Hospital, initially in September 2010, has been extremely problematic. There has been a perceived lack of support for staff and training during the change and there have been difficulties accessing the system and arranging patient appointments. The Health Board is taking action to address the identified problems and the lessons learnt will be used to inform implementation of the Myrddin maternity system at Bronglais Hospital which is due to be completed soon.

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18. The Health Board is also planning to use the Information Reporting and Intelligence System (IRIS) which will link to the Myrddin system. This system allows viewing of several types of information including financial, corporate and performance reporting and senior information managers report it to be a powerful tool. The Pembrokeshire county Head of Midwifery has been nominated as the key liaison and lead for information in respect of maternity services.
 19. The Health Board uses a maternity Dashboard which is broadly based on the Royal College of Obstetricians and Gynaecologists Maternity Dashboard: Clinical Performance and Governance scorecard. Currently the Dashboard is in its infancy and is not being used to inform and improve performance.
 20. The absence of robust information systems means that the Dashboard is populated retrospectively with the data used to populate the Dashboard taken from different electronic and paper sources. Work is underway to develop a maternity data set and this will be used to inform and drive the maternity Dashboard. The Dashboard has been expanded to include local performance measures, for example, escalation and staffing issues. Also work is underway to align it with the new information systems to allow automatic population of the Dashboard. This will reduce pressure on the senior midwives who currently manually input the data which is not efficient use of their time. Improvements in the way data is collected and reported will allow better reporting of maternity performance at Quality and Safety Committees and to the Board.

A demand mapping exercise led by senior midwives has made a valuable contribution to service planning

21. The ADM has led a large scale project, mapping capacity and demand for maternity services across the three counties. The aim of this exercise has been to inform the future redesign and modernisation of maternity services. The mapping has identified birth rates, the types of birth interventions and the choices offered to women. It shows maternity flows into and out of the Health Board including those coming to receive maternity services from Powys and South Gwynedd and those going to Swansea to receive maternity services. Due to the lack of good information, the exercise was manual using postcodes and birth ledgers. Although time consuming, this exercise provided valuable information to support service planning.

Although many initiatives are still at an early stage, the Health Board can demonstrate a commitment to seeking the views of users to inform service provision

22. The Health Board has put in place a Maternity Service Liaison Committee (MSLC), as required by the Welsh Government. The Committee was created in late 2010 and meets quarterly. Six sub groups have also been created to support and inform the Committee which include:
- user experience;
 - user information;
 - user environment;
 - promoting normality / understanding intervention;
 - infant feeding; and
 - antenatal education.
23. The purpose of the MSLC is to advise the Health Board on the maternity services provided for its residents and to make sure the views of women using the service are taken into account when planning, developing and running maternity services across the Health Board.
24. There is broad membership including midwives, obstetricians, GP representation, a paediatrician, anaesthetist and a voluntary sector and Community Health Council representative. The Committee is chaired by a service user and 12 other service users have been co-opted onto the committee. Senior midwives state that it has been difficult getting consultants to attend and to see the committee as valuable. Securing user representation, particularly fathers has been challenging and sustaining the momentum of user involvement in the Committee and sub committees is seen by senior midwives as a significant challenge.
25. A number of other approaches to user engagement are in place or under development and consideration. The approaches include:
- Patient diaries have been developed, drawing on the questions contained within the women's maternity satisfaction survey that we undertook to support our previous audit work. Letters are also sent to women offering them an opportunity to speak of their experience or to use a tape. The approach already successfully piloted in Ceredigion is to be rolled out across the Health Board.
 - Patient satisfaction postcards have been developed and will be placed at the end of all beds.
 - In addition to the MSLC, there is a patient experience group which is jointly led by the Assistant Director of Midwifery and a user, this group considers specific issues experienced by women.
 - Discharge interviews are being undertaken for all women discharged from the hospital and the maternity service.
 - Obtaining the users perspective as part of the Fundamentals of Care Audits.

The Health Board faces a number of challenges in deciding the future of its maternity services and although planning is well advanced, the strategic direction of maternity services is not yet clear

- 26.** The Health Board covers three local authority areas. The rural nature of and wide geographical area within the areas covered, present a number of service delivery and planning challenges in terms of accessibility and travel time. These are further compounded by the absence of an obstetric led service in Powys and the proposed loss of obstetric led service services in Hereford and Shrewsbury. In addition, the Health Board faces challenges in providing neonatal care in each of its units for those babies who needed specialised care. The majority of babies receiving neonatal care will have been born prematurely. Neonatal units require specialist equipment as well as staff with specialist skills. Neonatal care facilities are classified as level one, two or three depending on the type of care they provide. Wales in general has experienced challenges with matching neonatal capacity with demand and even though the Welsh Government has invested in neonatal services, many challenges remain.
- 27.** The Health Board is developing a five year strategic plan and a key strand in its development has been the use of clinical 'Think Tanks'. Seven have been established to engage with clinicians and inform the strategic direction. For each clinical area, clinicians are presented with all the key demand factors and constraints such as finances and skills shortages facing their service. Clinicians have been asked to examine their current service and to consider what a future service could look like. The aim being to identify a service that delivers quality, safety, and value for money and thereby establish a blueprint for change that has the support of all. Obstetrics and maternity services were included within the Women and Children Programme Think Tank and were informed by the maternity mapping exercise mentioned in paragraph 21. The process was completed in May 2011 and the various options were discussed at a key stakeholder event. As yet the future strategic direction has not been clarified.

Safe and effective care is prioritised with staffing standards largely met, improved training and appropriate risk management, although there are particular concerns about neonatal capacity and facilities at Bronglais Hospital

Midwifery staffing arrangements have improved although there are still some gaps in terms of overall staff numbers, skill mix and training, and consultant job planning is not consistent

28. The Health Board has yet to fully address the BirthRate Plus (BRP) recommendations but has workforce plans in place to address the deficits in a phased approach. The models of service provision are being defined before committing to staffing which may alter the opportunities to modernise services. Since the last report there has been a substantial investment by the Health Board at both midwifery and health care support worker level in all three counties to reduce the deficit.
29. The current deficit is approximately six whole time equivalent qualified staff. Although senior midwives felt that this shortfall was not having a direct impact on clinical care they recognised that it was having a negative impact on supporting functions, for example supervision, training and development. Some supervisors commented that it was difficult in some instances to find protected time to undertake the role fully. The Health Board is working in partnership with BirthRate Plus to consider the models of care for the future which will be the driving and influencing factors that determine the workforce requirements in the longer term.
30. As noted in our reports to the Health Board's predecessor NHS trusts, a significant number of senior midwives were due to and have retired over recent years. All areas have recruited to the vacant posts but largely with newly qualified staff as common with the rest of Wales there is a shortage of Band 6 midwives. This has, as a result, affected the overall skill mix.
31. The Health Board has appointed community team leaders in Carmarthen and Pembrokeshire aimed at empowering their team to drive the service and find solutions. They will focus on normality³, meaning midwifery led care supported by obstetricians where required. A lot of time and money has been invested in terms of appointments, support and training. Community team leaders have been used successfully for some time in Ceredigion.

³ Over the last three decades, care in pregnancy and labour has undergone significant changes. One consequence of these changes has been that midwives, doctors and childbearing women have become more dependent on technology in labour and birth. The Royal College of Midwives defines normal childbirth as one where a woman commences, continues and completes labour physiologically at term. The majority of women with uncomplicated pregnancies are fit and healthy and have the potential to give birth normally with healthy newborns as the expected outcome.

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- 32.** There are few apparent obstetrician capacity constraints but consultant job planning could be used more effectively, with some consultants expressing concerns about inequities in matching capacity and demand. Some parts of the Health Board appear to be adopting a less timely approach to the completion of job plans, with particular gaps reported in Carmarthen. The Health Board recognises that its current approach to job plan reviews is not yet sufficiently robust, as reflected in our recent local audit work on the consultant contract.
 - 33.** Consultants report a clear split between Obstetrics and Gynaecology activities but no evidence was provided to support this. Consultants report that the required⁴ 40 hour labour ward consultant presence is met. However, the guidance actually requires that consultant obstetricians be present on the labour ward and as none of the Health Board's obstetricians are able to do this, they do not fully comply. The consultants stated that they are available to respond quickly and were of the view that with their available resources basing themselves on the labour ward would not be good use of their time. Senior midwives confirm that this arrangement does not present a problem.
 - 34.** The Health Board has invested in a number of senior posts to improve training. In Carmarthen a practice development midwife has been appointed and although focused within that county the post holder links across the other counties which helps to promote a unified approach. The practice development midwife also helps train junior doctors. A training coordinator has also been appointed for Pembrokeshire and also currently provides support to Ceredigion which has helped to develop working relationships and networking.
 - 35.** There is a rolling programme of training for midwives and the required clinical skills training is reported to be complete. Other training such as the Free to Lead development programme for Band 7 midwives is undertaken. There is evidence of an increasing focus on dignity and respect training with midwives invited to attend study days and the Health Board has developed an e-learning Dignity and Respect tool. However, delivering mandated training is proving difficult due to staffing constraints and is more problematic in Pembrokeshire and Ceredigion.
 - 36.** The value of Maternity Care Workers has been widely recognised. Twelve Maternity Support Workers, four from each county, have been funded to complete the all-Wales training for Maternity Care Workers.
 - 37.** For obstetricians there are regular dedicated mandated training sessions with regular skills and drills training in all counties.

⁴ Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health, October 2007

Neonatal capacity constraints and the Bronglais Hospital maternity facilities present particular operational risks

38. The maternity services' physical capacity is broadly appropriate to meet demand, but this is not the case for neonatal services. Each unit routinely uses an escalation tool to assess any mismatch between capacity and demand. However, neonatal physical capacity and the associated staffing capacity can, at times, result in closure of some of the maternity units.
39. There are significant neonatal capacity constraints and challenges. The mismatch between capacity and demand mean that babies and their mothers are regularly transferred across South Wales and further. The Health Board does not have the highest level neonatal service, level 3, which is provided at Swansea. Carmarthen and Withybush work to level 2 but neither fulfil the requirements of level 2. The demand is such that the Carmarthen neonatal unit is frequently closed. Bronglais Hospital does not have a neonatal service but if required, provide short term neonatal care until transfer arrangements can be made.
40. The absence of a dedicated neonatal unit at Bronglais Hospital means that if a neonate is admitted, the maternity unit closes. To reduce risks it has been agreed that any women presenting a risk of a neonatal birth should be planned for delivery elsewhere. However, this does not reduce the risk from unexpected early deliveries which then also places increased pressure on the Health Board's other units. It is widely recognised by health boards across Wales that a strategic long term solution is required to the provision of Welsh neonatal services.
41. Although the Welsh Government has invested in a number of positive neonatal service improvements since January 2011, these only ease but do not resolve the problems for the Health Board. The improvements include the new fast response neonatal transport service for South Wales implemented on 5 January which is run by the all-Wales neonatal network. The service runs from 8am-8pm but for Bronglais, due to the geography and travel distances the service is between 10am-6pm. A new clinical information system, Badgernet, went live in January. It standardises clinical information collected for all babies requiring special care through hospital stay. The neonatal cot locator in Cardiff is seen as a good improvement as it means that staff no longer have to ring around hospitals locating a neonatal cot but the absence of links to maternity bed capacity mean that clinical staff still have to ring around to ensure there is a maternity bed.
42. While maternity facilities in Carmarthen and Withybush are deemed appropriate for the provision of safe care, senior midwives were of the view that the labour ward environments in all units were very clinical and did not provide a user friendly and 'homely' environment as recommended by the National Childbirth Trust's Better Birth Environment campaign.

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43. There are a number of concerns about the Bronglais Hospital facilities which are identified within the Health Board's risk register. The location of the theatres and the non designation of an emergency theatre at Bronglais Hospital in the event of an emergency Caesarean Section (CS) is an ongoing area of concern. As a result the Health Board is not always able to meet the 30 minute decision to incision target for emergency CS as defined within the National Institute for Health and Clinical Excellence (NICE) guidelines. The other main area of concern is about difficulties in providing dignity and privacy on the ward.
44. The Welsh Government's Chief Nurse has requested that all health boards develop an equipment inventory and we recommended that the inventory be available in all maternity units. An inventory would raise awareness of equipment needs with all staff and would support improved asset management. While there is no evidence of the Health Board having developed such an inventory, there are no significant concerns about equipment other than in Bronglais Hospital where some equipment was reported to be old.

The Health Board has put in place a number of mechanisms to improve safety and risk management

45. There are a variety of mechanisms on place to support safe and effective care and effective risk management. These include:
- The Health Board wide Quality and Safety Committee which is informed by county quality and safety committees.
 - Monthly labour ward forums within each county. These meetings are used as a forum where clinicians discuss incidents reported through the DATIX reporting system and provide opportunities to learn lessons.
 - There are good incident reporting mechanisms including a single trigger list for reporting untoward incidents, and a cross check of maternity information against DATIX to ensure all incidents are reported. Where an incident is not reported the senior midwife writes to the individual member of staff concerned. However it is acknowledged that within Pembrokeshire, there are DATIX entry backlogs as a result of work pressures and the learning loop is not always closed.
 - Monthly 'Mortality and Morbidity' meetings for clinicians within each county. Audit attendance at the Ceredigion Perinatal mortality meeting demonstrated a clear multi disciplinary approach with midwives and medical staff presenting the cases and debating the issues in a constructive way.
 - A comprehensive clinical audit programme.
 - Use of the Modified Early Obstetric Warning Score system. This is a national system involving a score chart for all pregnant or post natal women intended to identify sick women and initiate action at a time when treatment might make a difference.

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- Participation in the 1000 lives plus Transforming Maternity Services Mini Collaborative. The focus of the work is on improving recognition and response to deteriorating women and reducing the risk of deep vein thrombosis.
46. However, although underway the integration of policies from the predecessor organisations is reported by a number of staff to be slow.

The Health Board is improving the maternity care pathway, including better information provision and breast feeding management, although inconsistent practices and high Caesarean Section rates remain an issue

Antenatal processes and information provision have improved but inconsistent practices and high levels of scanning remain an issue

47. Our national report recommended that health boards should provide locally accessible community locations where women can access a midwife. While community midwives seek to be first point of contact for pregnant women, some women initially visit their general practice before being signposted to a midwife. Where the midwife is based in a practice or health centre, working alongside General Practitioners (GPs), then it is more likely that their role will be understood and they will be the first point of contact. However, relationships with general practice in parts of the Health Board are not good, with some Ceredigion and Pembrokeshire GPs stopping midwives from using their facilities.
48. Because of midwives' involvement with women throughout their pregnancy, GPs generally have a much smaller role to play in caring for these women. However, the Health Board is committed to improving GPs' understanding and involvement in maternity services with GP representation on the Women and Children Programme and on the Maternity Service Liaison Committee. Information from these committees is shared through the GP forum. The midwifery community team leaders have completed a 'normality' training module which has been jointly designed with the University of Wales, Swansea. The aim is to enhance skills and knowledge to enable the team leaders to support their team colleagues and women in providing and receiving Midwifery Led Services through their pathway of care.
49. Specialist midwives have been appointed in Carmarthen and Pembrokeshire to provide dedicated antenatal support to women who have specific social support needs. Such posts are seen as key to the success of meeting the public health agenda but there is concern that the funding is short-term and that the posts may be lost in the future.

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50. The new all Wales patient hand held maternity records, that spans the three main areas of clinical care, antenatal, intrapartum and postnatal, was heavily criticised by a number of the obstetricians. The Health Board will formally communicate concerns through the feedback mechanisms put in place by the Welsh Government.
 51. Considerable progress has been made in improving the provision of antenatal education. A Ceredigion senior midwife developed the Antenatal Education for Parents project aimed at improving the standard of antenatal education classes offered to expectant mothers and their families. The resultant Parentcraft classes are available in seven venues across the counties with some offering access outside standard working hours, including on Saturdays and in the evenings. Information is also available via the internet including a helpful virtual tour of all three maternity units and information on the Parentcraft programme. In addition, an information leaflet has been developed for fathers and work has been undertaken to encourage fathers to talk to expectant fathers. User feedback is actively encouraged and outputs from the above developments are regularly discussed within one of the Maternity Service Liaison Committee subgroups.
 52. The Health Board has undertaken a lot of work aimed at reducing variation in care management. A review of antenatal clinics and processes has just been completed and the findings recognise that further work is required to reduce inconsistency. By way of example, inconsistent advice by obstetricians in Pembrokeshire has resulted in three complaints.
 53. There remain concerns about the high levels of scanning reported in our previous local reports. Although no specific figures were provided, senior midwives felt that scanning rates have increased. There was little evidence to suggest that consultants intend changing their practice and consultants openly admit scanning women each time they are seen in clinic as they do not consider these to be formal scans. The Health Board has not audited ultrasound scanning practices.

Work is underway to increase normality but labour remains interventional with high CS rates

54. Home birth rates have increased since our last review with rates on average between five and eight per cent of all births. However, with some Health Board areas achieving higher rates, work is underway to understand the differences and improve the overall rate of home births.
55. Senior midwives confirm that one to one care in labour is maintained through the use of the escalation policy to assess whether staffing levels are 'safe' to support the labour ward. However, maintaining safe staffing levels on the labour ward can result in the cancellation of training or depletion of staff resources for postnatal activity.

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56. Although a lot of work is underway to promote normality there is still some way to go to achieving its aims. The Health Board reports increasing numbers of women presenting to maternity services that are obese or have diabetes. This makes care management more complex and as a result makes achieving normality more difficult. But there are also other factors that have a negative impact, for example the physical environment and obstetric practice.
57. In terms of the physical environment, on page 43 reference is made to the fact that the labour wards are not user friendly and do not provide a homely environment,
58. At the time of our previous local reports in 2008, care and treatment was considered interventional with high CS rates. The Health Board is using a traffic light system to monitor CS rates against a goal of 23 per cent and a 'red flag' rate of greater than 25 per cent. Within Wales the Welsh Government has not set a target rate but health boards are required to demonstrate significant reduction in rates and to demonstrate that they have put processes in place to reduce rates.
59. The Health Board has put in place a number of measures aimed at reducing CS rates. In June 2010 the Health Board implemented the Caesarean Section Tool Kit which had been developed by the NHS Institute for Innovation and Improvement aimed at reducing CS rates. The Tool Kit is intended as a multidisciplinary tool and as well as the midwives some of the Health Board's consultants have been involved in its use and implementation. Also, the VBAC (vaginal birth after Caesarean) Pathway is being used in an attempt to reduce CS rates, with letters sent to mothers who have recently delivered by CS. The opportunities for improving CS rates through the use of the VBAC pathway can only be realised at the next pregnancy.
60. Despite these efforts, the data suggests that CS rates are still high. CS rates for the 12 months to 30 April 2011 were as follows:

Exhibit 2: Caesarean section rates across the Health Board in 2007 and 2011

Hospital location	2007	2011 (May 2010 – April 2011)
Bronglais Hospital, in Ceredigion	26	27.7
Withybush Hospital, in Pembrokeshire	27	25
Glangwili Hospital, in Carmarthen	25	29

Source: Wales Audit Office and Hywel Dda Health Board

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61. Monthly level monitoring and reporting of intervention includes induction of labour, instrument delivery and CS rates. The CS rates are reported as planned, unplanned and total by each county but are not reported by individual consultants, and consultants state that they do not know their own rates. This is despite six monthly multi-disciplinary audits on the CS rates with findings discussed at the labour ward forums.
 62. Consultant obstetricians stated that there are a number of factors leading to the higher rates including medico-legal concerns, demand from women and newer consultants being less experienced in breech management. Our review suggests that the measures put in place to reduce CS rates may not be working due to difficulties influencing change, limited peer pressure, an absence of individual accountability and few corporate drivers for change.

Arrangements for postnatal care have improved, particular in terms of breast feeding management

63. The Health Board has approved a postnatal care policy and pathway aimed at improving and unifying care management. A number of mechanisms are in place to assess performance including: postnatal satisfaction assessed through discharge interviews of women; complaints monitoring and trend analysis; and Fundamentals of Care audits undertaken in all three units in the past two years. No areas of concern have been identified but patient satisfaction will also be an area for consideration in the MSLC sub group.
64. Great strides have been made in improving breast feeding. The Health Board is working towards Baby Friendly Status with Phase 1 UNICEF Baby Friendly accreditation⁵ achieved and plans for phase 2 to be achieved by June 2012.
65. The Health Board has appointed an infant feeding coordinator who, despite only being in post for a short time, has had a positive impact. The coordinator's work has included delivery of a training programme for a wide range of professionals including midwives, Maternity Support Workers, Health Visitors, paediatricians and special baby care staff. Post-training audits of breastfeeding knowledge are undertaken with further support provided if the score is low followed by a re-audit. The success of this training is demonstrated by the results from this audit work. For example, in a baseline audit of midwives' skills in expressing milk all staff scored zero per cent. Post-training, all staff achieved a score of 100 per cent.

⁵ The Baby Friendly Initiative works with the health-care system to ensure a high standard of care in relation to infant feeding for pregnant women and mothers and babies. Support is provided for health-care facilities that are seeking to implement best practice, and an assessment and accreditation process recognises those that have achieved the required standard.

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- 66.** Midwives' knowledge and understanding of breastfeeding is also enhanced by the display of easy to read and user friendly posters and the use of a 'crib' list that they can wear around their neck. The breast feeding rates are actively monitored. There are also information leaflets and DVDs for mothers and staff to use as well as breast feeding peer support groups.
- 67.** Our previous local reports highlighted the high average numbers of postnatal visits per mother with the higher than average number thought to be as a result of pattern of working rather than actual need. The number of visits is monitored monthly by community team leaders and audited by team leaders and supervisors of midwives on a six-monthly basis. Our previous local and national reports were deemed helpful in highlighting the need for intervention to reduce and rationalise the number of postnatal checks and to focus on the quality rather than the quantity of checks. Most areas are now providing an average of three visits which is close to half that previously reported.

Appendix 1

Recommendations from our 2009 *Maternity Services in Wales* report

Our *Maternity Services in Wales* report recommended that health boards should:

- Effectively plan and performance manage their maternity services. Appropriate information systems were required to enable systematic recording and analysis of maternity services to inform planning and to support performance management.
- Put in place measures to improve user engagement and to gather the views of their users to improve the user experience and inform planning. This included user representation on maternity forums and through surveys.
- Put in place processes and mechanisms to ensure the provision of safe and effective maternity care through the pathway of care. This included ensuring that maternity services have the appropriate number of adequately trained staff, facilities and equipment. It also included promoting a culture of openness and putting in mechanisms to support learning from incidents.
- Put in place measures to improve the experience for expectant and new mothers and their babies across the pathway of care:
 - during the antenatal phase, ensure timely access to midwives, improve the ways in which women make informed decisions about their pregnancy and care, ensure the appropriate number of checkups and scans, and where required improve access to and attendance at antenatal classes;
 - during labour, ensure continuity of care, reduce variation in management of care and take measures to reduce unnecessary Caesarean Sections; and
 - during the postnatal phase, improve women's satisfaction with their postnatal care, provide consistent and better support for women to breastfeed and ensure that the appropriate level of support and care is provided to new mothers.

Appendix 2

Findings from local audit work in predecessor NHS trusts in 2007-08

During 2007-08 we undertook and reported on maternity services in the former Carmarthenshire, Pembrokeshire and Ceredigion NHS Trusts. The overall conclusions from that work are summarised below.

Carmarthenshire NHS Trust

While mothers were generally very satisfied with maternity services and outcomes compared well, we concluded that the Trust could do more to develop midwifery-led services and that some aspects of service provision and practice could be further improved:

- the overall management framework and culture was supportive, but strengthened arrangements for some aspects of training were needed to ensure that care was as safe and effective as possible;
- while sufficient overall staffing existed, capacity and demand were not well aligned for delivery and neonatal facilities, with high incidence of neonatal unit closures;
- women's satisfaction and compliance with NICE guidelines were comparatively high although there was scope for rebalancing towards more midwifery-led antenatal care;
- care during labour was interventional but outcomes compared well and confidence levels amongst mothers and staff were good; and
- despite good levels of postnatal support, more mothers and babies were re-admitted than would be expected (although numbers were small).

Pembrokeshire and Derwen NHS Trust

The Trust provided a maternity service that achieved generally good levels of user satisfaction although there were a number of areas that had to be addressed to ensure high quality and cost effective services:

- a supportive culture had been fostered within the unit and there were high levels of satisfaction from women, although we concluded that increasing staff training and Criminal Records Bureau checks would reduce the risks to mothers and babies;
- the unit had adequate delivery capacity and was relatively well staffed but there were constraints on neonatal capacity and the high levels of antenatal admissions and their longer lengths of stay may have been increasing service costs;
- there was scope to rebalance the antenatal workload to ensure the most appropriate level of care for mothers and better use of resources;
- there was a high level of intervention during childbirth and the relationship between these interventions and some of the outcomes for mothers and babies required further analysis; and

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- there was frequent postnatal contact between mothers and midwives that might have been driving higher levels of readmission than would be expected, while more than one in three mothers felt they were not treated with respect and understanding.

Ceredigion and Mid Wales NHS Trust

Mothers reported high satisfaction with maternity services, although we concluded that the Trust could do more to develop midwifery-led services and that some aspects of service provision and practice could be further improved:

- there was a supportive culture within the maternity service but there were some gaps in core training;
- staffing and physical capacity appeared adequate, however consultant presence on delivery suites needed to be reviewed and we concluded that there may have been opportunities to use beds more efficiently;
- women's satisfaction and compliance with NICE guidelines were comparatively high although there was scope for rebalancing towards more midwifery-led antenatal care;
- there were a number of both positive and negative aspects of care and management during and shortly after birth and there are opportunities to improve women's satisfaction and potential outcomes; and
- women felt supported in feeding and caring for their baby and there are more postnatal visits than in many other trusts.



WALES **AUDIT** OFFICE

SWYDDFA **ARCHWILIO** CYMRU

Wales Audit Office
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@wao.gov.uk

Website: www.wao.gov.uk