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Maternity services: follow-up review

Cwm Taf Health Board

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Summary report

Summary

1. In June 2009, the Wales Audit Office published a national report entitled *Maternity Services in Wales*¹. 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 One 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 care; 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 North Glamorgan NHS Trust, and Pontypridd and Rhondda NHS Trust. Overall, we found there were many positive aspects of maternity care and women were largely satisfied but some aspects of practice needed to improve to ensure high quality and cost effective services. Many of the areas requiring improvement largely mirrored those identified within our national maternity report. Appendix Two describes in more detail the conclusions from the two local reports.
4. We presented our national report to the National Assembly's Public Accounts Committee in July 2009 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. 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 March and April 2011 we undertook some follow-up work to examine whether Cwm Taf 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

¹ The report can be accessed at:

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

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

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6. We have concluded that while Cwm Taf Health Board (the Health Board) has made progress in improving its maternity services it still faces some significant challenges in terms of planning for and ensuring safe and sustainable services. The reasons for reaching this conclusion are as follows:
- maternity services are a high corporate priority, and are supported by clear executive team and senior management engagement;
 - the Health Board is improving the evidence base to support service planning and performance management, although there is still scope to improve user engagement;
 - while safe and effective care is prioritised, there have been concerns about the Health Board's capacity to sustain existing services and work by the Welsh Risk Pool (WRP) has highlighted a number of other operational risks; and
 - the Health Board is improving maternity care, with a greater focus on delivering antenatal care in the community and improvements in breast feeding management, although high Caesarean Section (CS) rates remain an issue.
7. Our work has identified a number of issues that still require attention. These are shown below in Exhibit 1.

Exhibit 1: Key issues for the Health Board

Strategic direction

- Following its detailed maternity service planning work the Health Board still has to agree its future options and consult on them.

Performance management

- Demonstrating that performance management framework and accountability arrangements are driving improvements in performance, for example, in terms of influencing and changing consultant obstetrician practice.

User engagement

- Although some progress has been made in ensuring user engagement, the Maternity Services Liaison Committee needs to widen its membership to enable it to become fully effective.
- The Health Board needs to accelerate its efforts to develop effective engagement of service users.

Maintaining safe services

- Although a number of mechanisms have been put in place to support safe and effective maternity services, the Health Board needs to ensure that the midwifery staffing levels are balanced across the organisation.
- 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. High levels of ultrasound scanning and high CS rates remain an issue.
- The Health Board should review post-natal contacts to ensure that women's needs are being met, and that the numbers and length of post-natal visits are sufficient but not excessive.

Detailed report

Maternity services are a high corporate priority and are supported by clear executive team and senior management engagement

8. Maternity services are a high corporate priority for the Health Board, with clear executive team and senior management awareness of service issues. Several external reviews of local maternity services in recent years have highlighted the need for change and improvement. In addition, significant challenges to ongoing service provision have arisen. Most recently, the withdrawal of approval for some medical training posts in paediatrics by the Wales Deanery, with effect from June 2011, will have a significant impact on obstetrics services. The Health Board is also very aware of the potential political and public reaction to any proposals for service reconfiguration.
9. The Directorate Manager for Obstetrics, Gynaecology and Sexual Health said that the Annual Operating Framework service improvement plan for maternity services 2010-2011 had been informed by recommendations from our previous reviews, and that Local Delivery Plan progress reports are used as an opportunity to provide evidence of progress against our recommendations. A single action plan has been brought together in response to the Wales Audit Office's national report, and local reports for predecessor NHS trusts, on maternity services. This has been used to track progress in various clinical and strategic fora, including the Health Board's Integrated Governance Committee and the Quality, Patient Safety and Public Health Committee. Other reviews, such as the service assurance work of the WRP are also drivers for change. Senior midwifery and nursing staff were clearly familiar with our reports and recommendations, and saw our reviews as providing a focus for assessing progress and improvement.
10. Within the Health Board's organisational structure, maternity services are situated in the Directorate of Obstetrics, Gynaecology and Sexual Health, which is, in turn, part of the Integrated Services Division. The triumvirate directorate management model comprises the Clinical Director, the Head of Midwifery and Gynaecology Nursing, and the Directorate Manager, with the Clinical Director being the overall lead. The Divisional Nurse is also a midwife by professional background, as is the Executive Director of Nursing. The acting Medical Director is an obstetrician. The professional backgrounds of these staff and executives indicate a clear understanding of the challenges faced by maternity services at the highest level within the organisation.
11. Divisional Heads of Nursing meet on a monthly basis and divisional meetings take place fortnightly. Most key directorate meetings take place on a multidisciplinary basis, and include staff from both the main hospitals within the Health Board. There is a labour ward forum for each site, and these come together periodically to help ensure consistency of approach. However, the Executive Director of Nursing indicated that she would like to see greater progress in terms of the balance of midwifery staffing across the Health Board.

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12. Consultant obstetrician appraisals are undertaken by the Clinical Director. However, we found little clear evidence to show that the current structural and performance management arrangements are having a significant positive impact on clinicians' practice.

The Health Board is improving the evidence base to support service planning and performance management, although there is still scope to improve user engagement

There has been progress in terms of the development of the Health Board's maternity information systems

13. The Health Board is working to achieve consistent and effective information systems to support maternity service planning and performance management. The Myrddin patient information system has been successfully implemented, to capture various components of admission, discharge, and antenatal management information across the Health Board. There have been some problems relating to the consistency of information recorded on the system. This has been recognised and is being addressed through the provision of training for relevant staff.
14. The Health Board is also using the Maternity Information Technology System (MITS) to record and provide information relating to delivery activity in maternity. The system had previously been introduced by Pontypridd and Rhondda NHS Trust at the Royal Glamorgan Hospital. Work has been carried out to re-write the software to address known problems, and the updated software system has been introduced across the Health Board.
15. The Health Board introduced a Maternity Dashboard in May 2011, which is based on the Royal College of Obstetricians and Gynaecologists' Maternity Dashboard: Clinical Performance and Governance Scorecard. The Dashboard is being produced on a monthly basis for discussion as part of directorate and divisional performance management arrangements and is sent to the Executive Director of Nursing. At the time of our audit work, it was too early to say whether this information was being used effectively to improve performance at directorate level.

The Health Board is responding to the views of users, notably when undertaking a recent review of community midwifery, although user engagement arrangements could be further strengthened

16. Shortly after the Health Board was established it became apparent that community midwifery teams worked in a variety of ways. It was recognised that community midwifery arrangements needed to be sustainable and equitable, while meeting governance requirements and being both clinically and cost effective.
17. A review of community midwifery arrangements was carried out to establish a way forward for these services. The views of women who were using, or had previously used, the service were gathered as part of the evidence base for the review recommendations. Coming as something of a surprise to the Health Board, women indicated a preference for 'traditional' community midwifery teams, focusing on community antenatal and post-natal care, and on births at home and at the Tair Afon Birth Centre in Abercynon, as opposed to services based in GP practices and hospitals. The review made a number of recommendations for change, including for the establishment of a 'traditional' approach to community midwifery services. This recommendation was implemented from January 2010, although some community midwives said that varying midwifery team resource levels mean that their approach is not entirely consistent.
18. The Maternity Service Liaison Committee (MSLC) was established in late 2010. The MSLC fills a recognised gap in communication with women who use the service. 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.
19. There is broad membership including midwives, an obstetrician, GP representation, a paediatrician, a voluntary sector representative and a Community Health Council representative. The intention is to bring a consultant anaesthetist onto the Committee. The MSLC is chaired by a service user and a number of other service users have been co-opted onto the committee. There is no user representation from among fathers. The Executive Director of Nursing indicated that the MSLC is still in its early days and is not fully effective.
20. Members of the MSLC are encouraged to visit antenatal clinics to talk to women to better understand their views and concerns. The user representatives wanted to look at the content of patient information and the timing of provision of information to patients. Work is now being carried out on this area. Patients who have made a complaint are encouraged to join the MSLC.

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21. Some approaches to user engagement are in place, have been tried, or are under consideration. They include:
- patient diaries, although mainly in use on medical wards at present, and need to be implemented more fully as a valuable source of comment and feedback from women using obstetrics services;
 - satisfaction questionnaires for women and their families who have used maternity services, and a separate questionnaire is used specifically for neonatal services;
 - a directive to midwives to encourage patients to contact the MSLC if they have any feedback about the services they have received;
 - a neonatal services user committee, although it has proven very difficult to sustain the commitment of members;
 - ideas to develop an online site for neonatal service users as a 'virtual' approach to engagement;
 - consideration of the provision of a maternity website; and
 - consideration of online blogs to enable service users to discuss their experiences.
22. However, a number of these approaches are still only under consideration or in the early stages of development. The Health Board should accelerate its efforts to ensure that the views of service users are fully reflected in service development and improvement.

While planning work is continuing the strategic direction for maternity services is not yet clear

23. The Health Board covers a geographical area that extends from Llantrisant in the south, to Merthyr Tydfil in the north. This local area presents a number of service delivery and planning challenges in terms of accessibility and travel time. There are also nearby obstetrics units in other health boards in Bridgend, Cardiff, Newport and Abergavenny, a situation which provides added complexity in terms of service planning. A joint planning exercise was carried out by planners from Cwm Taf Health Board, Abertawe Bro Morgannwg University Health Board, and Aneurin Bevan Health Board during 2010. However, the Health Board has indicated that the momentum to consider these issues collectively has diminished.
24. There is clear recognition that the Health Board needs to focus on the future of its obstetrics units, given current demand and resources. A major internal planning exercise has taken place to set out different options for the Health Board, some of which take a regional approach, while others follow a unilateral approach. Senior staff anticipate that the Welsh Government will soon expect health boards to set out their plans for these services, and in particular to show how they intend to address challenges to sustaining service provision.

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25. A regional solution for neonatal care has already been implemented to address problems in providing safe and effective services for those babies needing specialised care. However, significant concerns about neonatal services remain, and these are discussed in more detail later in the report.

While safe and effective care is prioritised, there have been concerns about the Health Board's capacity to sustain existing services and work by the Welsh Risk Pool has highlighted a number of other operational risks

While staffing standards are largely met, and the skill mix has begun to improve, staff absences have led to concerns about the Health Board's capacity to maintain full services at both main sites

26. The Health Board meets and exceeds the overall level of staffing required by current Birth Rate Plus (BRP) recommendations. However, it has recognised the need to move from a staffing complement comprised entirely of midwives to the composition recommended by the BRP of 90 per cent midwives and 10 per cent other staff, such as Registered General Nurses. The necessary adjustment to staffing is being made as staff leave the organisation. The changes made to date have been noticed more at the Royal Glamorgan Hospital because of the faster turnover of midwifery staff in that unit.
27. As mentioned above, the Executive Director of Nursing is concerned about imbalances in midwife staffing across the Health Board. The WRP recently reported staff perceptions of low staffing ratios at Prince Charles Hospital. During the summer period of 2011 there were concerns within the Health Board about its ability to sustain full services across its two main sites due to problems with paediatric medical rotas, relating to sickness, annual leave and other absence-related issues.
28. The value of Maternity Care Workers has also been widely recognised. The Health Board has completed training for four Maternity Support Workers in 2011 and intends to deploy these staff in the community. However, the Head of Midwifery is concerned that it may not be possible to offer them the career development opportunities that were originally envisaged.
29. Two part-time consultant obstetrician posts have been introduced to provide additional resources. But consultant job planning could be used more effectively, with some consultants expressing concerns about inequities in matching capacity and demand.

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30. The Head of Midwifery reported a generally clear split between consultant obstetrics and gynaecology activities and that the recommended³ 40-hour labour ward consultant presence is met. The guidance requires that consultant obstetricians be present on the labour ward although some staff reported that this is not always the case. Recent WRP review findings indicated that consultants who are rostered as on call for the labour ward at Prince Charles Hospital are still expected to perform elective operating lists and clinic duties. Also, that consultant cover on the labour ward at the Royal Glamorgan Hospital can be compromised when a consultant is on leave as the consultant with the on-call commitment is often expected to run a clinic at a peripheral hospital. This contradicts National Institute for Clinical Evidence guidelines for intrapartum care.
 31. There are eight senior clinical midwives across the Health Board who cover junior doctors' duties at night and provide supervision for junior doctors during the day. Currently there are three senior clinical midwives at Prince Charles Hospital and five at the Royal Glamorgan Hospital. An integrated rota will be established across the Health Board later in 2011, with senior clinical midwives working across both sites to ensure greater flexibility of resources.
 32. 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 a focus on dignity and respect training as part of mandatory training. However, reflecting a wider issue for the Health Board, delivering mandated training is sometimes difficult due to staffing constraints. For obstetricians there are regular, dedicated mandated training sessions with regular skills and drills training.

A regional approach to neonatal services has been implemented although there are still concerns about capacity limitations

33. The majority of babies receiving neonatal care will have been born prematurely. Neonatal units require specialist equipment as well as staff with specialist skills, and are classified as level one, two or three depending on the type of care they provide.
34. Wales in general has experienced challenges in matching neonatal capacity with demand, and even though the Welsh Government has invested in a number of positive neonatal service improvements, these only ease and do not resolve the problems faced by the Health Board. A regional approach to the provision of neonatal care in South-East Wales was introduced in January 2011. Under the new approach, all level-three neonatal care (the most intensive level) in this region is provided at the University Hospital of Wales, Cardiff. This approach concentrates activity and resources within that unit, to improve capacity and to increase the quality of care.

³ *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.

The change was accompanied by the establishment of two consultant obstetrician posts at the Cardiff and Vale University Health Board. One of these was established by moving an obstetrician post, and the consultant filling it, from Cwm Taf Health Board.

35. Health Board staff clearly recognised the need to address problems with capacity in local neonatal units. However, senior staff are concerned that the changes made have not fully addressed the capacity problem. Each unit routinely uses an escalation tool to assess any mismatch between capacity and demand. They find that it is still necessary to limit service provision, and on occasion to close maternity units to stop further patients being admitted. This regional problem with capacity is said to reflect a wider situation across the United Kingdom. Staff have sometimes found it difficult to find a neonatal cot anywhere in the UK.
36. Other improvements introduced by the Welsh Government include the new fast response neonatal transport service which is run by the all-Wales neonatal network and runs from 8 am to 8 pm. And a new clinical information system, Badgernet, went live in January 2011. It standardises clinical information collected for all babies requiring special care through hospital stay. The neonatal cot locator service 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 means that clinical staff still have to ring around to ensure there is a maternity bed.

The labour ward environment was said to be safe and no significant concerns about equipment were reported

37. Although we did not assess the environment of the labour wards, all units were reported by staff to be safe. And no significant issues regarding the environment were highlighted by the recent WRP review. The environment at the Royal Glamorgan Hospital had previously been assessed as being too clinical and not fully providing the type of user friendly and 'homely' environment recommended by the National Childbirth Trust's Better Birth Environment campaign. As a result, improvements have been made taking account of user feedback. However, staff at Prince Charles Hospital did express concerns about additional sets of doors which have been installed between the obstetrics theatre on one side of a corridor and the delivery suite on the other, to create two 'air-locks' for additional security. The issue being that there is no override button to speed up access in emergency situations.
38. 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 is in evidence at the Health Board and there are no significant concerns about equipment, other than the lack of a birthing pool at the Royal Glamorgan Hospital. An endowment fund is used to help provide equipment for the community.

Although the Health Board has a number of safety and risk management mechanisms in place, a recent Welsh Risk Pool review highlighted several operational risks that need addressing

- 39.** A significant amount of work has taken place to integrate policies from the predecessor organisations, to ensure greater consistency of processes and practices. Although we have not tested their effectiveness, there are a variety of mechanisms in place to support safe and effective care and effective risk management. These include:
- Monthly labour ward forums at Prince Charles Hospital and the Royal Glamorgan Hospital.
 - A regular governance component of directorate meetings.
 - Clinicians discuss incidents reported through the DATIX reporting system at meetings specifically held for that purpose and in labour ward forums, to provide opportunities to learn lessons.
 - Incident reporting mechanisms based on a trigger list.
 - One-off and ongoing clinical audit activity.
 - Use of the Modified Early Warning Score system at Prince Charles Hospital and a pilot of the Modified Early Warning Obstetrics System at the Royal Glamorgan Hospital.
 - 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.
- 40.** However, the recent WRP review highlighted potential risks that need to be addressed by the Health Board, such as:
- the lack of safe operating capacity criteria;
 - inconsistent updates in scrub techniques for midwives;
 - compromised consultant cover on labour wards (see above);
 - no dedicated anaesthetic cover for obstetrics in the out-of-hours period; and
 - perceived low staffing levels at Prince Charles Hospital, and staff concerns that this may compromise patient safety during periods of high activity.

The Health Board is improving maternity care, with a greater focus on antenatal care in the community and improvements in breast feeding management, although high Caesarean section rates remain an issue

There is an increased focus on providing antenatal processes in locations to suit women's preferences although high levels of scanning remain an issue

41. 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 General Practitioners (GPs), then it is more likely that their role will be understood and they will be the first point of contact.
42. Because of midwives' involvement with women throughout their pregnancy, GPs generally have a much smaller role to play in that care. Some midwives commented that they would find it helpful if general practice receptionists could refer patients on to the midwifery service, and that this would be a matter of raising awareness amongst GPs and practice staff. The Health Board is committed to improving GPs' understanding and involvement in maternity services with GP representatives on the MSLC.
43. In our previous work we found that provision of antenatal monitoring at both the predecessor trusts compared well to other trusts. The Health Board's review of the community midwifery service has refocused the provision of antenatal care, by enabling midwives to provide services where women want them. Booking appointments provide the first point of contact with an expectant mother. Midwives try to provide appointments in the location that best suits women's preferences, such as in a general practice, the home, or a hospital clinic.
44. Routine antenatal appointments should be long enough for appropriate clinical checks to be undertaken and for clinicians to provide the necessary advice, and for women to have the opportunity to ask questions. Midwives said that while the amount of time offered for antenatal appointments varies, in some areas, such as Aberdare, appointments of half an hour are made. The Health Board needs to ensure that appointment times are reviewed and based on need.
45. The Health Board has audited the provision of antenatal classes to review availability and to help focus efforts towards improvement. Antenatal education is provided in a variety of ways, at different times of the day and evening, to enable people to attend. Staff said that the challenge is to involve those who are least aware of the need to be

well-informed about their pregnancy. Some one-to-one education sessions are provided in the home by midwives, to raise awareness among women who might otherwise not attend a formal session.

46. 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. Although there was little evidence to suggest that consultants intend changing their practice, midwives have limited the number of scan sessions to try to reduce the numbers of scans being requested by doctors.
47. The documentation of women's histories and needs is an important component in the process of providing safe and effective care. Health Board staff have been critical of the new all-Wales patient hand-held maternity records which span the three main areas of clinical care, antenatal, intrapartum and post-natal. The Health Board formally communicated these concerns through the feedback mechanisms put in place by the Welsh Government.

Work is underway to increase the proportion of normal deliveries but Caesarean section rates are still very high

48. Community midwives reported a slight increase in home birth rates among women linked to GP practices in the north of the geographical area covered by the Health Board. In 2010, 1.8 per cent of women in that area had a home birth, compared to less than one per cent in 2007. In the south, the 2010 figure remained unchanged from 2007, at three per cent. With some Health Board areas achieving higher rates there is recognition of the need to understand the differences and improve the overall rate of home births.
49. Senior midwives confirm that every attempt is made to maintain a ratio of one-to-one care during labour. However, there are occasions when this is not maintained for all patients. An escalation policy is in use to assess whether staffing levels remain 'safe' to support the labour ward, and the outcomes of assessments are reviewed over time to maintain a clear picture of the staffing situation. Staff said that there are occasions when maintaining safe staffing levels on the labour ward can lead to the cancellation of training or depletion of staff resources in other areas.
50. 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 who are obese, have diabetes, or problems with substance abuse. This makes care management more complex and as a result makes achieving normality more difficult. But other factors, such as obstetric practice, also have a negative impact.
51. At the time of our previous local reports in 2008, care and treatment were considered interventional with the predecessor NHS trusts recording high CS rates, with Pontypridd and Rhondda NHS Trust being the highest in Wales. In 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 vaginal birth after caesarean (VBAC) 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. Intervention activity is also subject to clinical audit and to work being carried out in conjunction with Public Health Wales.

52. Women who request a CS are referred in the first instance to a midwife for counselling regarding normal delivery, and are subsequently referred to a consultant obstetrician for a second opinion if they still wish to proceed with a CS. There has been resistance to this arrangement from some obstetricians at the Royal Glamorgan Hospital who wanted the final decision to be made by the midwife.
53. In 2007, 26 per cent of women at the North Glamorgan NHS Trust had a CS, while the figure for Pontypridd and Rhondda NHS Trust was 31 per cent. Exhibit 2 shows that, despite the efforts described above, CS rates within the Health Board remain very high. The Health Board is using a traffic light system, as part of its Maternity Dashboard, to monitor CS rates against a green flag goal of 25 per cent or less and a 'red flag' rate of greater than 30 per cent. The Welsh Government has not set a target rate but health boards are required to demonstrate a significant reduction in rates and that they have put processes in place to reduce rates. Other health boards consider a rate of 25 per cent to be high, and we would therefore question whether the local target rates are ambitious enough.

Exhibit 2: Caesarean Section rates in 2010

Location	Type	2010
Prince Charles Hospital	Emergency	15.0%
	Elective	14.7%
Royal Glamorgan Hospital	Emergency	15.6%
	Elective	14.7%
Health Board average (including Tair Afon Birth Centre, Abercynon, in addition to the two hospital units).	Emergency	14.8%
	Elective	15.0%
	Combined emergency and elective average	28.8%

Source: Cwm Taf Health Board

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54. Senior midwives said that despite their efforts, they have limited influence over consultant practice. There was general recognition of the need to ensure greater discussion about intervention methods among consultant obstetricians and to increase the focus on this issue as part of appraisal and job planning processes. There are a number of factors leading to the higher CS rates across the Health Board. Demand from women for this procedure is one reason. Staff said that some women from the adjacent areas of Cardiff and the Vale of Glamorgan opt to have their delivery at the Royal Glamorgan Hospital in part because there is a perception that it is easier to have a CS there. Other factors include medico-legal concerns, and newer consultants being less experienced in breech management.

Arrangements for post-natal care have improved, particularly in relation to breast feeding management

55. The Health Board has carried out a significant amount of work aimed at improving and unifying post-natal care management. A number of mechanisms are in place to assess performance including: post-natal satisfaction assessed through discharge interviews of women; complaints monitoring and trend analysis; and Fundamentals of Care audits undertaken in both 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.
56. Staff commented on the significant progress that has been made in encouraging and supporting breast feeding. The Health Board had achieved full Baby Friendly Status accreditation⁴ for its hospital services under the original UNICEF scheme and is working towards the new Stage 1 accreditation for its community services by the end of 2011. The Health Board intends to update its accreditation status by participating in re-accreditation processes as required by UNICEF.
57. A lead midwifery breast feeding advisor works to raise awareness of feeding, and to provide advice and support to mothers and staff across the Health Board. In addition, a part-time midwife feeding advisor is based at the Royal Glamorgan Hospital. The Health Board has also recently appointed a maternity nurse co-ordinator for breast feeding, funded by the Welsh Government, who works across neonatal care, maternity and paediatrics at the Royal Glamorgan Hospital. The co-ordinator's work includes direct support to mothers for feeding and delivery of training to a range of healthcare professionals.
58. Our previous local reports highlighted comparatively high average numbers of post-natal visits per mother at Pontypridd and Rhondda NHS Trust, while at the North Glamorgan NHS Trust we found a comparatively high amount of time allocated to individual visits and long periods of post-natal contact with midwives. Currently, the

⁴ 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.

Health Board's policy is that women should receive a minimum of three post-natal visits. However, the high CS rate across the Health Board leads to increased numbers of post-natal visits, as does the incidence of Child Protection issues. Plans to introduce Maternity Support Workers in the community later in 2011 were suggested as an opportunity to review the patterns of post-natal visits.

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 place 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 check-ups and scans, and where required improve access to and attendance at antenatal classes;
 - during labour, ensure continuity of care, reduce variation in the 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

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

During 2007-08 we reviewed maternity services in the former North Glamorgan and Pontypridd and Rhondda NHS Trusts. The overall conclusions from that work are summarised below.

North Glamorgan NHS Trust

Our report in September 2008 concluded that while the Trust provided a maternity service that achieved generally good levels of user satisfaction, we concluded that a number of issues needed to be addressed to ensure high quality and cost effective services:

- there was a supportive culture within the maternity unit and the level of training compared well;
- physical and staffing capacity compared well but there may have been scope to improve utilisation and rebalance neonatal capacity and demand;
- although women's satisfaction levels were good there may have been opportunities to rebalance the antenatal workload to make better use of resources;
- there was a high level of intervention during childbirth although most mothers were satisfied with their care; and
- despite generally good levels of post-natal support, breastfeeding rates remained relatively low and readmission rates of babies were relatively high.

Pontypridd and Rhondda NHS Trust

Our report in March 2008 concluded that there was scope for the Trust to improve its practice in a number of key areas in order to ensure that it could deliver a high quality and cost effective maternity service.

- The overall management framework and culture were supportive but strengthened arrangements for some aspects of training were needed to ensure that care was as safe and effective as possible.
- Capacity appeared to be sufficient to meet demand, although there were opportunities to use it 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 was a strong midwife presence during labour and levels of confidence among mothers and staff compared well, although care was highly interventional. However, consultant presence on the delivery suite was below the recommended minimum.
- Despite good levels of post-natal support more mothers were readmitted than would be expected.



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