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# Maternity Services: Follow-up Review

## **Aneurin Bevan Health Board**

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# Status of report

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## Summary

1. In May 2008, we produced a local report on maternity services in the former Gwent Healthcare NHS Trust (the Trust). Overall, we found that the Trust needed to review its practice in a number of key areas in order to ensure that it was delivering high quality and cost effective maternity services. While there were specific concerns about the Gwent maternity service, a number of the areas requiring improvement mirrored those identified within our national maternity report. Appendix 2 describes in more detail the conclusions from the local report. Shortly after we had completed our review, Healthcare Inspectorate Wales (HIW) undertook further review work on maternity services at the Trust, which resulted in these services being placed under 'special measures' during 2008-09 while improvements were planned and implemented.
2. In June 2009, the Wales Audit Office published a national report entitled *Maternity Services in Wales*<sup>1</sup>. That report summarised the findings of local audit work undertaken at each of the NHS trusts that existed in NHS Wales at the time.
3. 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.
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.
5. During 2011 we have undertaken follow-up work to examine whether Aneurin Bevan 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.

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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)

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6. We have concluded that there is clear evidence that necessary improvements in maternity services are being made, although momentum needs to be maintained and further work is needed to ensure that services are being delivered in line with national and local strategic plans.
  7. We came to this conclusion because:
    - there has been a discernable focus on improving maternity services, supported by a clear management framework and greater emphasis on multi disciplinary team working;
    - service reconfiguration plans are being taken forward;
    - improved staffing levels and approaches to risk management are assisting in the delivery of safe and effective services, however further action is needed on midwife training and appraisal; and
    - the services offered across the maternity care pathway are improving with reducing interventions and increased support for breastfeeding although variations in community midwifery arrangements need to be addressed.
  8. Our work has identified a number of areas that still require attention. These are shown below.

### **Key issues for the Health Board to address**

9. Ensuring service delivery matches strategic intentions:
  - The Health Board needs to ensure that the planned models of maternity service are working as intended. Key issues such as women choosing to give birth out of area, units not functioning as originally intended and variable community service provision may hinder delivery of the Health Board's maternity strategy.
10. Maternity information:
  - The poor functionality of the current maternity information system means that senior midwifery staff are using their valuable time to check and validate maternity statistics which is grossly inefficient. The Health Board needs to secure an effective information system that enables efficient collection and reporting of maternity information to support improved planning and performance management.
11. Midwife training and appraisal:
  - The Health Board needs to ensure that it secures the necessary attendance at all mandatory training events for midwives.
  - The Health Board must ensure that appraisals are held for all midwives.
12. Ensuring staff safety:
  - The current arrangements for community midwives visiting women out of hours present a potential risk and should be strengthened through use of the all-Wales ID badge system.

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**13. Antenatal education:**

- The planned improved provision of antenatal education classes needs to be implemented without delay.

**14. Hand-held records:**

- The Health Board needs to ensure that the intended benefits from the all-Wales hand-held patient record are secured in terms of providing a comprehensive multi-disciplinary record of care.

# Detailed Report

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## **There has been a discernable focus on improving maternity services, supported by a clear management framework and greater emphasis on multi-disciplinary team working**

### **The Health Board has a clear framework to manage and monitor its maternity services**

15. There has been a clear drive to secure improvements in the Health Board's maternity services and to address the issues that resulted in the imposition of special measures during 2008-09. The Health Board agreed a Maternity Strategy in October 2009 and service developments are being supported by a clear management framework that has the following key components:
  - a strong drive amongst executives and staff for improvement with clear executive accountabilities and named independent member responsibilities for maternity services;
  - a Maternity Services Board to oversee the delivery of the services and to support reporting to the Board and relevant sub-committees;
  - monitoring of service delivery and quality and safety issues through a Maternity Dashboard and monthly multi-disciplinary clinical governance meetings; and
  - a Maternity Services Liaison Committee, chaired by a lay member, to facilitate capture of service user views.
16. Collectively these provide the Health Board with a well-defined framework of management arrangements to continue to develop its maternity services. The Maternity Services Board fulfils a key role and, after some initial uncertainty over its function, it is being used in an increasingly effective manner to drive service change.
17. The Maternity Service Board reports regularly to the Quality and Patient Safety Committee and there are also periodic updates on specific updates to the main Board. In particular, we have noted the report to the November 2011 Health Board meeting which sets out the position of maternity services in the Health Board against the Welsh Government's all Wales action plan, and points to a number of positive developments
18. It is understood that there are plans to produce an annual maternity report for the full Board. This would be a positive development and should be used as vehicle to give Board members a full picture of maternity services and the necessary assurances that service improvements are being secured.

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## Performance reporting has improved, despite being constrained by the lack of an effective maternity information system

19. Regular monthly monitoring across the maternity service is undertaken using a Maternity Dashboard which is based on the Royal College of Obstetrics and Gynaecology model. The Dashboard provides information on:
  - activity – including bookings, births and interventions;
  - workforce measures – including consultant cover of the labour ward, staffing levels measured against Birthrate Plus, mandatory training, sickness, etc; and
  - clinical indicators – including maternal and neonatal morbidity.
20. The Clinical Director implemented the Dashboard, taking account of lessons learnt from its application in her previous hospital, and its format is regularly reviewed by the Maternity Services Board where it forms an important part of the bi-monthly meetings. Each measure in the Dashboard has an agreed target range of performance. A red flagging system identifies measures that are not performing within their agreed target range, and these are then subject to review and agreed action by the Maternity Service Board and the monthly Obstetrics and Gynaecology Directorate Clinical Governance meetings.
21. The Dashboard is supported by a monthly *Closing the Loop* report to the Divisional Clinical Governance meeting. This report focuses on serious incidents, infection control, health and safety compliance, appraisals completed, sickness and absence, complaints and litigation. Together the Dashboard and *Closing the Loop* documents provide up-to-date information to support the maternity service in performance management and service planning.
22. Whilst the above arrangements create a clear framework for reporting and monitoring performance and quality and patient safety issues, the Health Board does need to address underlying problems with its information systems.
23. A 'Protos' maternity system was implemented by Gwent Healthcare NHS Trust in 2009. However, the data collected by Protos does not always concur with that collected by the Patient Administration System (PAS). As a result, considerable effort is expended to address the areas of discrepancy between PAS and Protos. A Senior Midwifery Manager is nominated as the Lead Information Midwife and is responsible for data checking and validation on a monthly basis. When there are discrepancies between the two systems she accesses the birth register for clarification. This is time consuming and costly.
24. The maternity service recognises that the existing maternity information system is limited in its functionality and the Directorate (Obstetrics and Gynaecology) Information Group has been established by the Clinical Director to improve data collection and analysis. The Health Board has recently replaced its old PAS with the new Myrddin system. Most other health boards across Wales have adopted and are using the Myrddin maternity model. Although the Health Board acknowledges weaknesses in its maternity information system, there are no plans in place to change the current system.

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## **There is evidence of improved multi-disciplinary working within maternity services**

25. In our previous report, we expressed concern that multi-disciplinary team working arrangements were not effective, that practices were inconsistent and there was not an open culture in which information was shared between medical and midwifery staff and lessons learnt.
26. Developing clinical leadership has been a priority for the Health Board and arrangements have been strengthened, assisted by the appointment of a Clinical Director post in Obstetrics and Gynaecology in January 2009, and more generally by the Health Board's new management structures.
27. These new arrangements have helped to reinforce local clinical leadership and multidisciplinary team working. There are clear lines of accountability and delegation, and a well-developed structure of management meetings within the Division and at maternity service level. The Acting Head of Midwifery, Clinical Director and Divisional General Manager are involved in maternity management meetings and with the Divisional Director in Divisional meetings.
28. We interviewed a range of staff across the maternity service and overall, the staff we interviewed considered that clear organisational arrangements and management structures had been implemented, and that these arrangements now provide greater clarity of roles and responsibilities and an improved sense of direction for the maternity service.

## **The Health Board has established mechanisms to capture and respond to the views of service users**

29. Women using the Health Board's maternity services are encouraged to provide feedback on their experiences through a number of mechanisms such as:
  - all mothers are given a 'point of view' questionnaire on discharge;
  - graffiti boards have been introduced to public areas in the maternity units – on antenatal clinic and wards (June 2010) to enable women, or their partners, to share their views about the service in an anonymous manner; and
  - parents panel groups were established in April 2010, meet on a monthly basis, and have proved popular, with each meeting focusing on a particular topic.
30. Information obtained from the sources listed above is used to inform service review and development. Service changes as a result of this feedback are publicised in the relevant clinical area and in the maternity newsletter. Patient stories are also developed and used to inform the Health Board and to aid staff learning and development.
31. While women indicate that they value visiting the maternity facilities, feedback from women's questionnaires confirms that they also appreciate access to electronic information. As a result virtual tours of the maternity facilities have been produced and uploaded onto the Health Board website.

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32. A Maternity Services Liaison Committee has been established as required by the Welsh Government and met for the first time in July 2011. The Liaison Committee is chaired by a lay member and provides a mechanism to actively seek the views of service users. Issues raised by the Liaison Committee are reported to the bi-monthly meetings of the Maternity Services Board.

## **Service reconfiguration plans are being taken forward**

33. The configuration of maternity services is changing as part of the Health Board's wider Clinical Futures strategy. A Divisional Reconfiguration Group has been established in the Family and Therapy Division to plan the future provision of services based on a single Specialist Critical Care Centre supported by local hospital services. For maternity services, this will translate as a single obstetric unit supported by midwifery-led units at the local hospitals.
34. Key elements of these plans have already been achieved with the opening of the new Ysbyty Aneurin Bevan and Ysbyty Ystrad Fawr hospitals which have midwife-led birthing units. These units, alongside the obstetric and midwife-based services at the Royal Gwent and Nevill Hall hospitals provide a wider choice of care settings for women. Although, the number of births at the Ysbyty Aneurin Bevan unit has been low to date, high numbers were not anticipated. The unit ethos is that it provides a 'home from home' as an alternative for those mothers who would not normally consider giving birth within their own homes, and care is provided by the community midwifery team.
35. The Clinical Futures model will not be fully operational for number of years (the current target date is 2017) and the Health Board will need to ensure that its maternity services remain sustainable in the intervening period.
36. In addition, there are other patterns of service use that need to be examined by the Health Board:
- Mapping of demand information has shown that the midwifery and obstetric-led units at Nevill Hall Hospital are not functioning as two discrete units. There needs to be greater clarity between the functions of the midwifery-led unit, which adopts a 'normal pathway', and the obstetric-led unit which is more interventional. At the time of our audit, the roles of these units were being redefined, with associated staff training and development programmes being run by the maternity service.
  - The Maternity Services Board has also discussed issues relating to the flow of women from the Caerphilly area to deliver their babies in Cardiff. Further work is being undertaken by the Health Board to fully understand the reasons behind why women are choosing to have their babies in the new midwifery-led unit in Cardiff rather than in facilities in Gwent.

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## Improved staffing levels and approaches to risk management are assisting in the delivery of safe and effective services, however, further action is needed on midwife training and appraisal

### Birthrate Plus recommended staffing levels are being maintained and 60-hour obstetric input to the labour ward is being achieved

37. Increasing the presence of consultant obstetricians on the delivery suite has been shown to be a major contributor to improving the safety of women and babies. Within the Health Board the Clinical Director for Obstetrics and Gynaecology has used the job planning to help reallocate responsibilities, and as a consequence the Health Board is achieving the required 60 hours of obstetric input on the labour ward<sup>2</sup>.
38. In 2009 a number of senior midwifery posts were not substantively filled. This position has now improved and the Health Board has filled senior midwifery posts including a Head of Midwifery and several Band 8 midwifery manager posts. The Health Board has also developed a new leadership programme – the ‘Aspiring Lead Midwife Programme’.
39. In addition, the Health Board has funded the maternity service to provide staffing which meets the recommended Birthrate Plus levels. However, in common with other parts of Wales, recruiting skilled Band 6 midwives has been difficult. The shortage of Band 6 staff has resulted in more reliance on Band 5 midwives with an associated need for these staff to be more closely supervised for a period of 12 months.
40. A further challenge for the Health Board has been that over a period of time the roles taken on by midwifery staff have expanded into areas that were not envisaged when the funded establishment was originally created. The additional duties involve:
  - supporting Caesarean deliveries in theatres; and,
  - undertaking scans.
41. The Maternity Services Board is aware of these issues and the following action has been taken:
  - **Elective theatre support:** Additional staffing costs of £58,000 have been identified as being required to provide the necessary support for elective Caesarean sections in theatres. A business case was supported by the Health Board with the requirement that the operation of the new system be reviewed in six months and a report presented to the maternity services board. This is an ongoing project with a business case in development for additional staff for the emergency Caesarean sections in theatres.

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<sup>2</sup> *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.

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- **Scans:** a review is underway to consider the transfer of this role to sonographers but with national sonographer resource constraints this is acknowledged to be a long-term plan.
42. Despite the improved midwifery staffing levels, there remain some concerns that the resource allocation between obstetric units and community services is not balanced. The Birthrate Plus Review (2010) found that there was a higher proportion of staff working in the community than in hospital maternity services. A means of addressing this imbalance has been to use community midwives on a flexible basis, to cover hospital sessions.

### **Whilst there have been improvements, midwives are not fulfilling all their training requirements and less than half had received performance appraisals**

43. Staff training and development have improved since our previous review. An action plan to improve training was implemented in June 2009. At present there are three mandatory training days per year and attendance is routinely monitored. The maternity service aims to achieve 100 per cent attendance at these events. Monitoring information for the period January to June 2011 indicated that the maternity service was likely to achieve between 80 to 90 per cent attendance during 2011. Of concern was that attendance on Mandatory Study Day Three was lower overall, and particularly low for Nevill Hall Hospital and Caerphilly Birth Centre midwives. Therefore, this is an area where the Health Board needs to focus attention to ensure the necessary levels of attendance are achieved.
44. More encouragingly, it is noted that the monthly clinical governance meetings mentioned earlier in the report are providing a good opportunity for multi-disciplinary training supported by use of the maternity dashboard, as well as analysis of complaints and risk management information.
45. Another positive development is the use of Maternity Support Workers (MSWs) by the Health Board which has been the first in Wales to use the newly developed curriculum to train these staff. The training programme has been organised with support from the National Leadership and Innovation Agency for Healthcare (NLIAH) and was completed in April 2011. No commitment has been made to appoint all the staff trained, but it is likely that most will be recruited and will be used to deliver a wide range of roles, including helping mothers with breastfeeding, delivering education and maintaining cleanliness in theatres.
46. Of concern, however, is that at the time of the audit only 46 per cent of midwives had received an appraisal. Work was underway to address the issues which were impeding appraisal interviews. These included constraints on time and the level of confidence of the midwifery managers to undertake appraisals.

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**New processes have been introduced to ensure staffing levels match demand and to improve risk management although arrangements to ensure the safety of staff working in the community can be strengthened**

47. Maternity staffing levels are routinely reviewed to ensure adequate staffing to support women in labour. Midwifery managers review staffing levels on each shift and assess this against the workload within maternity units. Using a quantifiable measurement tool the acuity<sup>3</sup> can be assessed and decisions made on whether to increase staffing, if that is feasible, or in extreme cases to divert women to deliver in other units. These improved systems of working have reduced the number of occasions when the maternity units have had to close due to staffing issues.
48. The Maternity Services Escalation policy has been redrafted to take account of the revised system of acuity assessments. During escalation, acuity is assessed on a regular basis. The aim of the new policy is, where possible, not to close units but to divert women for a short period of time. This process involves using the workforce more flexibly and with community midwives supporting obstetric units when necessary. Where there are no neonatal cots available the Health Board prefers not to close maternity units but rather to modify the risk and limit the women who can be accepted to those categorised as low-risk normal birth with high risk pregnancies temporarily diverted to other units.
49. There are a variety of other mechanisms in place to support safe and effective care and effective risk management. These include:
- the multi-disciplinary Clinical Governance Days provide a focus on risk management and key outcomes for the month are reviewed using the Maternity Dashboard and the *Closing the Loop* reports;
  - a Health and Safety Forum is held monthly, chaired by the Divisional Patient Quality and Safety Lead midwife, and focuses on the outcomes in *Closing the Loop*;
  - a comprehensive clinical audit programme is in place;
  - use of the Modified Early Obstetric Warning Score system – this is a national system involving a score chart for all pregnant or postnatal women intended to identify sick women and initiate action at a time when treatment might make a difference; and
  - 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.
50. However, the current arrangements for community midwives visiting women out of hours present a risk and should be strengthened to offer the staff adequate protection. Each community nurse carries a mobile phone and is expected to inform the Labour

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<sup>3</sup> Acuity is the number of women in the maternity unit and their clinical condition assessed against the number and skills of staff available.

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Ward of her work schedule. This arrangement is relatively informal and could be strengthened by giving midwives access to the all-Wales ID badge system which enables staff to alert a security company of their whereabouts and to use a panic button facility in an emergency.

## **The services offered across the maternity care pathway are improving with reducing interventions and increased support for breastfeeding although variations in community midwifery arrangements need to be addressed**

### **Hand-held records are provided but not all health professionals make use of them**

51. Following a period of piloting and consultation the new all-Wales patient hand-held maternity records, which span the three main areas of clinical care (antenatal, intrapartum and postnatal) were due to be introduced in the latter half of 2011. The all-Wales hand-held maternity record aims to enable information to be more readily available and shared between the different health professionals who see women during their pregnancy.
52. At the time of the audit, the Health Board generated its own hand-held records at the women's first appointment. Although midwives complete these hand-held records, medical staff do not – it is the aim to promote multi disciplinary record completion once the all-Wales hand-held records are introduced.

### **Antenatal service provision has changed and plans are well advanced to improve process and information provision to women**

53. A review of antenatal care has been carried out within the Maternity Service with the aim of streamlining service delivery. The outcome has been:
  - women now have their scan and any tests they require on the same day as they attend an antenatal appointment;
  - fewer hospital antenatal clinics are held, and they are targeted more specifically at women with higher-risk pregnancies; women with lower-risk pregnancies are typically put under the care of community midwives; and
  - women are transferred back to midwifery care after an obstetrician appointment, where appropriate.
54. Surveys and user groups have been used to assess how women view the service. These indicate that women consider that they are well informed of the choices available to them in relation to where they can give birth. Options include home births,

the birthing centre, midwifery-led units and obstetric units. Information is provided to women at their booking appointment, and an initial plan for the pregnancy and birth are discussed.

55. In 2008, at the time of our previous report, antenatal classes were poorly attended. Following this, a review undertaken by the Health Board, which included the views of women using the service, has led to a number of planned improvements. New sessions are to be introduced into community-midwifery parent-education sessions in the near future. The sessions have been standardised for use in all areas and will be given as a rolling programme.

### **Ensuring normality in labour is a key priority and work is ongoing to continue to reduce unnecessary Caesarean sections and improve consistency of community-midwifery services**

56. Our previous report highlighted that care and treatment in labour involved comparatively high levels of Caesarean sections. There has been a considerable amount of progress made since then, with reductions in Caesarean section rates at both the Royal Gwent and Nevill Hall hospitals (Exhibit 1).

**Exhibit 1: Caesarean section rates across the Health Board – 2007 and 2011**

Hospital location	2007	2011 (Jan to May )
Royal Gwent – obstetric unit	27%	23.5%
Nevill Hall – obstetric unit	30%	24.6%

Source: Aneurin Bevan Health Board – Family and Therapy Division data.

57. Intervention levels are now monitored on a monthly basis and reported to the Maternity Service Board, Clinical Governance Meetings and the Labour Ward Forums. Regular monitoring of intervention levels includes induction of labour and caesarean section rates. Where performance is at variance with the target set by the Maternity Service, activity is reviewed and where appropriate further analysis is undertaken and/or corrective action is planned. The maternity service has set a tolerance range for caesarean sections of 23 to 26 per cent; while above 26 per cent is flagged as red.
58. The Health Board has implemented the Caesarean Section Tool Kit which had been developed by the NHS Institute for Innovation and Improvement and aims to reduce caesarean section rates.<sup>4</sup>
59. Historically, the level of Caesarean sections has been higher at Nevill Hall Hospital and while that remains the case overall, the difference is reducing. The focus on reducing Caesarean sections at Nevill Hall Hospital is linked to the work underway to

<sup>4</sup> The toolkit is designed to help maternity services review and assess their current practice in promoting normal birth and reducing Caesarean section rates. The toolkit also provides practical techniques to support sustainable changes in maternity services.

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separate out the obstetric unit from the midwifery-led services at this hospital, which should promote more normal labour for a number of women.

60. Cardiotocograph (CTG) equipment is used to monitor foetal heart beat during labour. However, this intervention reduces the woman's mobility and its use is not routinely required in normal labour. Multi-disciplinary training arrangements are in place to provide guidance on when the use of CTG training is indicated and we understand its use to be reducing.
61. Home birth rates vary across the Health Board area and while the maternity service aspires to achieve a target of 10 per cent of births being at home, this is more likely to be attained in certain areas than in others.
62. The Health Board's mixed model of community midwifery also impacts on its ability to meet the home birth target. There are two teams which provide a case-holding service. This system provides continuity of care for women and achieves higher levels of home births, however it is very demanding on midwives' time particularly with the significant 'round the clock' on call commitment. In addition, staff working this system are less available to support the obstetric units when the units are short staffed. Other midwifery teams operate a named midwife system and midwives in these teams support the obstetric units when additional staff are needed.
63. Action has been taken to secure improvements in postnatal care and breastfeeding support. In our previous review, some women indicated that they did not feel they received sufficient postnatal support. We also found that less women than average in Gwent chose to breastfeed. The Health Board's own analysis shows that with the exception of Monmouthshire, breastfeeding at birth in all localities is below the Welsh average.
64. Since our original audit, the Health Board has taken a number of positive actions to promote breastfeeding. These have been detailed in a progress report to the Health Board in July 2011 and it is encouraging to note that all the Health Board's maternity units have achieved full accreditation for the Unicef Baby Friendly Initiative<sup>5</sup>. In addition, progress has been standardised across the five localities with Stage 1 accreditation having been achieved and Stage 2 being worked towards.
65. The maternity service has piloted 'Transforming Care' at Nevill Hall Hospital. This initiative has been devised by the Welsh Government in conjunction with NLIAH and, while it has wider application, is considered to be helpful in addressing a range of issues in postnatal care. It aims to improve 'hands-on' midwifery care by identifying direct patient care to be delivered by midwives and support which can be carried out by other staff. The initial results have been encouraging and have enabled staff to recognise how best to focus attention on the care of the woman.

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<sup>5</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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- 66.** Community midwives report that routine postnatal visits are made to women. Well-developed systems of support are available postnatally especially in areas of social deprivation, for example, through the 'Flying Start' Baby Cafe in Blaenavon, Pontypool 'Living Centre' and County Hospital, Drop in 'Centre' .

# 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 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

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## Findings from local audit work in Gwent Healthcare NHS Trust in 2007-08

During 2007-08 we undertook and reported on maternity services in the former Gwent Healthcare NHS Trust. The overall conclusions from that work, reported in May 2008, are summarised below.

We concluded that the Trust needed to review its practice in a number of key areas in order to ensure that it is delivering a high quality and cost effective maternity service.

- Staff training, support, supervision and processes and systems for multidisciplinary working needed to be improved to deliver safe and effective care and improve women's levels of satisfaction with the service:
  - views expressed by a range of staff gave concern about the consistency of practice and advice and the need for the multi-disciplinary team to drive service improvement;
  - while core maternity skill training was well developed, the Trust needed to improve multi-disciplinary training; and
  - while the Trust had actively sought women's views, existing forums needed to be fully representative and the monitoring of outcomes needed to be improved to deliver better services for women.
- There was variability in the level and distribution of midwifery staff and services between units and a lack of obstetrician presence which may have affected the optimal delivery of service:
  - the Trust had the largest maternity service in Wales;
  - the Trust was reviewing overall neonatal cot and staffing capacity;
  - antenatal assessment facilities and opening hours supported women and reduced antenatal admissions and the level of delivery, antenatal and postnatal beds was adequate;
  - the Trust needed to review midwifery staffing levels across the three units and increase consultant obstetrician presence in the delivery suites; and
  - service provision for women with mental health needs was not comprehensive.
- There was good provision for antenatal monitoring and screening but antenatal class provision was limited:
  - antenatal monitoring and screening provision compared well although antenatal appointment times were short;
  - the Trust publicised the provision of its midwifery-led services; and
  - while women were given choice about where to have their baby, there was poor provision of antenatal classes and women did not feel fully involved in decisions about their care.

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- Women reported being left alone and worried during and shortly after labour, care and treatment were interventional and outcome measures were limited:
    - a high proportion of births were induced and the rate of Caesarean sections was above average during the review period;
    - while there was a consistent level of midwife support during labour a third of women reported being left alone and worried during or shortly after birth; and
    - maternal and baby outcome measures needed to be reviewed and where necessary further data collected and regularly analysed.
  - Women reported not feeling well supported after discharge although the Trust provided an above average number of postnatal midwife contacts:
    - less women than average chose to breastfeed;
    - women did not feel well supported in caring for their baby after discharge and re-admissions of babies was above average; and
    - while less women than expected report having physical and psychological checks undertaken, re-admission rates for women are comparatively low.





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