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Maternity services: follow-up review

## **Betsi Cadwaladr University Health Board**

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# Status of report

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The team who delivered the work comprised Mandy Townsend and Tracey Davies.

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## Summary

1. In June 2009, the Wales Audit Office published a national report entitled *Maternity Services in Wales*<sup>1</sup>. 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 Conwy and Denbighshire, North East Wales, and North West Wales NHS Trusts<sup>2</sup>. We found there were many positive aspects of maternity care and women were generally quite satisfied, but some aspects of care needed to improve across all three 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.

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<sup>1</sup> The report can be accessed at:

[http://www.wao.gov.uk/assets/englishdocuments/Maternity\\_services\\_eng.pdf](http://www.wao.gov.uk/assets/englishdocuments/Maternity_services_eng.pdf)

<sup>2</sup> In 2008, Conwy and Denbighshire and North East Wales NHS Trusts merged to form North Wales NHS Trust.

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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 May 2011, we undertook some follow-up work to examine whether Betsi Cadwaladr University 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<sup>3</sup>.
  6. We have concluded that there is evidence that the Health Board is making good progress in improving its maternity services although further work is required and momentum needs to be maintained. The reasons for reaching this conclusion are set out below:
    - maternity services are a high priority with good executive engagement and strong clinical leadership, but new management structures are still developing;
    - the Health Board has improved the evidence base for service planning and performance management, but still lacks an effective information system and there are several challenges in developing detailed plans for service change;
    - the Health Board has put in place better safety processes and has increased staffing levels, but there are still some midwifery and neonatal capacity gaps; and
    - the Health Board has a clear focus on improving the maternity care pathway, although inconsistent practices and high Caesarean section rates in some areas are still a concern.
  7. Our work has identified a number of areas that still require attention. These are shown below in [Exhibit 1](#).

### **Exhibit 1: Key issues for the Health Board**

#### **Key issues**

##### **Strategic direction**

Completing the Women's and Children's service review process within the defined timescales. Securing agreement through wide engagement will be critical to the successful implementation of the future maternity strategy.

##### **Management arrangements**

The slow pace of change around middle and lower management arrangements is causing uncertainty. The Health Board should ensure that management structures are finalised by the end of 2011.

##### **Performance management**

The current performance management framework and accountability arrangements are not yet driving improved performance and particularly need to link to consultant job planning to influence and change consultant obstetrician practice.

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<sup>3</sup> Our audit work consisted of interviews with a number of key personnel at the Health Board, focus groups, document reviews and site visits.

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## Key issues

### 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.

### User engagement

Although a lot of progress has been made in securing user engagement, sustaining the momentum is key. The Health Board must continue to use the opportunities from this engagement to raise its importance and ensure that outputs and results are more visibly used as key drivers for change.

### Maintaining safe services

Although a number of mechanisms have been put in place to support safe and effective maternity services there remain some capacity gaps, especially in neonatal services, and the Health Board needs to ensure that it delivers the planned changes in midwifery staffing, and 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 and Caesarean section rates remain an issue.

## Maternity services are a high priority with good executive engagement and strong clinical leadership, but new management structures are still developing

8. The Health Board's maternity services are a corporate priority. The Health Board sees maternity as one of its key challenges because of the potential political and public reaction to plans for service change. Reviews of Women's and Children's services have been prioritised and should be completed in 2011.
9. The Health Board's organisational structure is based on an inverted triangle with a 'small' corporate function supporting the strategic and operational delivery of clinical care through 11 Clinical Programme Groups (CPGs). Each CPG is led by a chief of staff, who is a clinically qualified practising professional. Chiefs of staff are responsible for managing the delivery of safe and high-quality services and act as advocates for their portfolio of clinical specialties. Each chief of staff is accountable to an executive director, and have established CPG level boards to manage their services.

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10. The Chief of Staff for the Women's and Maternity Services CPG (the CPG) is an obstetrician, supported on each acute site by clinical directors, and by an Associate Chief of Staff (Operations) and Associate Chief of Staff (Midwifery and Nursing). Together, they are starting to influence and change consultant staff clinical practice. A job planning pilot is underway within the CPG, intended to address an inherited variation in job plans, with no outcome or activity measures in place.
  11. The Associate Chief of Staff for Midwifery and Nursing is the strategic and professional midwifery lead. She is supported by two heads of service responsible individually for inpatient and outpatient care. The Associate Chief of Staff provides monthly updates to the Director of Nursing, Midwifery and Patient Services, and has direct access to the Chief Executive as required.
  12. The three areas – west, east and central focused around the acute hospitals of Ysbyty Gwynedd, Wrexham Maelor and Glan Clwyd – are starting to come together through the CPG structure. But progress in agreeing permanent management structures and filling posts substantively has been slow. The midwifery structure below Tier 4 has now been agreed by the executive team, and the process to fill substantive posts has started. The management structure under the Associate Chief of Staff (Operations) is still under discussion.
  13. The Annual Operating Framework improvement plan for maternity services 2010-11 is largely framed around the recommendations from our previous work. The Local Service Plan<sup>4</sup> (LSP) is also used to report progress against our recommendations to the Health Board and Welsh Government. All of this, plus action plans from the predecessor NHS trusts, as well as local operational requirements have been incorporated into the CPG's operational plan. The CPG Board is the main forum within which the operational plan is considered and it appears to be driving and co-ordinating progress effectively.
  14. The senior midwives and the obstetricians we spoke to were familiar with our previous reports and recommendations. The senior midwives in particular saw our reviews as providing a focus for assessing progress and improvement. Junior midwives were less aware of our previous work. Other reviews such as the Welsh Risk Pool's assurance work are also drivers for change with improved performance evidenced this year (now 95 per cent compliance with Welsh Risk Pool standards compared to an average of 65 per cent across predecessor NHS trusts in 2008).

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<sup>4</sup> The LSP is an action plan outlining the actions being taken by the Health Board to improve a specific service in line with external review recommendations and other national requirements.

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**The Health Board has improved the evidence base for service planning and performance management, but still lacks an effective information system and there are several challenges in developing detailed plans for service change**

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

**The Health Board now has good information on the performance of maternity services, but achieving this without an effective organisation-wide information system is very resource-intensive**

15. The Health Board now has appropriate processes in place that provide the required information to support effective planning and service management. However, in the absence of IT systems these information-gathering arrangements are resource-intensive and require significant investment of senior clinical time. The Health Board is intending to implement the maternity module that forms part of Myrddin Patient Administration System, but the timescales are not yet clear. Implementation of the maternity module has not been without its problems elsewhere. Given these problems, successful implementation requires staff training and support, as well as sufficient access to the system. In the interim, different information systems are in place in different locations, so substantial manual data collection and intervention is required.
16. The CPG uses a maternity dashboard which is broadly based on the Royal College of Obstetricians and Gynaecologists *Maternity Dashboard: Clinical Performance and Governance Score Card*. Currently the data to populate the dashboard are taken from different sources, both electronic and paper. Consistent definitions agreed across the Health Board now provide information for a maternity dataset, 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 information systems to allow automatic population of the dashboard. This will reduce pressure on the senior midwives who currently manually input the data. Whilst the dashboard is produced monthly and discussed at a CPG level, only some of the indicators are reported through the Finance and Performance Committee to the Board.

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17. In terms of changing practice the dashboard is used to stimulate discussion and identify actions. The dashboard is also widely discussed at labour ward forums and quality and safety meetings at CPG level, but it is not used to inform consultant job plan reviews.

### **The Health Board now has a much improved understanding of its maternity service capacity and demand**

18. With support from the corporate planning and public health directorates, the CPG has led a large-scale project mapping maternity services across the whole of North Wales, including bordering counties both in Wales and England. The aim was to inform the future redesign and modernisation of maternity services. The mapping exercise identified birth rates, the types of birth interventions and the choices offered to women. It also shows maternity flows for Powys and from South Gwynedd. The results are being used to inform the overall strategic direction for maternity services, and underpin the Health Board's strategic intention to maintain and develop three maternity units.

### **User engagement is taken seriously with a number of mechanisms in place or under development to inform service planning and delivery**

19. The Health Board has in place a Maternity Service Liaison Committee (MSLC), as required by the Welsh Government. 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. There is broad membership including several users, midwives, obstetricians, a General Practitioner (GP) representative, and neonatal and anaesthetic representatives. There is also a voluntary sector representative and a representative from the Community Health Council. The committee is chaired by one of the Health Board's independent members. The group was set up late 2010 and meets bi-monthly. While users have been actively engaged to date, sustaining the momentum of user involvement is seen as a significant challenge.
20. A number of other approaches to user engagement are in place, or at an advanced stage of development. The CPG is drawing together themes from the output of user engagement into a single report. The approaches include:
- Patient satisfaction postcards developed and available throughout all the Health Board's sites.
  - Regular focus groups with mothers organised and led by a non-clinical staff member. These are held on a six-monthly basis and based within individual localities. Attendance is variable but all localities get sufficient attendees (at least six mothers) to make the sessions worthwhile.
  - A patient satisfaction survey is given out to all mothers with the results analysed on a monthly basis.
  - Midwives undertake discharge interviews with all women discharged from the hospital and maternity service.

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## **The Health Board faces a number of challenges in deciding the future of its maternity services and is still developing detailed plans for service change**

- 21.** The Health Board covers six local authority areas. The rural nature and wide geographical area present a number of service delivery and planning challenges in terms of accessibility and travel time. For example, travel time for mothers who live in South Gwynedd can be up to two hours. The absence of an obstetric-led service in Powys and the planned loss of obstetric-led services in Shrewsbury present further challenges. The Health Board clearly understands patient flows, and how these will need to change to support three units safely over the medium term.
- 22.** In addition, the Health Board faces challenges in providing neonatal care in each of its units for those babies needing 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 1, 2 or 3 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 additional resources in neonatal services, many challenges remain. Given these challenges it is widely recognised by health boards across Wales that a strategic long-term solution is required to the provision of Welsh neonatal services.
- 23.** The Health Board outlined its overall strategic vision for all services, in *A Strategic Direction 2009-12*, published in October 2009. The strategy provides a clear blueprint for the future delivery of services in the context of five clinically-focused strategic themes: making it safe; making it better; making it sound; making it work; and making it happen.
- 24.** Underpinning this high-level strategic direction is a series of 'service reviews'. The service review process builds on the tried and tested three-cycle model used to develop the Health Board's vision and strategy. The outcome of the three-cycle model is a summary of the solution identified by the process – the 'preferred way forward'. If the 'preferred way forward' relates to service configuration then there may be a recommendation to the Health Board for 'no change', or for a 'change'. The Health Board intends to complete the two service reviews for Women's and Children's services in the autumn of 2011. There are clear links between the two reviews.

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## **The Health Board has put in place better safety processes and has increased staffing levels, but there are still some midwifery and neonatal capacity gaps**

### **Despite wider financial pressures, the Health Board is working towards recommended clinical staffing levels**

25. The Health Board recognised that provision of safe midwifery staffing levels is vital and protected posts when they became vacant. Staffing levels remain at 1 April 2010 establishment level, against a backdrop of controls in recruitment in some areas.
26. The total direct clinical midwifery establishment is 277.74 Whole Time Equivalents (WTE), with 3.2 WTE midwife vacancies. This establishment number includes 6.7 WTE covering advanced midwifery practitioner roles, where midwives cover junior doctor roles. Across North Wales, this still leaves a capacity gap of 16.5 WTE midwives compared with the BirthRate Plus recommended level of 294.76 WTE based on the numbers of births. Although the senior midwives do not believe this shortfall is having a direct impact on clinical care, it is reported to impact negatively on supporting functions, for example, supervision, training and development. Work is underway using the BirthRate Plus tools to determine future staffing needs based on the results of the recent capacity and demand mapping exercise, and taking into account emerging plans for service change.
27. The gap is compounded by midwives in Glan Clwyd doing 'theatre' tasks (recovery). Obviously transferring this task to the theatres team would release midwives for core midwifery tasks. There is an ongoing debate, directed by the Director of Nursing and Associate Chief of Staff (Women's), between the CPGs involved in transferring this task to theatre, but theatres will only accept the transfer of tasks if the funding follows. A new task and finish group is expected to identify a solution and a plan to implement within three months.
28. The Health Board also plans to release capacity by changing the skill-mix, which should help them achieve BirthRate Plus staffing levels. Midwifery Support Workers (MSWs) are being trained to work alongside midwives as part of the maternity team and to complement the midwifery role. Two cohorts of MSWs are in training, and the remaining posts are now being recruited. Once training is complete, there will be 29.4 WTE qualified MSWs. BirthRate Plus allows for a 10 per cent skill-mix. Ultimately once training is completed MSWs will represent 10 per cent of establishment thus the Health Board will meet the BirthRate Plus standard for MSWs.

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29. Overall there is also a small gap in support functions. In the main MSW posts have been recruited internally from Health Care Assistants (HCA) on Agenda for Change Grade 2. Of the MSWs, 18.7 WTE were new posts, and for acute HCA staff appointed internally their posts were backfilled. Community HCA posts have not been backfilled. The previous BirthRate Plus exercise also identified a small gap in Band 2 posts (5.5 WTE). In addition, the Health Board does not meet the administration standard of the Safer Childbirth standards, with only partial administrative cover in Ysbyty Gwynedd and Glan Clwyd.
  30. There was a shortage of obstetricians in the Wrexham unit. They were two posts short in order to provide the necessary 60 hours a week cover to the labour ward (based on 2,500 to 4,000 births a year). This was resolved in July when two new 'junior consultant' posts were filled. The other two sites have the obstetrician numbers to cover the labour ward for the 40 hours a week necessary to meet the standard for those sites (based on less than 2,500 births a year).

### **Facilities continue to be improved although there are still significant neonatal capacity constraints**

31. Overall, the facilities and equipment available across the Health Board's maternity services are sufficient and appropriate. There has been an investment in all areas to improve facilities, with recent investment in labour wards. However, many labour rooms do not have en-suite facilities. And Glan Clwyd does not have an on-site antenatal outpatient clinic, which means that midwives are staffing community obstetric clinics. The CPG demonstrated good evidence of progress on this issue including the use of National Childbirth Trust tools, the mothers' survey, and mothers' focus groups to identify areas for improvement. Future proposed plans include a midwifery-led suite for the Wrexham Maelor site.
32. The Welsh Government's Chief Nurse requested that all health boards develop an equipment inventory. The Health Board inherited separate inventories at site level, and is merging these into a central Health Board-wide spreadsheet. There were few issues with equipment reported during our fieldwork.
33. Although maternity services' physical capacity is broadly appropriate to meet demand, this is still 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 the closure of some of the maternity units. The demand is such that neonatal beds are still on occasion closed to new admissions, and a new 'Neonatal Closure Policy' is in use across the Health Board.

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34. Neonatal capacity constraints and challenges remain. The mismatch between capacity and demand means that babies and their mothers are regularly transferred around North Wales and further into England, although this is less frequent than in the past. The Health Board has no units which currently meet the definition of a Level 3 neonatal unit. Glan Clwyd and Ysbyty Wrexham Maelor work at Level 2, but Ysbyty Gwynedd is at Level 1. The Health Board has been aware of capacity shortcomings since a Health Commission Wales Neonatal Review in 2005. However, progress depends on the outcomes of the ongoing service reviews for Maternity and Child Health services, and the availability of investment.
  35. 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. For example, it has been possible to use some of the funding made available by the Welsh Government to begin building the capacity to provide a 12-hour neonatal transport service. There are already improvements in the ability to transfer babies between units, avoiding some transfers outside North Wales. However, due to the failure to appoint one of two new consultant paediatricians, and the current absence of nursing staff being trained on the Advanced Neonatal Nurse Practitioner course, the 12-hour service is not always guaranteed across North Wales.

### **A new mandated training programme is rolling out**

36. Statutory training has recently been completely redesigned, and is now delivered as part of a Health Board-wide annual programme. Midwifery staff have just started to be released for three-day blocks of training. All mandated training is included in the programme, and completed in the block, including the skills and drills training elements. This training also supports integration across the Health Board as staff from different areas get to know each other.
37. The Health Board recognises that succession planning is important, and is investing in training staff so they will be able to take up new roles in the future. A good example of this is the *Free to Lead, Free to Care* development programme for Band 7s. In addition, a 'Development' Band 7 post is in place in the west as a one-year temporary post to allow development of professional skills; the Head of Midwifery plans to expand this to east and centre as suitable vacancies arise.
38. Maternity support workers have been supported to complete the All Wales training for MSWs.
39. The arrangements for obstetricians are less clear, although 'skills and drills' sessions are undertaken, and there are advanced plans to include doctors in the skills and drills elements of the three-day package; multidisciplinary training is considered good practice. We found no evidence that obstetricians are not completing their mandatory training, and good anecdotal evidence that they are undertaking appropriate Continuing Professional Development (CPD). Such CPD activity should be linked to expected outcomes for supplementary professional activities as part of the consultant job planning review.

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## **The Health Board has put in place a number of mechanisms to improve safety and support effective risk management, and the process of updating key policies and procedures is underway**

- 40.** There is a variety of other mechanisms in place to support safe and effective care in terms of risk management and incident reporting. These include:
- A Health Board-wide Quality and Safety Committee. The CPG has also established a CPG-level Quality and Safety Committee, and a safety report is produced monthly for the CPG Board.
  - Monthly labour ward forums within each main site (Ysbyty Gwynedd, Glan Clwyd and Wrexham Maelor). These meetings are used to discuss reported incidents and provide opportunities to learn lessons.
  - The North Wales Labour Ward forum brings together all site-based labour ward forum information, and analyses risk information at a strategic level. This group is also responsible for reviewing and standardising policies across the Health Board.
  - There are good incident reporting mechanisms including a single trigger list for reporting untoward incidents, and a cross check of birth logs against the DATIX reporting system to ensure all incidents are reported.
  - Monthly perinatal mortality and morbidity meetings within each main site. The minutes of these meetings demonstrate a clear multidisciplinary approach with midwives and medical staff presenting the cases and debating the issues.
  - A comprehensive clinical audit programme within the CPG.
  - 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.
  - Participation in the 1,000 Lives plus Transforming Maternity Services Mini Collaborative. The Health Board has put in place a team and the focus of the work is on improving recognition and response to deteriorating women and reducing the risk of deep vein thrombosis.
  - An escalation acuity tool to ensure safe staffing levels on labour wards, which is reported by senior midwives to work well operationally.

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41. Whilst policy integration is underway, it is reported by a number of staff to be slower than desirable, mainly because lower-tier midwifery and nursing posts are not yet in place. Examples of policies which have been integrated include:

- antenatal care, including guidance on Parentcraft courses;
- promoting normality<sup>5</sup>;
- a neonatal closure policy;
- an escalation procedure; and
- a post-natal care policy.

## **The Health Board has a clear focus on improving the maternity care pathway, although inconsistent practices and high Caesarean section rates in some areas are still a concern**

### **Antenatal processes and information provision have improved, but variations in clinical practice remain an issue**

42. 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 the 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 GPs, then it is more likely that their role will be understood and they will be the first point of contact. Given the geographical spread and rural nature of some parts of North Wales, this is physically challenging, but in the Health Board, relationships with primary care are good. Despite the challenges of finding the right location, the Health Board has indicated that midwives are the first point of contact for the majority of bookings. The Health Board now provides antenatal classes in all localities, except Aberconwy.
43. Promoting normality is recognised as important throughout all areas of the Health Board, and was recently the subject of an education day for the whole of North Wales. This day was well attended by staff from both the midwifery and medical professions.

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<sup>5</sup> 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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44. The Health Board has started work aimed at reducing variation in care management. For example, the new Head of Outpatients is reviewing antenatal clinic practices, and the mix of inpatient and outpatient antenatal care. A case-note audit was completed by Health Board staff and learning points implemented at team level. An audit of scanning practices resulted in the Health Board developing its own local information leaflets to supplement the all-Wales screening information.
  45. Parentcraft classes are available in many venues, with some offering access outside standard working hours, including Saturdays and evenings. Information is also available via the internet, including information on the Parentcraft programme and maternity booking. In addition, user feedback is actively encouraged and outputs from the above developments are regularly discussed within the CPG management team.
  46. There was much criticism of the new patient handheld maternity records. Points made included: the record being too focused on antenatal screening; not user friendly; with too small a space for writing; and a high risk of loss of clinical information due to the need to staple in results. Similar points were across Wales. The Welsh Government has put in place a process for feedback of concerns.

### **Work is underway to increase normality during labour, but Caesarean section rates are still a concern**

47. The home birth rates have increased in some areas since our last review with rates on average between two and five per cent at main site level. However, some Health Board areas achieve much higher rates and work is underway to understand the differences and improve the overall rate of home births, with some localities aspiring to nine per cent. It should be noted that some parts of Wales are already achieving much higher rates of home births in excess of 20 per cent.
48. Health Board focus groups report that continuity of care during labour is good, with one-to-one care in established labour. There is an escalation policy to 'protect' safe staffing levels on the labour wards. As part of the escalation policy, community midwives can be called in to provide post-natal support, or to work on the labour ward to free-up capacity for one-to-one care. The CPG monitors the acuity levels by site, and can demonstrate that this policy has helped maintain safe midwifery levels over the last 18 months.
49. The consequence of safe labour ward staffing levels is cancellation of antenatal or Parentcraft classes, or depletion of the community post-natal staffing levels. The CPG monitors the impact on community services, but this is not reported outside the CPG.
50. Although much work is underway to increase normality, it is acknowledged, and there is evidence that there is still some way to go to achieving this aim. The increasing acuity of mothers, for example greater numbers of women who are obese or have diabetes, is said to be making care management more complex which makes achieving normality more difficult. But there are also other factors, for example the physical environment and medical staff practice that negatively impact on achieving this aim.

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51. Intervention during labour has historically been different across North Wales. For example, in 2007 we found (compared to the all-Wales and England average) higher induction rates in Wrexham, medium in Glan Clwyd, and lower in Ysbyty Gwynedd. This legacy of very different clinical cultures will take time to resolve, and these overall trends mask large variations between localities and clinical teams.
52. In our previous reports, we identified high Caesarean section rates in some areas ([Exhibit 1](#)). The North Wales average still compares well with the 2007 overall trust average of 24 per cent.

### Exhibit 1: Comparison of Caesarean section rates

Area (acute hospital)	2007 (per cent)	2010 (per cent)
East (Wrexham Maelor)	26	23
Centre (Glan Clwyd)	24	28
West (Ysbyty Gwynedd)	21*	22
Average (across North Wales)	24	24

Source: *Wales Audit Office*

\* 21 per cent was the lowest rate in Wales, and in the lowest quartile.

53. In 2009, the predecessor NHS trusts implemented the Caesarean Section Toolkit which had been developed by the NHS Institute for Innovation and Improvement aimed at reducing Caesarean section rates. The toolkit 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. The CPG has built on this, via 'study trips' to other hospitals where high Caesarean section rates have been reduced, and the vaginal birth after Caesarean pathway has been chosen as a focus for reducing the rates. All mothers who have recently delivered by Caesarean section are reviewed and debriefed, with letters sent to the mothers, and copied to primary care containing advice for future pregnancies. A pilot of Vaginal Birth after Caesarean clinics in centre is due to start summer 2011. Our review suggests that the measures put in place are not yet working in Glan Clwyd due to difficulties in influencing change, limited peer pressure, an absence of individual accountability and few corporate drivers for change.

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## Arrangements for post-natal care have improved, particularly in terms of breast feeding management

54. Much has been done to improve mothers' experience post-natally, and the new post-natal care policy is aimed at improving and unifying care. A number of mechanisms are in place to assess progress including feedback from user engagement activities, complaints monitoring, and the Fundamentals of Care Audit undertaken in all three units in the past two years. No areas of concern have been identified but it remains an area for consideration in the MSLC.
55. While support for breastfeeding is developing at different rates across North Wales good progress has been made overall. As of August 2011, both west and central areas have Baby Friendly accreditation<sup>6</sup> at Level 2 across community midwifery and hospital services. The east has Level 1 accreditation, but all the units are working towards achieving the next level of accreditation. The Health Board hopes to apply for Level 3 in 2012, for the west and centre initially but recognises that success depends on wider partnership arrangements, particularly with local government. Hence, whilst the Strategic Breastfeeding Group is developing a paper to take the issues forward, we concluded that the Health Board is still developing in this area.
56. In 2008, we reported that the levels of post-natal visits were high in some areas, particularly in the west. Work has been undertaken to understand the level of support required and provided. Our previous reviews were deemed helpful across Wales in providing the stimulus to rationalise post-natal checks with many parts of Wales now reporting fewer post-natal visits. In North Wales, the average is now five for a first baby (Exhibit 2); with subsequent babies averaging one fewer visit. But some other parts of Wales are now averaging three post-natal visits focusing on quality rather than the quantity of visits.

### Exhibit 2: Comparison of post-natal visit numbers for first babies

Area (acute hospital)	2007 (average number)	2010 (average number)
East (Wrexham Maelor)	5	4
Centre (Glan Clwyd)	5	4.6
West (Ysbyty Gwynedd)	7	6
Average (across North Wales)	6	5

Source: Wales Audit Office

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<sup>6</sup> 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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- 57.** The Health Board is undertaking work to examine how best to check women and their babies' health six weeks post birth. In the interim, all GP practices have confirmed that they are undertaking these checks.

# Appendix 1

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## 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 post-natal phase, improve women's satisfaction with their post-natal 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

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

In 2008, we reported on maternity services in the former Conwy and Denbighshire, North East Wales, and North West Wales NHS Trusts. The reported local issues largely mirrored those identified within our national maternity report. Overall, we found there were many positive aspects of maternity care and women were generally quite satisfied, but some aspects of care needed to improve across all three trusts. The conclusions from that work are summarised below.

### Conwy and Denbighshire NHS Trust

- team working, confidence levels and the quality of training needed improvement to ensure safe and effective care, and that an open and supportive culture existed;
- although overall bed capacity was sufficient, staffing levels and practices may have been hampering efficiency and effectiveness;
- antenatal care compared well, as did women's satisfaction, although some staff practices could have been limiting women's choices;
- whilst intervention rates were average for Wales, there were some key gaps in outcome data, and labour ward staffing levels posed a significant risk; and
- good levels of post-natal support were in place, although there was scope to improve arrangements, particularly around infant feeding.

### North East Wales NHS Trust

- arrangements for staff training, support and supervision needed review to support safe and effective care, and an open and supportive culture;
- although capacity overall matched demand, there was scope to re-balance resources;
- whilst access to antenatal care was good, satisfaction was low;
- although women were very satisfied with care during labour, high intervention rates and limited outcome data made assessing the impact difficult; and
- despite good levels of post-natal check, and good management of women, the readmission rate for babies is high and breastfeeding rates showed scope for improvement.

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## North West Wales NHS Trust

- the service promoted an open and supportive culture that enhances safety, but inadequate staff training was a risk and user engagement needed to improve;
- overall capacity was sufficient to meet demand, however, the high rate of neonatal admissions required further exploration;
- midwifery-focused antenatal care compared well with other services, and women's satisfaction was comparatively high, but some opportunities were identified for further improvements;
- women were comparatively satisfied during labour and shortly after birth, and the Trust had the lowest Caesarean section rates in Wales, but the level of transfers to intensive care required further exploration; and
- midwives provided good levels of post-natal support, although we identified some scope to refocus post-natal checks.





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