Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

National Review:

Maternity Services

Phase One

National review of the quality and safety of maternity services

Content

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales receive good quality healthcare.

Our values

We place patients at the heart of what we do. We are:

- Independent
- Objective
- Caring
- Collaborative
- Authoritative

Our priorities

Through our work we aim to:

Provide assurance:
Provide an independent view on the quality of care.

Promote improvement:
Encourage improvement through reporting and sharing of good practice.

Influence policy and standards:
Use what we find to influence policy, standards and practice.

Foreword

In its 2019-20 Operational Plan, Healthcare Inspectorate Wales (HIW) committed to a programme of national reviews which included maternity services. Our decision to undertake this review was based on a number of concerns relating to the pressures around maternity services in Wales, including the issues identified during HIW's inspection of maternity services at the Royal Glamorgan Hospital in the former Cwm Taf University Health Board[1] in October 2018, and the subsequent Royal College of Obstetricians and Gynaecologists report of the former Cwm Taf University Health Board in April 2019[2].

At time of writing, health and care services across Wales have had to rise to meet the challenges of a global pandemic, COVID-19. This has introduced unique and unprecedented pressures on the system that will continue through the winter months. Services have adapted, changed and expanded to cope with these pressures and the response across Wales has to be commended.

It is important to highlight that this review and fieldwork were undertaken between June 2019 and January 2020, prior to the COVID-19 pandemic, and publication of this report was delayed due to measures we took to reduce the burden of our work on services during the height of the pandemic. As such, our review has not examined in any way how maternity services across Wales have undertaken their role, or responded during the pandemic.

Our National Review of Maternity Services out to specifically assess how women perceive the care available to them; how it is delivered and whether quality and safety is maintained throughout their experience. The review has also considered how staff working within the services were supported and encouraged to undertake their relevant roles.

This report brings together the findings from the first phase of our national review, which consisted of a programme of inspection, document review, interviews, and comprehensive surveys of the public and staff working in maternity services. This report highlights the key themes, good practice and recommendations for improvement, to have emerged from our work so far.

We would like to express our sincere thanks to all who have participated in this review, and in particular to the women and families who participated and shared their views and experiences with us. The views and opinions from all contributors, have been considered to help develop our findings and recommendations.

[1] Since 1 April 2019, Cwm Taf University Health Board became Cwm Taf Morgannwg University Health Board following the incorporation of the Bridgend area within the health board.

[2] See: https://gov.wales/review-maternity-services-former-cwm-taf-university-health-board

Summary

This report set out the findings from the first phase of our National Review of Maternity Services across Wales, which explored the extent to which health boards across Wales provide safe and effective maternity services.
The key findings are as follows.

Our overall view is that those working within maternity services across Wales are extremely committed and dedicated to providing the best standard of care to women and families. It is clear that the various professionals working in maternity services take great pride in what they do, and strive to ensure that the journey through the pregnancy pathway is as positive an experience as possible. We believe that the quality of care is good, and that maternity services in general are delivered in a safe and effective way.

This is supported by the responses we had to our public surveys, with the overwhelming majority of respondents satisfied and positive with the standard of care and support that they received along each stage of the maternity pathway. We have however, identified some areas for improvement.

Is the care given well informed, individualised and family centred?

Overall, we found that care being delivered within maternity services across Wales was of good quality, well informed, individualised and family centred. It is clear that women were generally positive about the care and communication they received from services at each stage of their pregnancy. It is also clear to us that those working within maternity services are committed and dedicated to providing the best possible care they can. However, there are some themes and messages that have emerged from our review that require attention, with a particular focus on communication and consistency of care.

We heard concerns regarding whether women feel their views are listened to, valued, and responded to. Whilst women generally feel well supported, and were given enough information in order to make informed choices about their care, a number did not feel that they were able to express opinions and concerns about their birth choices, or felt ignored. Whilst there may be medical reasons why individual birth choices cannot always be followed, our survey suggests that this is an issue that needs to be explored further across Wales.

It is also evident that more needs to be done to ensure that women are able to communicate in their language of choice, enhancing the ability of women to feel heard and listened to, during what can be an uncertain and frightening time. Further to this, there is an inconsistency in the ability of partners or families to be present at all stages of the maternity pathway. We believe that open visiting should be available at all units across Wales.

We noted concerns raised by women regarding continuity of care. In particular, these concerns related to women feeling that they did not receive consistent care due to the number of professionals that they saw on their pregnancy journey. This impacted on, or impaired, their ability to build a rapport or relationships with a small group of healthcare professionals, and had a detrimental impact on the woman's perceived continuity of care. It can be traumatic for women to have to repeatedly recall or recount their medical history, or perhaps traumatic birthing or pregnancy experiences to different healthcare professionals. It can be difficult to ensure that women see the same professionals throughout their pregnancy, however, we feel that this is an area in need of focus nationally.

Generally, the level of support, advice and guidance for women and families was positive, with good examples evident of health boards promoting positive health and well-being initiatives throughout pregnancy. Whilst breastfeeding is well promoted across Wales, there are concerns raised by both women and staff over the ability to provide sufficient breastfeeding support, as this is often hampered or restricted by staff numbers and workload. This is an area requiring improvement generally.

Of particular concern is the need for further attention around the adequacy of perinatal mental health support available to women. An inadequacy of mental health support can have a severe and lasting impact on women. We believe that mental health support requires focus and improvement nationally, to ensure appropriate support is available in times of crisis. If left untreated, mental health issues can have significant and long lasting effects on woman, their baby and the wider family.

Bereavement services and support were generally adequate, but access to timely bereavement training for staff requires improvement. We did note some positive initiatives by some health boards in providing support services to women who have suffered traumatic experiences.

One of the key areas that requires attention across Wales relates to health boards sharing outcomes and changes, that have been implemented as a consequence of feedback provided by women or families about their experiences. We believe that there is an opportunity for services to demonstrate how they adapt and change in response to issues raised by women and families.

Are women in Wales receiving safe and effective care?

The majority of our findings in relation to this question are based upon the programme of inspections we undertook of all maternity units across Wales. Whilst we found adequate processes in place across Wales to provide women with safe and effective care, we did identify a number of patient safety concerns.

It was disappointing to note how often we identified issues around the checking of neonatal resuscitaire and emergency equipment, medical emergency arrangements, security of newborn babies, environment of care, and medicines management. Although these concerns did not directly impact on the quality of care being provided to women and babies during our inspection, they increased the risk of an issue occurring which could have a significant impact upon patient safety. Each of these issues were addressed through our Immediate Assurance process, and each health board has since provided us with the appropriate assurance following identification of these concerns.

We were generally satisfied with arrangements around safeguarding, and found additional specialist knowledge and support was available in all units for a variety of issues. These included teenage pregnancy, domestic violence, asylum seekers and female genital mutilation.

We found that maternity services generally had clear and robust process for reporting and investigating clinical incidents and concerns. However, a clear issue that requires improvement relates to learning and service improvements as a consequence of incidents or concerns. We found that learning was not always shared with staff in a timely and effective way. This issue needs significant attention from all health boards to ensure that staff are able to deliver the best standards of care, safely.

Nearly half of all staff who responded to our staff survey felt that their organisation did not treat staff involved in incidents fairly. Additionally, a high number of staff with whom we spoke during inspection felt that incidents were dealt with in a punitive manner, with a blame culture evident. This is clearly an area of concern. If staff feel that incidents are not going to be managed in an open, and transparent way, it will serve as a deterrent to those wishing to raise concerns. Given the prevalence of this issue within the Royal College of Obstetricians and Gynaecologists' report of the former Cwm Taf University Health Board, this is an issue all health boards need to consider, with action being taken to do all it can to promote a positive reporting culture amongst all staffing groups.

Are women receiving care from skilled multi-professional teams?

In general, we found multi-professional team working was strong, and we identified effective working relationships throughout midwifery, medical, obstetric theatres, pharmacy teams and clinical research and innovation leads. This teamwork allowed for effective communication, enabling health boards to provide good care to women.

We saw evidence of innovative practice across Wales, including teams working together to implement noteworthy initiatives, such as Babies Don't Bounce, Epilepsy in Pregnancy and Practical Obstetric and Multi-Professional Training (PROMPT)[3]. Health boards need to do more to harness the opportunity of sharing good practice and innovations such as these across Wales.

Overall, we were satisfied with processes to ensure that staff were sufficiently skilled in their roles. Mandatory training compliance is acceptable, however, staff are not always able to undertake refresher training promptly due to workload and resource pressures.

Can the quality of services be sustained?

We have seen strong evidence of an extremely committed group of professionals, who are striving to deliver high quality care to women on their journey along the maternity pathway. However, there are risks in the ability of health boards to ensure that sufficient levels of staff are in place to enable the safe delivery of care at all times.

Whilst health boards were generally working in line with requirements such as Birth Rate Plus[4], it was clear from our inspections and survey results that staff are working under pressure, and feel that there are not enough staff to enable them to do their job properly. It is also evident that there are stresses and strains on the medical workforce, with on-call rota deficits and concern over compliance with working time directives. Our inspections found there to be a very strong team working ethos amongst staff within maternity units, despite the challenges they face. Staff covering other staff shortages to allow services to continue to function is a regular occurrence. It is clear that this good-will can have potentially detrimental effects on well-being and work-life balance, with potential implications for the quality of care being provided.

Whilst we appreciate that resolving staffing shortages is a challenging issue for health boards, they must ensure that they do all they can to maintain safe and effective delivery of care at all times.

[3] PROMPT – Practical Obstetric and Multi-Professional Training. Its importance is to train teams to be teams within their working environment.

[4] https://www.birthrateplus.co.uk/

How well are maternity services led and managed?

The way in which maternity services are led and managed has a significant bearing on the overall quality of care provided, and consequently upon the experience of those using the services. Overall, we have seen services led by a hugely committed group of service leads, endeavouring to provide the best level of care, and deliver a positive experience for women and families. As our public survey has demonstrated, the majority of women were pleased with the level of care and support that they received at each stage of their pregnancy.

Our programme of inspections have nonetheless highlighted some concerns over the effectiveness of the management of some maternity units. It has been striking to note how consistently we identified patient safety issues, which gave rise to concern over local management and governance arrangements of these units. It is clear that there is room for improvement, to ensure that safe and effective care is being provided consistently across Wales.

Whilst we did not note any significant concerns with governance oversight of services in each health board, we did identify areas for improvement. In general, clear organisational structures are in place throughout Wales, with clear lines of reporting and accountability. Across our inspections we found that in general, risk assessments and risk registers were completed and maintained, and were updated regularly. We also found during our governance work that executive teams and boards monitored high risks regularly, with each health board holding monthly governance meetings that considered risks and clinical incidents and assigning actions as applicable.

While we did not identify any concerns regarding under reporting of clinical incidents in any health board, there is significant room for improvement in ensuring that trends, themes and learning arising from incidents are effectively shared with staff, in order to improve the quality of care. Significantly, we feel there remains work needed for all health boards in relation to ensuring a positive, clear and transparent culture is present within their maternity services. This in particular was evident in relation to the negative perception amongst staff about the way they would be treated if they reported incidents or concerns. This is an incredibly important issue that demands attention, given that the culture of a service has a direct impact upon the quality and safety of care that is provided to women and families.

Context

The Royal College of Obstetricians and Gynaecologists (RCOG) and Royal College of Midwives (RCM) were commissioned by Welsh Government in October 2018, to carry out an independent review of the maternity services at the former Cwm Taf University Health Board. This followed serious concerns that initially came to light as a consequence of the under reporting of serious incidents in its maternity services.

Their review report [5] was published in April 2019, and raised a number of significant concerns around staffing, processes and the underlying culture in maternity services that compromised care. This resulted in Cwm Taf Morgannwg's maternity services being placed in to Special Measures in April 2019, under the NHS Wales Escalation and Intervention Arrangements[6].

Following the report's publication, and given the seriousness of this situation, the Minister for Health and Social Services required health boards to consider their own maternity services, in the context of the recommendations of the report, and to provide immediate assurances in this regard.

Welsh Government worked with Heads of Midwifery, Clinical Directors and user-led maternity service liaison committees, to ensure that the learning from this report informed the actions for Wales, in the development of a five year strategy for maternity services; Maternity Care in Wales: a five year vison for the future (2019-2024)[7].

In April 2017, under a new model for clinical supervision, the health boards took responsibility for the supervision of midwives practicing in Wales (previously undertaken by the Local Supervising Authority for Midwives). Since this change, there has not been a national overview of the delivery of midwifery supervision across Wales, therefore an independent review of maternity services is now timely.

The aim of our review has been to provide a national picture of the quality and safety of maternity services across Wales, to understand whether the care being provided is safe, and to identify wider learning to improve services for women and their families.

[5] https://gov.wales/sites/default/files/publications/2019-04/review-of-maternity-services-at-cwm-taf-health-board_0.pdf

[6] https://gov.wales/sites/default/files/publications/2019-04/nhs-wales-escalation-and-intervention-arrangements.pdf

[7] https://gov.wales/written-statement-publication-maternity-care-wales-5-year-vision-future

The types of maternity services available in Wales

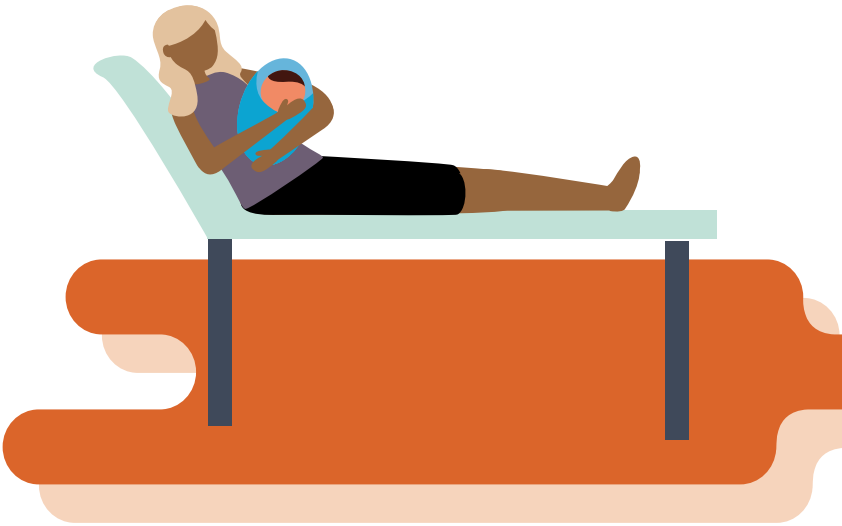
Maternity services across Wales are offered to all women and their families living within the geographical boundary of each health board. However, services may also be provided to women who reside outside of the geographical boundary, but who chose to birth in that health board's facilities.

The seven health boards in Wales are:

- Aneurin Bevan University Health Board[8] (Aneurin Bevan)
- Betsi Cadwaladr University Health Board[9] (Betsi Cadwaladr)
- Cardiff and Vale University Health Board[10] (Cardiff and Vale)
- Cwm Taf Morgannwg University Health Board[11] (Cwm Taf Morgannwg)
- Hywel Dda University Health Board[12] (Hywel Dda)
- Powys Teaching Health Board[13] (Powys)
- Swansea Bay University Health Board[14] (Swansea Bay).

Women who birth within Wales have the choice of birth setting as highlighted below (detail obtained from Your Birth – We Care (Heads of Midwifery Advisory Group (HOMAG), 2017[15]):

- Home birth within a familiar environment, with family present and care provided by midwives
- Freestanding midwifery-led units, providing similar care to that provided in a home environment by midwives, but in a freestanding clinical unit. These units are not always co-located near to a district general hospital
- Alongside midwifery-led units, based within the district general hospital site with care provided by midwives for healthy women, experiencing uncomplicated pregnancies
- Obstetric-led units, located within a district general hospital for women who need to be cared for (high-risk pregnancies[16]), or would like to be cared for by both obstetric consultants and midwives.



[8] http://www.wales.nhs.uk/sitesplus/866/home

[9] https://bcuhb.nhs.wales/

[10] http://www.cardiffandvaleuhb.wales.nhs.uk/home

[11] https://cwmtafmorgannwg.wales/

[12] https://hduhb.nhs.wales/

[13] http://www.powysthb.wales.nhs.uk/home

[14] https://sbuhb.nhs.wales/

[15] https://gov.wales/sites/default/files/publications/2019-03/your-birth-we-care.pdf

[16] A high-risk pregnancy is where a woman has one or more health concerns that increase her or her baby's chances for further health problems or a preterm (early) delivery.

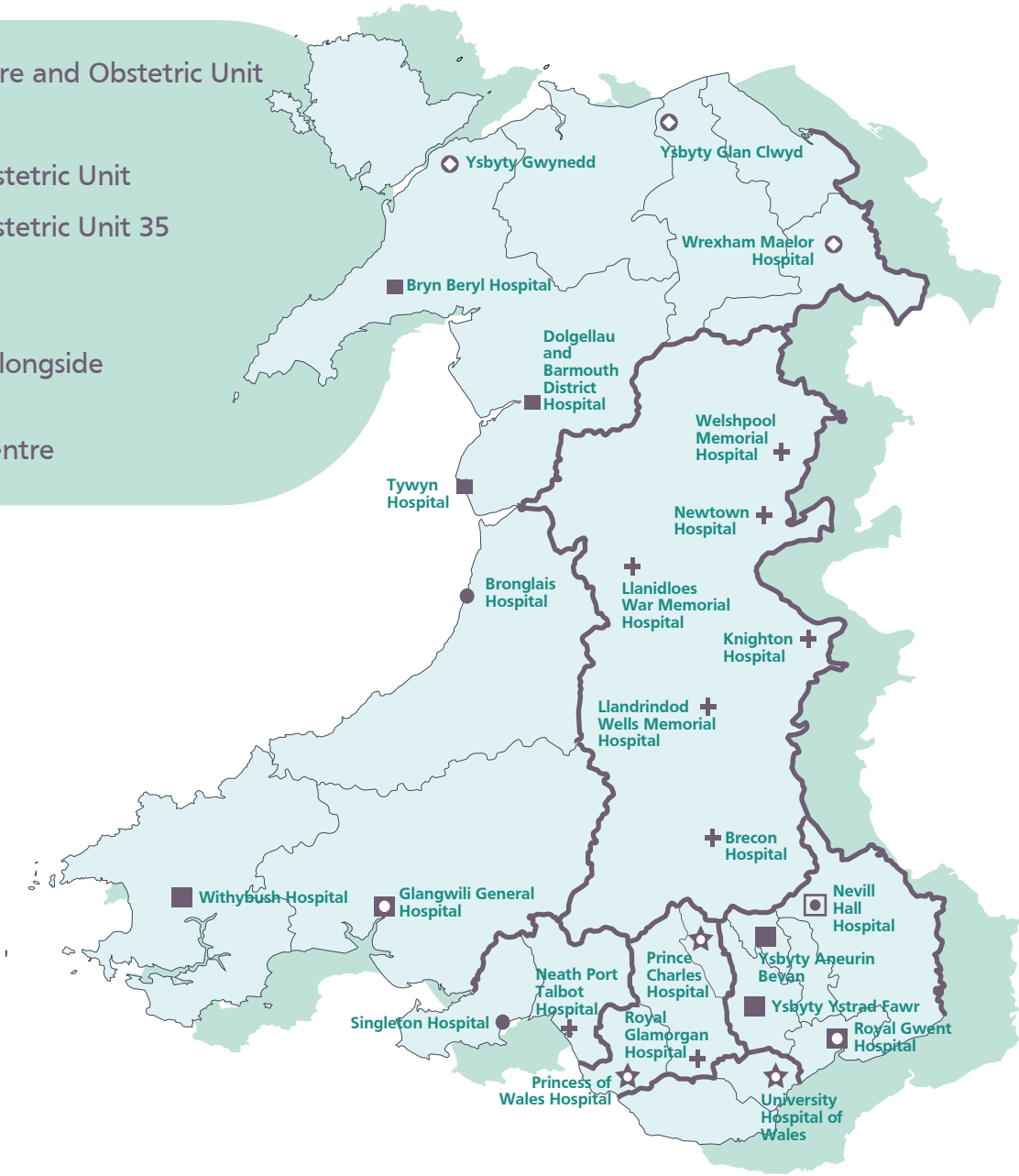
The map below details the location of each maternity service across Wales

Wales Maternity Units

University Health Board (UHB)
(1 April 2019)

Local Authority Boundary

- Alongside Birth Centre and Obstetric Unit
- Birth Centre
- Birth Centre and Obstetric Unit
- Birth Centre and Obstetric Unit 35 week model
- Obstetric Unit
- Obstetric Unit and Alongside Midwifery-led Unit
- Stand Alone Birth Centre



Did you know?

During 2019 across Wales...

14,513
baby girls were born

15,191
baby boys were born

861 were multiple births with
435 being boys &
426 being girls

Areas of Birth (% by Population)

19.3% born within the locality of Aneurin Bevan
(Population of 594,164)

19.5% born within the locality of Betsi Cadwaladr
(Population of 699,559)

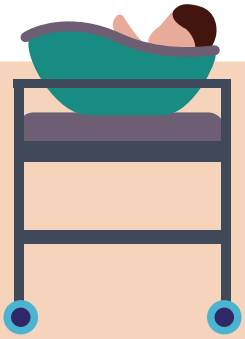
18.5% born within the locality of Cardiff and Vale
(Population of 500,490)

12.2% born within the locality of Cwm Taf Morgannwg
(Population of 448,639)

10.8% born within the locality of Hywel Dda
(Population of 387,284)

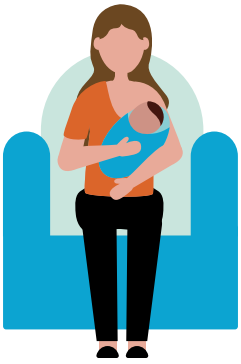
0.8% born within the locality of Powys
(Population of 132,435)

18.9% born within the locality of Swansea Bay
(Population of 390,308)



Types of Birth

63% were spontaneous delivery
14% were emergency C-section
13% were elective C-section
8% were forceps delivery
2% were ventouse delivery



63%
intended to breastfeed their babies

Data provided by Office of National Statistics (ONS) and North Wales Informatics Service (NWIS) 2019

What we did

The journey from early pregnancy to birth, and following birth, is a hugely important time for both mother and baby, and is often complex. In this first phase of our review, we examined the standard of care provided by each maternity service across Wales. We listened to the accounts of women, their partners and families, to understand their experience of using services before giving birth, and the support provided during and after the birth.

Focus of review

The purpose of our review was to understand how maternity services across Wales meet the needs of women and their families during their antenatal (before birth), intrapartum (labour) and postnatal (after the birth) stages of pregnancy. To accomplish this, we divided our national review into two phases. This report relates to the first phase, during which we explored the following main themes:

- **Quality of experience** – including overall experience, staying healthy, dignified care, timely care, individual care, information and communication and learning from feedback
- **Delivery of safe and effective care** – including managing risk, promoting health and safety, falls prevention, infection prevention and control, nutrition and hydration, medicines management, safeguarding, medical equipment use, quality improvement, research and innovation, information governance and record keeping
- **Quality of management and leadership** – including governance, leadership, accountability and workforce.

Throughout, we considered the following key questions:

- Is the care given well informed, individualised and family centred?
- Are women in Wales receiving safe and effective care?
- Are women receiving care from skilled multi-professional teams?
- Can the quality of services be sustained?
- How well are maternity service led and managed?

Scope and methodology

Phase One of our review explored the extent to which health boards across Wales:

- Provide safe and effective maternity services within acute hospitals and freestanding birth units
- Understand the strengths and areas for improvement within their maternity services.

As part of scoping our review, we engaged with other organisations who had recently conducted or planned to undertake further work in relation to maternity services, such as Welsh Government – Independent Maternity Services Oversight Panel[17] and Maternity Network Wales[18].

[17] https://gov.wales/independent-maternity-services-oversight-panel

[18] http://www.walesneonatalnetwork.wales.nhs.uk/maternity-services

We also worked with a range of stakeholders, including representatives from the Heads of Midwifery Advisory Group (HOMAG)[19], Community Health Councils (CHC)[20] and third sector organisations such as Mind Cymru[21]and National Society for the Prevention of Cruelty to Children (NSPCC) Cymru[22]. This helped us achieve our aim of engaging directly with women, their partners and families through the active promotion of a national survey, in order to understand their experiences of using maternity services.

Phase One

Phase One of our review took place between June 2019 and August 2020. The focus was on the quality of care provided in maternity units[23], up to the point of discharge, and included some aspects of antenatal care provided in the community. This consisted of:

- 15 unannounced inspections of maternity services within acute hospitals
- 10 announced inspections of free standing birth units
- A range of interviews with key leaders in each health board, including:
  - Chief Executive
  - Executive Director of Nursing
  - Medical Director
  - Chair.

Each individual inspection resulted in a report published on our website[24]. To supplement our fieldwork activity, we also carried out:

- A national survey of people using maternity services
- A national survey of staff working within maternity services
- A review of self-assessments completed by each health board.

[19] http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/HOMAG%20TOR.pdf

[20] http://www.wales.nhs.uk/sitesplus/899/home

[21] https://www.mind.org.uk/about-us/mind-cymru/

[22] https://www.nspcc.org.uk/about-us/what-we-do/wales/

[23] Home from home units, free standing midwife led units, alongside midwife-led units and obstetric units.

[24] https://hiw.org.uk/national-review-maternity-services

Participation in the review

Stakeholder group

We established a stakeholder group to provide professional advice and support to inform the delivery of the review. The group also enabled us to engage with key organisations to share significant progress and key messages to the service throughout the review.

The stakeholder group representatives included:

- Community Health Councils Wales
- Director of Nursing representative
- General Medical Council
- Lay representatives
- National Institute of Health and Care Excellence (NICE)
- NHS Wales Delivery Unit
- NHS Wales Heads of Midwifery Advisory Group
- NHS Wales Maternity Network
- NHS Wales Neonatal Network
- NSPCC
- Neonatal Maternity Network
- Mind Cymru (Mental Health Charity)
- Public Health Wales
- Royal College of Anaesthetists
- Royal College of Midwives
- Royal College of Obstetricians and Gynaecologists
- Royal College of Paediatrics and Child Health
- UK Nursing and Midwifery Council
- UK National Childbirth Trust
- Welsh Government.

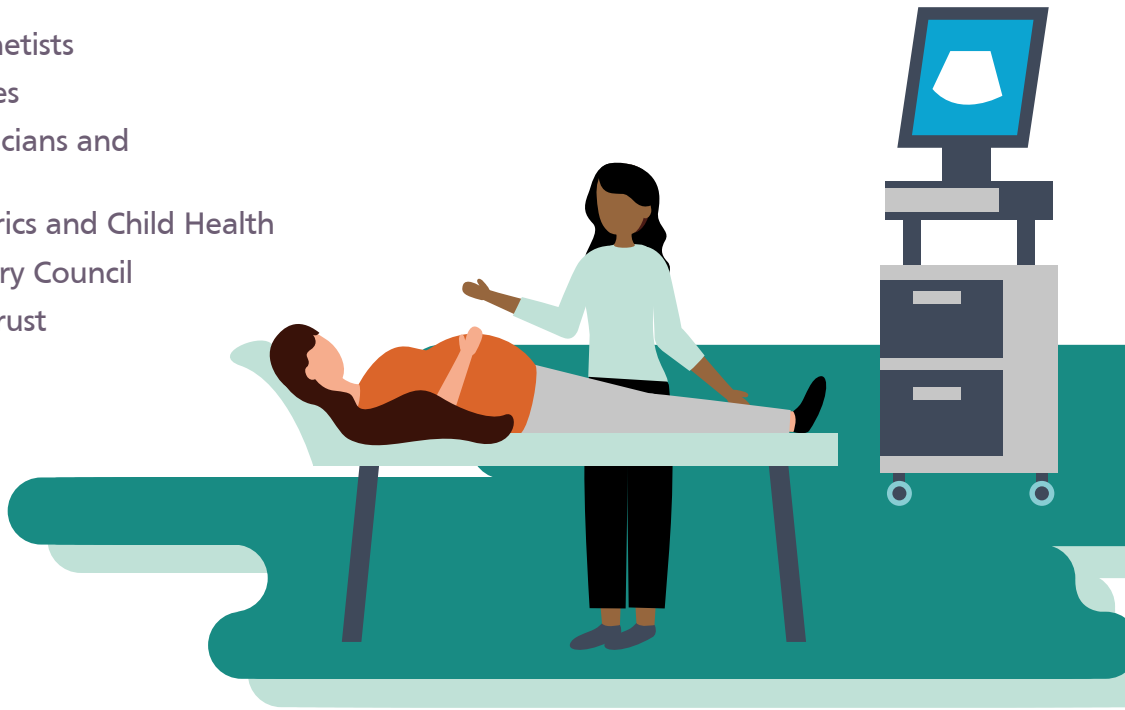
Advisory group

We also convened an advisory group in order to obtain expert professional views and opinions on specific maternity services topics, or issues that arose during the course of the review. The members had a diverse background within their specialty and had significant expert experience in maternity and/or obstetric care, and consisted of:

- Two professionals from the Obstetric specialty
- Two professionals from the Midwifery specialty
- Two professionals from the Anaesthetics specialty.

Document review

We completed an in-depth review of documents that we had requested, alongside a self-assessment that was sent to each health board, and considered local and national performance data and statistics.



National surveys

It was vital for us to gain an understanding of both public and staff views and opinions of maternity services across Wales. Whilst we captured and used the views of those using services, and those working within services on each individual inspection, we felt that this required specific attention. As such, we developed and launched two national surveys in order to gather a more detailed understanding of what people thought about maternity services.

Public survey

We launched a national survey in the autumn of 2019, which was developed in conjunction with the Community Health Councils. The survey enabled us to gather experiences from a broad range of women and their partners or families, who used maternity services across Wales. The survey questions covered experiences during pregnancy, birth (whether at home or in a maternity unit) and after the birth. We are very grateful for the assistance that the Community Health Councils provided in publicising this survey. As a consequence of this, and utilising our own social media channels, we received a considerable number of responses to this survey, containing rich information about the experiences of those who have used maternity services.

In order to ensure we captured and used this information effectively, we commissioned Wavehill[25] to undertake a detailed analysis of these responses. The report produced by Wavehill containing the full detailed results of the survey can be found on our website[26]. We have also released the data relating to the public survey in PowerBI format for people to be able to delve deeper into the responses. This can also be found on our website. At the earliest opportunity, and in advance of this report, we also shared with each health board some of the key themes emerging from the qualitative data from our survey. We did this in order to ensure that heads of service could use the information to inform their improvement agenda.

Staff survey

In parallel with the public survey, we also launched a national staff survey, to capture the views of staff working in maternity services. The survey covered patient care, professional development, health, safety and well-being and an overview of the organisation they worked within.

The results and findings from both surveys will be reflected throughout this report and the response data is detailed in the tables below.

Public survey response

We received 3,303 responses to our national survey from women and their families. The respondents represented all geographical areas of Wales, however, 20 responses were received from people living outside of Wales, or who did not provide sufficient information to determine their location. In addition to the national survey, we also received 122 completed patient experience questionnaires during our inspections. These were referenced within the individual inspection reports, which are available on our website.

[25] https://www.wavehill.com/

[26] https://hiw.org.uk/national-review-maternity-services

Public survey responses for each health board

Health Board	Number of Responses	Percentage of Responses	Percentage of Births
Aneurin Bevan	535	16%	21%
Betsi Cadwaladr	792	24%	20%
Cardiff and Vale	657	20%	18%
Cwm Taf Morgannwg	599	18%	11%
Hywel Dda	408	13%	11%
Powys	43	1%	2%
Swansea Bay	249	8%	8%
Total	**3,283**		

Staff survey response

We received 564 responses to our staff survey, with 71% of these completed by midwives. The remaining responses were received from consultants, healthcare support workers, administration staff, and those detailed as 'other'. Just over half the responses, at 57%, were from staff who had been working in their current role for more than five years.

Staff survey responses for each health board

Health Board	Number of Responses	Percentage of Responses	Staff Numbers[27]	Staff as % of National Total
Aneurin Bevan	90	16%	5,314	16%
Betsi Cadwaladr	113	20%	7,200	22%
Cardiff and Vale	76	13%	5,538	17%
Cwm Taf Morgannwg	57	10%	4,781	15%
Hywel Dda	87	15%	3,937	12%
Powys	52	9%	790	2%
Swansea Bay	89	16%	5,161	16%
Total	**564**		**32,721**	

[27] Staff numbers are taken from Stats Wales "Nursing, midwifery and health visiting staff" on 12 March 2020. Staff numbers shown are for September 2019 https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Staff/NHS-Staff-Summary/nhsstaff-by-staffgroup-year

What we found

Is the care given well informed, individualised and family centred?

The Welsh Government's Maternity in Wales's Five Year Vision[28], sets an aim for maternity services across Wales to provide care to women, their babies and families based on their needs and decisions, where they have genuine choice, informed by unbiased information. Respectful care that is family centred allows women to have control over their treatment, enhances personalised care planning and informs choices available for the place of birth.

Women have the right to be involved in discussions and be fully informed about the care they receive, to allow them to make informed decisions about their care. Women are more likely to have positive experiences of childbirth regardless of the outcome, if their care is personalised, if they are treated with dignity and respect, and if they are fully involved in their care planning process.

Every women is different; some may be first time mothers, some may have experienced previous births which were positive and some may have had traumatic experiences. All women should feel empowered to be fully involved and able to make those important choices at a time that can shape lives.

[28] https://gov.wales/written-statement-publication-maternity-care-wales-5-year-vision-future

Communication

A number of the findings that we identified in relation to this area came under the general category of communication. We have broken this down below into the key elements that warrant attention.

What did people think about communication?

We found that most women and their families were extremely positive about the care and support that was available to them at all stages of their journey through maternity services. Our national survey noted that 84% of responses related to *'good care'*, where women said they felt *'cared for'*, '*listened to*' and *'supported'*, with 16% reporting mixed experiences.

Support with communication

Overall, we found that women were positive about their interactions with staff during their care. In relation to measures and systems to support good communication, we found that communication aids such as hearing loops, braille facilities or translation services were readily available if required, to benefit people with hearing, sight or language barriers.

For those who needed to communicate in the language of their choice, 76% of women told us that this was offered during their maternity care, which allowed for continued communication, regardless of barriers. However, this also means that nearly a quarter of all respondents were not able to communicate in their language of choice. Our inspections noted that information was available in both Welsh and English in all units, although content varied from setting to setting. However, we saw little evidence informing women how they can request information or support in other languages.

Being able to communicate effectively in the language of choice can have a significant and lasting impact on the women's experience of using maternity services, making them feel heard and listened to, during what can be an uncertain and frightening time. We believe more needs to be done to address this issue.

Birth plan choices

Both medical and midwifery staff told us that promotion of individual care and choices for women was a priority in care planning. However, only 68% of respondents to our public survey said their birth wishes had been listened to. Whilst this may suggest there were instances of women's choices being ignored, some responses may not have taken into account medical circumstances, which may have made it not possible to grant a woman's wishes in order to maintain the safety of the mother and baby. Across Wales, women's perception of choices being ignored was found to be higher during intrapartum care, rather than in antenatal and postnatal care.

In 2016, health boards across Wales adopted the 'Birth Place Decision' leaflet[29], which informs women of their options for birth place. Birth choice clinics and antenatal clinics operate in all health boards, to improve support for women and their families in making informed choices about their birth options. Whilst we found that water births were well promoted across Wales, in some units within Betsi Cadwaladr and Powys, access to water birthing pools was not always possible. This therefore limited the birth choice for some women in these areas.

[29] https://gov.wales/sites/default/files/publications/2019-03/your-birth-we-care.pdf

"Not able to offer choice of pool birth due to H&S risk with plumbing and financial restraints."

Views from staff who work in the service

To ensure the options highlighted are equally accessible to all women, we believe that water birth facilities should be available throughout all birth settings. Further work across Wales is required to ensure that this is prioritised to meet the birth choices of women.

Spiritual choices

Throughout Wales, all health boards provide a multi-faith chaplaincy service and within all acute hospitals a small chapel or multi-faith room was available for women and their families. We were also told by staff and women across Wales that arrangements or assistance was in place to enable women from different faiths to access the chapels or multi-faith rooms to meet their spiritual needs.

Partner or family involvement

We found that generally, a woman's partner or family was able to help provide support or assistance during their pregnancy journey, and could be involved with care in accordance with a women's wishes and preferences.

Open visiting was available in the majority of units, allowing the partner or a designated other to visit freely. However, our survey highlighted concerns that this arrangement was not always available across all health boards. This concern was also described by women and families as having a negative impact on their birthing experience, and is an area that we feel requires improvement.

"Partners were not allowed in the ward at night. My legs were numb. I couldn't get my bag for nappies, baby clothes, my pjs. I wasn't told until we got to the door of the ward. One of the most vulnerable times in my life and I should never have been left alone with a baby. All four mothers in the ward were awake all night. All were massively struggling. Their partners should've been allowed to stay. Preposterous that depending on what time of day you have your baby, is whether you are left alone to cope."

"Partner was made to leave every night during the induction process (we live an hour away). He was allowed to stay till 11pm. I gave birth at 10.30. It was scary and isolating sending my husband, who was my biggest support away. It also left him with very little chance of the initial bonding."

Views of women who accessed the service

Being listened to

A key theme to have emerged from our review, and in particular from our survey, related to concerns expressed by women of not being listened to during their care. In particular, there were frequent examples of women expressing they had not been listened to, or supported through the pre-delivery stage of labour, although they indicated they received excellent care from the delivery team. Only 2% of respondents across Wales highlighted they received care which exceeded their expectations during the birthing stage.

"We had a truly fantastic midwife who listened to my views. I had been advised to have an epidural as soon as I was induced, but this was not my wish. My midwife was fully supportive with this and ensured my birth went the way I wanted. The consultant was on hand to deliver twin 2 and he was brilliant through the whole delivery. On twin 2, he guided him in to place and talked to me about what was happening and kept me calm whilst the midwife delivered him. I felt supported in having a birth I wanted, thanks my brilliant midwife."

"There was a refusal from midwives to believe that I was in active labour, as when I went into hospital, I was not sufficiently dilated. They refused to give me any pain relief and I was left to labour in a little room for four hours. They would not re-examine me, and when they finally did, they realised I was 9.5cm and the baby was in the back to back position. I felt that given this was my second labour, that my first had only been five hours from the first contraction, and that I had a good understanding of how labour felt, they would have given more credence to my opinion on whether I was entitled to any Entonox."

"I was ignored a lot and unless you were one of the mothers making a giant fuss you received no help or support. Staffing levels were so low that I was often left alone crying with no pain relief or support after a c section looking after a new-born on my own. My partner was not allowed in as much as we would have liked and I desperately needed the help and emotional support."

Views of women who accessed the service

Consistent care

Despite positivity from women regarding their journey through maternity services, a further theme related to women raising concerns over the numerous different midwives or clinicians they saw throughout their care. Women expressed a view that having contact with a consistent number of the same individuals enhanced their continuity of care, and made it more personalised to them. Concern was raised around having to repeatedly recount medical history to numerous healthcare professionals for instance, with this being challenging for those recalling traumatic birthing or pregnancy experiences. Whilst we appreciate that it may be difficult to achieve at all times, there is undoubtedly a significant benefit in women receiving care from a smaller group of individuals, with whom they can build a relationship and receive more holistic and personalised care. This is something that all health boards should strive to achieve.

Single electronic patient record

There are possible benefits to the introduction of a single electronic patient record in addressing the issue of continuity of care. The introduction of this system is in the planning phase across Wales currently. It is widely felt that implementation of this system would improve the continuity of care, meaning women would not have to repeat their history or recent care and circumstances on numerous occasions, especially where trauma had previously been experienced.

"I saw a different community midwife at every appointment during my pregnancy so was unable to build up any set of relationship. Luckily my pregnancy was straightforward, but it meant I didn't feel like I could share or discuss any emotions or worries as she was basically a stranger every time."

"I had to go over the experience of giving birth every time a different midwife came to the house – which is traumatic after a difficult birth and emotionally jarring."

Views of women who accessed the service

Recommendations

All health boards should:

- Ensure that women are aware of how they can request information or support in their language of choice
- Ensure that wherever possible, women are able to communicate in their language of choice
- Consider how water birth options can be made available across all units
- Improve the ability of birth partners or family members, to be able to support women, in line with a woman's wishes
- Take steps to ensure that women have contact with a consistent group of healthcare professionals, to improve continuity of care.

Recommendations

Welsh Government should:

- Ensure that the implementation of an electronic record is achieved as soon as possible.

Sharing experiences

Throughout our fieldwork, we identified some good examples of information sharing and opportunities for women and their families to share experiences of maternity services. This included information displayed to highlight who would be caring for the women and their families during their visit, notice boards highlighting information about a unit and its performance, engagement through social media, and health board surveys, for women and families to feedback about the services provided.

This included:

- **Who's Who Board** – staff information board which was useful in informing women and families who they would be likely to see within the units.
- **Notice boards for the benefit of women and their families** – detailing statistical data, compliance rates and key performance indicator data
- **Closed Facebook pages for the benefit of the women** – for sharing of information and a platform to share experiences
- **Friends and Family Test**[30] – introduced to allow for concerns, comments and good practice to be shared widely within the health board.

[30] Friends and Family Test is a questionnaire which Swansea Bay University Health Board have introduced to gain feedback, opinions and comments regarding the services, care received and improvements which could be made.

We found an example of noteworthy practice in Powys, known as Birth Reflections. This service is provided by midwives to allow women and their families to explore their birthing experiences, giving them an opportunity to gain clarity around any issues they may have encountered during the birth. Feedback obtained from women and their families allows suggestions to be made to services to improve the care and experiences of women and their families. The women we spoke with gave praise to the availability of this service.

Support, advice and guidance

Most women were satisfied with the amount of information, guidance and support that was available to them during their antenatal care across Wales. Examples of the type of support groups we saw included:

- Powys Mums Matter
- Breastfeeding Support Groups
- Yoga and Aqua Natal Classes
- Hypnobirthing
- Parent Craft Classes
- 36 Week Birth Choice Clinics.

For many pregnant women or new first-time mothers, the change in life can be substantial. Many women enjoy the experience, however, the journey can be challenging. By being part of a support group, such as those highlighted above, women and their families can talk to their peers and seek support from women who are in a similar situation.

Guidance from NICE[31] states that postnatal care should be holistic and individualised to a woman and her baby following on from birth, with the appropriate guidance and support provided. For the majority of women, the postnatal period ends between six to eight weeks after the birth, once they have received their postnatal check. Although, for some women, their postnatal care can be extended in order to meet any ongoing needs. However, the feedback we received from women about the support and guidance experienced during the postnatal phase was less positive than other phases of their pregnancy. We also found through our discussions with women that aftercare support is an area requiring improvement in after birth care in all health boards.

To ensure that a woman's care and support needs are met holistically throughout their postnatal phase of pregnancy, we recommend that each health board considers how it can obtain the opinion and experiences of women using their services. This will inform how it can improve the support and guidance required, to meet individual needs.

Promoting health and well-being

Our inspections found that the level of information available to women and their families for promoting health and well-being was appropriate and readily accessible. We saw plenty of literature advising women how to stay safe and healthy during and after pregnancy. Information in relation to self-care advice and support was displayed throughout units across Wales, informing women about the benefits of maintaining their health, and preparing them and their partners for parenthood. Overall, 64% of respondents to our public survey highlighted that they received a good level of information about their health and well-being, which included advice on healthy eating, the dangers of smoking, alcohol and drug use, and vaccinations during pregnancy.

[31] https://www.nice.org.uk/about/what-we-do/into-practice/measuring-the-use-of-nice-guidance/impact-of-our-guidance/niceimpact-maternity/ch2-maternity-and-mental-health

Smoking cessation

The majority of sites throughout our inspections adequately promoted smoking cessation. However, this was not replicated throughout all units, with Aneurin Bevan, Betsi Cadwaladr, Cwm Taf Morgannwg and Hywel Dda needing to improve in this regard. Our inspections noted that some units had established smoking cessation leads, who provide support and information to women to help them or their partners to stop smoking. However, these posts were not in place in all areas of the country. Further work with Public Health Wales[32] should be considered, to strengthen support in this area, to allow women and their families the best opportunity in achieving healthier lifestyles.

Promoting breastfeeding

It was positive to find during our review that breastfeeding was promoted throughout Wales, and staff highlighted that full support would be offered with breastfeeding when there were adequate numbers of staff on duty to allow for this. However, 10% of women responding to our survey said they had encountered negative experiences regarding breastfeeding support. This was in accordance with our findings during our inspections, where the service offered by breastfeeding support staff across the majority of Wales was compromised by high workloads, and the numbers of staff available. Health boards should consider how breastfeeding support can be improved and maintained at all times, for all women.

> "I was trying to breastfeed, and every midwife suggested and advised something different."
>
> "We were moved to a postnatal ward for 48 hours post birth due to my antidepressants. Multiple times I asked for help with breastfeeding and some of the midwives never came after saying they would. We were left to fend for ourselves. No one asked if I needed help in the shower. Had to nag for pain relief at times; especially after being promised it and people never came with it. […] No one was interested in how we were coping or my feelings."
>
> **Views of women who accessed the service**

[32] https://phw.nhs.wales/

Mental well-being and perinatal mental health support

It is highlighted by NICE[33] that women can develop mental ill health for the first time during pregnancy, and pre-existing mental health conditions can deteriorate in the perinatal period. Perinatal mental health problems affect up to 20% of women during pregnancy, or within the first year after giving birth. Depression and anxiety are the most common mental health problems during pregnancy, with around 12% of women experiencing depression and 13% experiencing anxiety at some point; many women will experience both[34]. In such cases, NICE guidance[35] recommends that women and their families need access to high quality, evidence-based care with discussions and on-going care planning taking place during all stages of pregnancy. This will allow for women and their families to receive the appropriate mental health support when required.

We saw that antenatal appointments in general made a specific attempt to discuss the changes in emotional well-being that can arise after the birth. However, from discussions with both women and staff we found concerns were raised about the perinatal mental health advice and support available during the earlier stages of pregnancy, where it was found to be limited. Within our patient survey, we also found concerns regarding the availability of postnatal mental health support.

"Overall I was not supported, [I] felt I was forgotten about often. I was very emotional and frightened on my first night, I called my mum and partner crying, midwives knew and nobody came to help. I had a post-dural puncture that went unnoticed for 2 days despite me telling them I had a headache."

"I struggled with breastfeeding and postnatal depression, the services for mothers for postnatal depression is lacking. I was in real need and there was no postnatal mental health care."

Views of women who accessed the service

[33] https://www.nice.org.uk/about/what-we-do/into-practice/measuring-the-use-of-nice-guidance/impact-of-our-guidance/niceimpact-maternity/ch2-maternity-and-mental-health

[34] https://www.nice.org.uk/guidance/cg192/resources/antenatal-and-postnatal-mental-health-clinical-management-and-service-guidance-pdf-35109869806789

[35] www.nice.org.uk/guidance/cg190

Our review identified that midwives across Wales are offered training in perinatal mental health, and are able to provide some support to women with mental health needs. They work collaboratively with adult mental health teams in each health board, to help ensure that care and advice is provided in a holistic way. However, staff we spoke with across Wales told us that the perinatal mental health support available to women required improvement and strengthening.

We found an example of noteworthy practice in Swansea Bay, where there is a joint working group in place, which consists of midwives, health visitors, social services and voluntary agencies, such as Surestart and Homestart (which are available through the Perinatal Response and Management Services (PRAMS))[36]. We found the PRAMS service leading the way in Wales, in treating and supporting pregnant women and new mothers who may be at risk of developing mental health problems. This is something that should be considered by all health boards, where it has not already been introduced.

Whilst the overall number of people who raised concerns with us about mental health support was low, it is clear that the adequacy of mental health support can have a significant and lasting impact on women who use maternity services. We believe that mental health support requires focus and improvement nationally, to ensure appropriate support is available in a timely manner during times of crisis. If left untreated, mental health issues can have significant effects on woman, their baby and the wider family.

Care during trauma or bereavement

A stillbirth or a death of a baby following the birth process can be hugely traumatic for both parents, as well as for other family members. During our review, we found that overall, each health board provided appropriate help and support in these tragic circumstances.

Our inspections found each maternity unit had dedicated bereavement rooms available for grieving parents and families, which offered a calm and peaceful environment.

Specialist bereavement midwives were in post in all health boards, and were very knowledgeable, supportive and approachable. Almost all staff we spoke with said they had received bereavement training and were confident in caring for any recently bereaved parents, and that guidelines, local policies and other support were available to enhance this. Midwives and maternity support workers highlighted in our staff survey that bereavement training was provided to a very high standard. This was consistent with our findings throughout our inspections. However, it was noted that access to timely bereavement training requires improvement.

Numerous bereavement support services are in place, to support women and families who have experienced a traumatic birth, or for those who want to question or gain further understanding about their birth experience. Women were also given the option of meeting with senior midwives to talk though their experiences and receive additional support and information. Each health board had its own bereavement support service in place for women and their families.

[36] http://www.wales.nhs.uk/news/12068

Recommendations

All health boards should:

- Consider the introduction of smoking cessation leads
- Consider working with Public Health Wales to further promote healthier living and lifestyles
- Ensure the appropriate level of breastfeeding advice, guidance, and support is provided at all times
- Review the adequacy and availability of perinatal and postnatal mental health support for women
- Consider the introduction of PRAMS across its services
- Ensure that staff are able to access bereavement training in a timely manner.

Learning from women and their families

Feedback from those who have used services

A key element of ensuring that services improve, is listening to the experiences of those who have used them. We found that regular feedback is collected by all health boards from women and their families. The mechanisms for doing this range from the usage of comment cards and closed social media platforms to questionnaires or surveys, which encouraged both positive and constructive feedback, to help improve services. Within our public survey, the majority of women said they felt able to express their opinions and concerns with health boards, around their beliefs, emotions, language choice, home life and their overall health during pregnancy.

In our staff survey, 53% of respondents told us that although patient feedback is actively collected from women and their families and used to make improvements or changes in service delivery. Staff in the Hywel Dda and Aneurin Bevan had a more negative response on this issue. In addition, a theme emerged around the fact that women or families are not routinely being made aware of any actions or changes being implemented in response to their feedback. This is something that requires strengthening across all health boards.

Patient stories

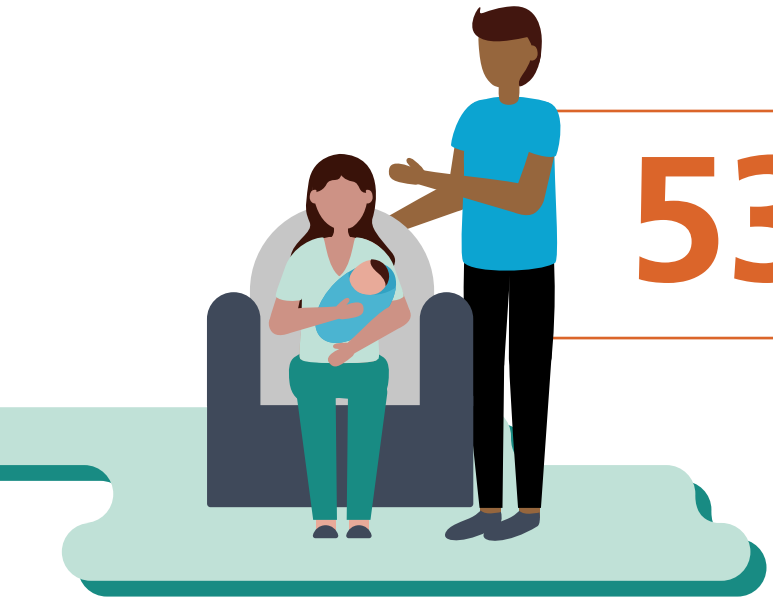
We learned that that whilst women's voices were heard at health board meetings through the presentation of patient stories, all health boards acknowledged that face to face sharing of experiences by women or families, to board meetings, or quality and safety committees was an area to improve upon. We feel this is an important issue as it ensures that leaders hear directly from people about their experience of using services, so that this can help influence and inform improvement. This can also be a positive way of achieving closure for women who have experienced poor care.

We did see some evidence of good initiatives enabling active listening to women and their families' experiences following birth. In Cwm Taf Morgannwg for example; Story Boards[37] were displayed across all units, and Maternity Conversation Cafés[38] were in use. Women and their families are invited to a café having used the health board's maternity services, to share their views and experiences with the health board and other families, on what is important to them, and how their experience can help shape the maternity services for the future. As a consequence, the health board reports that it has seen improvements in learning from its maternity service users over the last 17 months.

Recommendations

All health boards should:

- Consider what steps can be taken to ensure that learning from women's experiences can be improved, with a particular focus on sharing what has changed in response to feedback
- Consider strengthening arrangements for sharing patient stories at board and quality and safety committees.



53% of respondents told us that patient feedback is actively collected from women and their families and used to make improvements or changes in service delivery.

[37] http://cwmtafmorgannwg.wales/Docs/Integrated%20Medium%20Term%20Plans/IMTP%202017-20/IMTP%202017-20.pdf

[38] https://cwmtafmorgannwg.wales/maternity-conversation-cafes/

Are women in Wales receiving safe and effective care?

The health, safety and well-being of people should be a priority for maternity services, and people should be kept safe and protected from avoidable harm through appropriate care, treatment and support.

A service focused on safe care and support looks for ways to improve the quality of the service it delivers. Although the provision of care sometimes has an associated element of risk of harm, safe care will identify, prevent or minimise unnecessary or potential harm.

Maintaining quality and safety

Women and their families should receive safe and effective care throughout their pregnancy journey. The NICE[39] highlight that complexity in pregnancies has increased in recent years, and with this brings added pressures on staff and services to maintain effective and evidence based practice throughout. Quality and safety is everyone's responsibility, and should be prioritised in care planning and overall service provision.

To achieve safe and good quality care, there must be suitable processes and procedures in place, along with adherence to policy or guidance. Audit measures should be in place to monitor the safety and well-being of women and their babies, assessing risk throughout every step of the journey.

Key themes from our inspections

As we have noted previously, our overall view of the quality of services being provided within maternity units across Wales is very positive. We have no significant concerns over the delivery of care to women, and it is clear that the safety of women, babies and their families is a high priority for all health boards. As outlined earlier within the report, the results from our public survey are overwhelmingly positive and supportive of this view, with women and families pleased with how they were cared for.

An aim of this review is to ensure that health boards learn and improve from what we have found over the course of our work. As such it is pertinent to draw out some of the issues that we identified in order that each health board is aware and can learn from them.

[39] https://www.nice.org.uk/guidance/ng25/resources/preterm-labour-and-birth-pdf-1837333576645

Key themes requiring immediate improvement

Each of the following issues are matters that resulted in us issuing Immediate Assurance letters following some of our inspections. It is important to note that these issues were not present across all inspections and are not general theme. However, we feel it is relevant to highlight them in order that all health boards take note and learn from them.

Checking of neonatal resuscitaire and emergency equipment

One of the most common themes to have emerged from our programme of inspections was in relation to the adequacy of arrangements of checking neonatal resuscitaire and emergency equipment. This is a significant issue that resulted in 11 Immediate Assurance letters being issued following inspection. We found that mandatory checks on neonatal resuscitaire[40] units and other emergency medical equipment were inconsistently recorded in all health boards except for Powys. Consequently we could not be assured these checks were completed regularly and in line with health board policy, to maintain the safety of women and their babies.

This is an important issue to address, as the failure of this equipment in an emergency situation can have significant and adverse consequences. Since our inspections, health boards have provided us with assurance that these issues have been resolved. However, this remains an area that requires ongoing monitoring and audit to ensure that emergency equipment is checked in line with health board policy.

Medical assistance in emergencies

One of the key areas that we examined during our programme of inspections was the arrangements for accessing medical assistance in the event of an emergency. We found that in all units, all rooms had access to emergency buzzers and call bells to alert others in the event of an emergency, such as patient collapse. We also found that emergency equipment trollies, were well organised and contained all the required equipment, to support an emergency situation. The emergency drugs were also easily accessible to staff in emergencies, however, as highlighted above, safety checks of resuscitation equipment was inconsistent across Wales.

We also found in some units within Aneurin Bevan, Betsi Cadwaladr, Cwm Taf Morgannwg, Hywel Dda and Powys, inconsistencies in planning for emergency situations, emergency drills and the availability of policies and guidance for staff to ensure the correct processes are followed in the event of an emergency. These issues were raised following each inspection, and each health board has provided us with assurance through their action plans to confirm that these issues have been addressed and rectified. It is however, incumbent upon each health board to ensure that staff are fully aware of their roles, and the procedures to follow in the event of any emergency.

[40] Device to have during labour and delivery procedures, combining an effective warming therapy platform along with the components needed for clinical emergency and resuscitation.

Birth pool evacuation

Within most health boards, staff told us that the choice of having a water birth is steadily increasing across Wales. Consequently, in order to maintain the safety of women and their babies, staff should be adequately trained in birth pool evacuation, and emergency evacuation equipment should be readily available in all relevant units.

Our programme of inspections found that emergency equipment was available in all units. However, we found in some units in Hywel Dda and Powys that staff were not adequately trained or following correct procedures in birth pool evacuation. These concerns were escalated during the inspections and the health boards have now provided assurance that training has been reviewed and received by staff, and suitable policies are being appropriately followed.

Security of newborn babies

Our inspections considered the security of newborn babies. We found various procedures and systems in place across Wales, to help keep babies safe and prevent the risk of abduction. These included systems for security tagging, cot security alarms and closed circuit television cameras. Although every unit had implemented security measures, we found that these arrangements were insufficient in a small number of units, and the risk of abduction remained.

Some examples of this included the entrance of a maternity unit where a camera was inadequately placed, prohibiting identification of people entering or exiting the department. In addition, on some units we found that ineffective door security allowed people to exit and enter a department without staff being aware. There were inconsistencies regarding abduction management across all health boards other than Powys, with poor compliance with abduction drills, or units not adhering to health board policies. Furthermore, we found risks associated with some cot alarms inactivated by parents or the easy removal of baby alarm tags.

To maintain the safety of babies, a consistent approach to this risk should be considered on an all-Wales basis, ensuring best practice is followed by each health board in using the most secure systems, policies and procedures.

Infection Prevention and Control (IPC)

We saw that IPC was of a high standard across the majority of units that we inspected. However, where modernisation and improvements in amenities were required, particularly for older buildings, compliance with IPC was not always to an acceptable standard. This was particularly an issue when it came to risks such as broken floor coverings (lino), carpets, fabric curtains and old wooden fixtures, fittings and furniture. We recommend that all units are reassessed and actions taken to ensure each environment is fit for purpose and fully compliant with IPC requirements, to maintain safety of staff, the women and their families.

We saw evidence of good compliance with IPC across the majority of units, and this was also confirmed by the staff we spoke with during our fieldwork. In the majority of health boards we saw good outcomes from IPC audits with follow-up work from IPC teams where necessary. However, in some units improvement was required to implement action plans following on from audits.

Hand hygiene

During our inspections we observed the majority of staff across all health professions adhering to the standards of being 'Bare Below the Elbow'[41]. However, some midwives were noted to be wearing jewellery, such as engagement rings, watches and false nails, which posed a risk to infection prevention and control.

We observed good hand hygiene techniques in all units, with hand hygiene facilities easily accessible to staff and women or visitors, and posters advertising the correct hand washing technique displayed. Hand hygiene gels were also readily available throughout all the units, to help minimise the risk of cross infection.

We also found that Personal Protective Equipment (PPE) was easily accessible and readily available, and staff confirmed that they were happy with the amount of PPE available to them.

Secure storage of chemicals

Many units that we inspected were noted to have unsecure storage for Control of Substances Hazardous to Health (COSHH)[42]. This posed a risk to the health and safety of women and visitors if unauthorised access was gained to these areas. Whilst most units were able to immediately rectify these issues during our inspections, we recommend that each unit regularly audits compliance in this area.

Equipment storage

The clinical areas in the majority of units we inspected were well organised, uncluttered, and clean and tidy. However, in a number of units, we found corridors were very much cluttered and being used to store large and bulky equipment or furniture. We found this was restricting safe movement and increasing the risk of trips and falls. In addition, these issues could impede safe evacuation in the event of an emergency, since furniture and other items were, in some instances, blocking fire exits.

[41] Best practice is for staff involved in direct patient care to be bare below the elbow. This includes wearing short sleeved clothing, not wearing jewellery (with the exception of a plain wedding band), wrist watches, nail polish or false nails.

[42] https://www.hse.gov.uk/coshh/

Recommendations

All health boards should:

- Ensure the ongoing monitoring in line with health board policy of neonatal resuscitaires and emergency medical equipment
- Ensure staff awareness of procedures and responsibilities to follow in the event of a medical emergency
- Ensure staff awareness of procedures and responsibilities to maintain the safety of the women using water birthing facilities
- Ensure that a clutter free and safe environment is maintained across units
- Ensure adequate infection control measures are in place, and adhered to
- Ensure the safe storage of COSHH substances at all times.

Recommendations

Welsh Government should:

- Consider the benefits of a consistent approach across Wales to prevent baby abduction.

Medicines management

During most inspections we found acceptable arrangements in place for the management of medicines, however, some improvement was required. These improvements are noted below. We found that midwives were appropriately trained to safely administer medication in line with the Nursing and Midwifery Council (NMC)[43] Code of Conduct and health board policy. Medication advice and pharmacy support was seen to be available along with health board policies which were in place, up to date and easily accessible.

Medication storage

We found in some units across Aneurin Bevan, Cardiff and Vale, Cwm Taf Morgannwg and Hywel Dda, that there were inconsistencies in the way temperatures were monitored and recorded for medication fridges, and fridges containing expressed breast milk.

It was apparent from our inspections that staff were not always clear on their role and the relevance of their tasks in respect of medicine management. For instance, some were unable to clearly explain why the information was recorded, and what they should do if the temperatures fell outside of manufacturer's recommendations. Staff within some units were also unable to locate the policy which would provide appropriate advice in this regard.

[43] https://www.nmc.org.uk/

Prescribing and administration

We reviewed the arrangements for the safe prescribing and administration of medication in all units inspected. Some inspections found issues regarding the prescribing and the administration of medication during labour, with particular concerns in Betsi Cadwaladr and Cwm Taf Morgannwg. Their processes being followed were not in line with the health board's policy, and some medication for the induction of labour was being administered outside of licence guidance. Whilst these concerns were dealt with and resolved under our Immediate Assurance process, this is an issue that all health boards should consider, to maintain the safety of women and their babies.

We also reviewed samples of patient records in each unit throughout our inspections and overall we found that drug charts had been completed in the correct and appropriate way. In addition, women were wearing identification bands to help ensure medication could be administered safely.

Pharmacy teams

Each unit across Wales had the support of dedicated ward pharmacists during the day. During periods such as nights and weekends, staff were able to obtain medication or advice from on-call pharmacy support teams or hospital site managers. We found that medication and pharmacy audit activity was of a good standard throughout Wales, with actions, improvements and active learning taking place when or if required.

Recommendations

All health boards should:

- Ensure that staff are aware of their responsibilities in relation to the safe storage of medication
- Ensure that the prescription and administration of medication for the induction of labour is done in line with health board policy.

Safeguarding children and adults

Across Wales, it was reassuring to see that policies and procedures were in place to promote and protect the welfare of children and adults who are vulnerable or at risk. Safeguarding training was mandatory, and 98% of staff who completed a HIW questionnaire told us they had received training within the past 12 months. In our staff survey, 78% of staff said they would know how to raise a safeguarding concern about a child or an adult who may be at risk.

Safeguarding teams

Throughout our review, we saw dedicated safeguarding teams supporting maternity services in each health board. The teams provided specialist safeguarding advice and support to staff and women when required. Women identified as having safeguarding needs were referred to receive dedicated care and support where required.

Specialist safeguarding knowledge

We found that the majority of midwives within each health board had received training, and developed specialist knowledge in variety of subjects that are associated with safeguarding, which included:

- Substance misuse
- Perinatal mental health
- Smoking
- Teenage pregnancy
- Domestic violence
- Asylum seekers
- Female Genital Mutilation (FGM)[44].

Within Cardiff and Vale, a specialist FGM clinic was held by staff from maternity services, and had been in operation for around 18 months. The clinic provided psychosexual therapy to women who had experienced FGM, with the aim of providing support, help and advice to aid recovery. We found this to be noteworthy practice, and ought to be considered in all areas of Wales.

Recommendations

All health boards should:

- Ensure women have access to Female Genital Mutilation clinics.

[44] https://www.nhs.uk/conditions/female-genital-mutilation-fgm/

Risk management

Effective risk management arrangements are necessary to ensure that the risk of harm associated with providing care is managed and minimised as much as is possible. Risks can be identified by staff, women or families using services, or as a consequence of incidents. Health boards must have in place robust reporting processes and measures to manage risks once they have been identified, in order to minimise their likelihood or impact. Furthermore, health boards need to demonstrate learning as a consequence of any adverse incidents or concerns, to ensure that staff and services provide safe and effective care, and risk of harm is reduced.

Risk management and incidents

Our inspections found that overall, units demonstrated clear and robust processes for reporting and investigating clinical incidents and concerns. We saw there were lead governance and risk midwives in post across all health boards, who held responsibility for reviewing, and clinical management of multidisciplinary investigations.

However, staff across Wales told us that learning and service improvements as a consequence of incidents or concerns, was not always actively shared with staff.

An impressive 90% of respondents to our staff survey told us that their organisation encourages them to report errors, near misses or incidents. This was further supported by our discussions with staff during our inspections. However, only 52% of staff we surveyed said that their organisation treats staff involved in incidents fairly. Moreover, a high number of staff whom we spoke to during inspection felt that incidents were dealt with in a punitive manner, with a blame culture evident. This is clearly an area of concern. If staff feel that incidents are not going to be managed in an open, and transparent way, it will serve as a deterrent to those wishing to raise concerns. Given the prevalence of this issue within the RCOG report of maternity services within Cwm Taf Morgannwg, this is an issue that health boards need to take seriously, doing all they can to promote a positive reporting culture amongst all staffing groups.

"Heavy handed approach to errors/incidents involving midwives. The unit encourages honesty and transparency but often hard on midwives involved. Doctors and midwives treated very differently following incidents."

"Sometimes feels as though midwives are blamed/punished when a clinical incident occurs yet the doctors are not put under the same stresses. It would be better if midwives and doctors involved were treated fairly and also discussed situation together."

Views from staff who work in the service

Investigating clinical incidents

Staff within the majority of health boards said they were given ample opportunity for non-clinical time, allowing them to review or investigate incidents appropriately, which may include root cause analysis methodology. However, we were told by staff in Aneurin Bevan and Swansea Bay that they did not always have time to investigate incidents properly. In addition, across all health boards, we were told that active learning does not always take place following investigations. This was highlighted to us by staff, who said little learning is shared or seen following incidents. Again, this is a significant matter of concern, and requires urgent attention and action from all health boards. If learning cannot be demonstrated following an incident or investigation, this can severely undermine confidence amongst staff in reporting incidents in future, and increase the likelihood of similar incidents occurring again.

Audit activity

In general we have found that audit activity is of a good standard. However, throughout our inspections, staff reported that they felt there were opportunities for better learning, and increased awareness of implementation of actions and improvements following audit activity. This chimes with the feedback we had from staff regarding learning from incidents, and we believe is an area that requires strengthening across all health boards to ensure that staff are fully aware of the outcome of audit activity, and ensure that effective sharing of learning takes place. We have made a series of recommendations around strengthening the breadth of audit activity.

Learning from external audit

National maternity audits are important methods for identifying improvements to services. One such audit is Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE[45]), which aims to identify what went wrong in pregnancy and why, so that care across the UK can be improved for all mothers and babies in the future. Similarly, Each Baby Counts (EBC[46]) is a national quality improvement programme introduced by the RCOG, to reduce, through data gathering and scrutiny, the number of babies who die or are left severely disabled as a result of incidents occurring during intrapartum care.

Our review has found that actions and recommendations emerging from national maternity audit, such as MBBRACE and EBC, are generally acted upon effectively by health boards. We also saw that annual external validation is received from national audit bodies such as MBBRACE and EBC, with ongoing work carried out by senior midwifery teams to ensure units are operating in line with the recommendations made. These relate to areas such as human factors and behaviour, workload and workforce challenges and communication. Progress against these recommendations was noted and this was seen to be consistent and well managed across Wales.

Single maternity dashboard across Wales

Dashboards are electronic tools that monitor the clinical performance and governance of each maternity service. They can help to identify patient safety issues and ensure timely and appropriate action can be taken, where required, to ensure high quality care. Data from the dashboards is presented to Welsh Government annually, who monitor performance of each health board.

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[45] MBRRACE – Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK with the aim of providing robust information to support the delivery of safe, equitable, high quality, patient-centred maternal, new-born and infant health services.

[46] Each Baby Counts – the Royal College of Obstetricians and Gynaecologists (RCOG)'s national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour.

Whilst we saw the active use of maternity dashboards in all units, due to different methods of capturing data, health boards are not currently able to review themselves against others and understand how they are performing. We are aware that work is underway to address this and introduce a single maternity dashboard. We believe this would be a positive development, enhancing the ability of health boards and Welsh Government to monitor performance locally, and nationally.

Recommendations

All health boards should:

- Ensure learning and service improvement actions are implemented following incidents, concerns or audit, is effectively shared with staff across all sites
- Ensure that steps are taken to encourage staff to speak up and report incidents without fear of reprisal or repercussion.

Recommendations

Welsh Government and the health boards should:

- Ensure the timely implementation of a single maternity dashboard across Wales.

Evidence based practice

Guidelines, policies and procedures

Staff within each maternity unit had access to their health board's intranet, and had an area dedicated to maternity services. Staff could access a wide range of midwifery, medical and clinical guidelines, and the health board's policies and procedures. However, our inspections found that many health boards had policies or standard operating procedures in place which had not been reviewed or updated in a timely manner and were therefore out of date.

Staff told us during inspections they felt there were issues with communication and a lack of consultation with teams when developing or implementing new policies and sharing this information. Our review has highlighted that all heath boards need to ensure that staff have access to the most up-to-date information, and are informed when documents are being updated. This is important because failure to do this can result in unsafe care being provided.

Recommendations

All health boards should:

- Ensure that policies and procedures are updated, ensuring staff are aware of updates to maintain the delivery of safe and effective care.

Are women receiving care from skilled multi-professional teams?

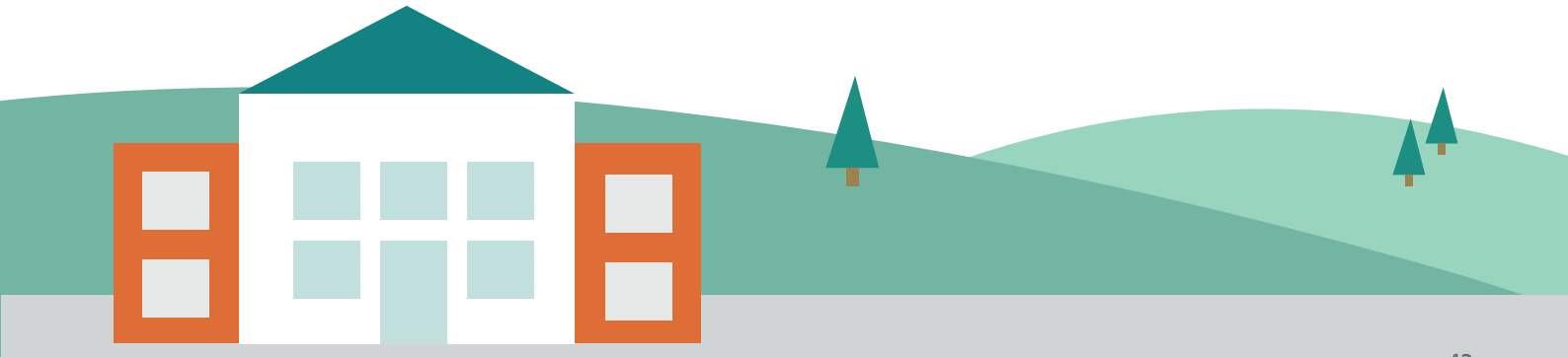
It is recognised by the RCOG and RCM that effective multi-professional working is a key component in the delivery of safe maternity care. Underpinning this is the importance of respectful team working to build a supportive workplace culture.

Multidisciplinary teams

Multidisciplinary teams within maternity services are a team of professionals from a range of different disciplines who co-ordinate and work together, to deliver comprehensive care to address a woman's needs in order to improve her and her baby's care and outcomes. Across Wales we consistently found teams working collaboratively within each maternity service, bringing together their expertise and skills to assess, plan and manage care. This was noted to improve health outcomes and enhanced satisfaction for women and their families.

Staff across all health boards told us that working relationships between consultants and midwives had not always run smoothly over previous years. However, they highlighted that improvements had been made more recently, resulting in effective team working. During our inspection programme, we found that relationships were strong and having an effective influence on the care of the women and their babies.

To ensure optimum functioning of the teams and effective outcomes for women and their babies, the roles of the multidisciplinary team members in care planning and delivery must be clearly negotiated and defined. We found this to be in place within all health boards and identified good examples of respect and trust with good use of skill mix. We also found jointly agreed processes were in place to maintain effective communication and interaction. Staff also told us that strong clinical and midwifery leadership helped to drive improvement in this area.



Multidisciplinary patient safety at a glance

Throughout our inspections, we saw multidisciplinary teams using Patient Safety at a Glance (PSAG) boards[47], on a daily basis. These boards clearly communicated patient safety issues and daily care requirements and plans, as well as individual support required and discharge arrangements. We found noteworthy practice within Betsi Cadwaladr's acute hospital sites, where a live camera link from the ward's PSAG board displayed information in handover rooms. This ensured the most up-to-date information was available for discussion during handover. Other health boards may wish to consider this initiative, to strengthen communication throughout teams, and allow for live up-to-date communication sharing.

Obstetric theatres

Obstetric theatre staff carry out surgical intervention for the safe delivery of babies through an assisted birth[48] or caesarean section[49], instead of a normal vaginal delivery. They ensure a safe and sterile field for this major abdominal surgery, for the safety of both mother and baby. To assist the obstetrician with surgery, a midwife will require specialist training. The majority of midwives we spoke with confirmed that unless they were trained to do so, they were not expected to undertake the role of a scrub nurse[50] and assist the obstetrician with the surgery.

Midwifery staff within Cwm Taf Morgannwg told us however, that on occasion they had been asked to assist in theatre and had not received appropriate training, or had their competencies signed off to safely perform scrub tasks and duties. This was identified also during our inspection of maternity services at the Royal Glamorgan Hospital in 2018, and was escalated at that time. Our findings during this review were raised with the health board during the inspection through our recommendations, and we have since received assurance that staff no longer practice in theatre unless appropriately trained. Nonetheless, we feel this is an issue that all health boards need to be aware of, putting measures in place to ensure that only those midwives who have completed an appropriate level of training are able to assist in theatre.

Recommendations

All health boards should:

- Consider the implementation of a live PSAG display feed, to enhance patient handover
- Ensure all midwives complete appropriate training before being required to assist in theatre.

[47] The Patient Status at a Glance Board (PSAG) is used in hospital wards for displaying important patient information such as; the infection risk levels, mobility, admission and discharge flow, occupied number of beds, nursing and medical teams, amongst others.

[48] An assisted birth (also known as an instrumental delivery) is when forceps or a ventouse suction cap are used to help deliver the baby.

[49] A caesarean section, or C-section, is an operation to deliver your baby through a cut made in your abdomen and womb.

[50] Scrub nurses are registered nurses (or midwives) who assist in surgical procedures by setting up the room before the operation, working with the surgeon during surgery and preparing the patient for the move to the recovery room.

Research and innovation to improve practice

Midwifery and obstetric professionals should be committed to ensuring that care delivery is based on the best available evidence with research generating innovation in day to day practice. During our review, we explored the evidence-based care being provided within the maternity units, and through this we had multiple conversations with different staff groups across Wales.

We found that multidisciplinary teams had a good understanding of research and innovation, and that change was purposeful for the benefit of women and their babies. We were told that staff endeavour to provide women and their babies with the best care and services they can, and as previously highlighted, we found some good examples of this across Wales.

Each health board had a lead clinical research or improvement midwife in post. Their role is vital in undertaking research and enhancing patient care and experience through staff development.

We found some good examples of noteworthy innovations across Wales, to improve the care and services provided to women. These included the following:

- Babies Don't Bounce
- Birth choice clinics
- Epilepsy in pregnancy
- Growth assessment protocol – GROW – Gestation related optimal weight (GAP and GROW)[51]
- Learning through postpartum haemorrhage (PPH) (heavy bleeding from the vagina following childbirth).

The research and improvement midwives identify learning through a variety of sources, such as clinical incidents, complaints, training needs analyses or personal and professional development of staff. They share the learning not only through the development of care pathways and standard operating procedures across their maternity service, but by training and developing staff within the services.

Within Aneurin Bevan, we found that there were research and improvement champions in place to help ensure that this area was consistently highlighted within the local units. We were also told by staff across Wales that such roles would be introduced in all units in the near future. This role supports learning between the wider team of medical, midwifery and healthcare support staff. This was an example of noteworthy practice in encouraging and supporting innovative work and further research projects, and should be considered within all health boards across Wales.

Over the course of our review, we identified a number of innovative practices in place across Wales, which improved the safety of women and their babies and supported positive outcomes in the care given. These included:

Babies Don't Bounce

The Babies Don't Bounce[52] initiative has been established by Cardiff and Vale. This was in response to a number of incidents where babies had fallen out of cots and off beds within hospital units. Since its implementation, staff told us that they had seen a significant reduction in the incidence of babies falling or being dropped. We believe this to be an initiative that all health boards should consider learning from or adopting, to help reduce the risk of such incidents occurring.

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[51] GAP and Grow - A procedure designed to monitor potential problems during gestation, specifically for women who have previously delivered small babies)

[52] https://gov.wales/sites/default/files/publications/2019-06/implementation-of-all-wales-intrapartum-fetal-surveillance-standards-for-maternity-services.pdf
http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/Babies%20dont%20bounce%20poster%20barcodes.pdf

Birth choices

Birth choice clinics and antenatal appointments are held for women and their partners in all health board areas. These ensure consistent and appropriate advice and guidance is provided to prospective parents, in a balanced and unbiased manner to help with their pregnancy and labour or birth choices. The clinics have a positive impact on a woman and her family's experience and was noted to be good practice across Wales.

Cardiotocography (CTG)[53] monitoring

Within Cardiff and Vale, we found a live CTG viewing system had been implemented for staff within its labour ward. This system, along with midwives providing care for women, allows all maternity staff, to view and monitor the fetal heart rate electronically and remotely from outside of the individual delivery rooms throughout their care journey. We consider this system to be good practice and recommend that all health boards consider implementation of this this system.

Within our staff survey, 95% of respondents said they had received the appropriate CTG training within the last 12 months. We saw evidence to support this during our fieldwork and compliance was consistent across Wales. However, in some health boards we found inconsistencies in the way CTG is managed and reviewed, which may impact on the safety of women and their babies. We noted a tendency to review CTG traces in isolation, as opposed to at the bedside where the women and her entire clinical picture could be considered. We also found some inconsistencies in annotated CTG prints filed within health records and varied evidence of a 'fresh eyes' approach to CTG reviews. To ensure variations in practice are reduced and care is consistent, health boards must ensure CTG training and processes are in line with the All Wales Maternity Network 'All Wales Intrapartum Fetal Surveillance Standards[54]'.

Recommendations

All health boards should:

- Consider the implementation of champion midwives to support further innovation and research
- Consider the introduction of live stream CTG monitoring in all units.

[53] Cardiotocography (CTG) is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy.

[54] http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/Babies%20dont%20bounce%20poster%20barcodes.pdf

Learning and development

Midwives and medical professionals are required to revalidate every three and five years respectively. Revalidation is the process by which professionals must complete a number of requirements set by their regulatory body to remain on the midwifery and medical register. In order to successfully complete this requirement, midwives and doctors must ensure their learning, training and development is comprehensive and up-to-date, along with regular appraisal processes.

Throughout our review, we found that staff were positive about the training available to them but stated that more timely access to initial training and updates would be beneficial. Overall, we found compliance with training was satisfactory to maintain safe care, although as highlighted earlier, improvement in accessibility to bereavement training is required throughout Wales.

Mandatory training compliance

Overall, we found robust processes in place to monitor staff attendance and compliance with mandatory training, such as health and safety, fire safety, infection prevention and control and safeguarding. Across Wales, this training was predominantly completed on-line and recorded centrally through an electronic staff record. We were told that both staff and managers receive prompts to inform them when staff required updates or refresher training. Training compliance was regularly monitored at a senior level, and any issues or discrepancies identified, were addressed with staff teams and escalated as required. Within our governance interviews, this was confirmed by the executive directors of nursing during our discussions, with examples provided to us on how this is managed locally across the units in Wales.

We found that each unit also held mandatory training specifically for midwives and obstetricians throughout the year. This included GAP and GROW[55], CTG and adult and neonatal resuscitation. However, we found that only 68% of staff in our survey had received this training. Some staff commented that this training would be beneficial to them, and women and their babies. We therefore recommend that all health boards review the access available to these training sessions, to ensure all relevant staff have timely opportunity to attend.

We also reviewed training records within each unit inspected, and discussed training opportunities with numerous staff. Through this we identified inconsistencies with compliance in timely training and/or updates. We found that the need to maintain safe levels of staffing in clinical settings often impacted on the ability of staff to attend training when required. Whilst units had allocated time for staff training, this was sometimes cancelled at short notice to prioritise clinical care.

Learning from postpartum haemorrhage

Postpartum haemorrhage (PPH), is the most common form of major obstetric haemorrhage. The RCOG suggests that between one and five women in every 100 experience PPH, and it is more likely to occur following a caesarean section birth.

Throughout our review, we found work had been undertaken across Wales in relation to the management of PPH (Maternity Care in Wales – A Five Year Vision for the Future 2019-2024)[56]. We found the work undertaken by all health boards, in line with the five year strategy, was positive, together with the ongoing plans in place to develop work to enhance the care and safety for women using maternity services across Wales.

[55] GAP and Grow – A procedure designed to monitor potential problems during gestation, specifically for women who have previously delivered small babies)

[56] https://gov.wales/written-statement-publication-maternity-care-wales-5-year-vision-future

90% of respondents to our staff survey said they had regularly received PROMPT training.

Practical Obstetric and Multi-Professional Training (PROMPT)

Each health board endorsed regular PROMPT training. This well-established course provides training for maternity staff and helps midwives, obstetricians, anaesthetists and other members of maternity teams to maintain safe practice, and to be more effective in the care they provide.

Almost 90% of respondents to our staff survey said they had regularly received PROMPT training, and that they found this to be excellent and very informative. Our conversations with staff throughout our fieldwork, largely supported this response.

Vaginal Birth after Caesarean Section[57] (VBAC)

We found effective implementation of the Vaginal Birth after Caesarean Section (VBAC) protocol. The VBAC process allows healthcare professionals to determine if a woman is able to choose between a repeat caesarean section and vaginal birth, following a previous caesarean section birth.

We found that women were engaged in the development of this service, and health boards had implemented training for VBAC. This has increased staff learning and development, is considered noteworthy practice, and will further develop the service across Wales.

Recommendations

All health boards should:

- Ensure that staff have timely access to the training that is required for them to carry out their roles effectively.

[57] VBAC – Vaginal Birth After Caesarean Section – Where many women who have had one previous caesarean section can safely have a vaginal birth in a subsequent pregnancy, or they can choose to have a caesarean section.

Continuous professional development

Appraisal compliance

During our discussions with them, staff told us that appraisals were an important part of their development. In our staff survey, 86% of respondents confirmed they had received an appraisal, or personal annual development review in the last 12 months. However, only 65% of these staff said that training, learning or development needs were identified during the appraisal process, which suggests scope for improvement in how appraisal systems operate throughout Wales.

Clinical supervision for midwives

In April 2017, under a new model for clinical supervision, health boards took responsibility for the supervision for midwives practising in Wales. Since this change, the delivery of midwifery supervision has operated at health board level rather than nationally.

Throughout our inspections, we reviewed the processes in place for clinical supervision. We spoke with clinical supervisors in all health boards about their role in providing support and professional supervision to registered midwives. There is a national target[58] to ensure supervisors meet with each midwife for four hours each year, and we found good compliance across Wales in achieving this target.

Induction and mentorship for midwives and medical staff

Overall, we found robust induction programmes in place for midwifery staff in all units, and staff advised these were of great benefit when commencing their role. However, induction programmes or packs were not consistently available in all units for new medical staff. During our inspections, we found that most units were in the process of addressing this.

We saw that ongoing training and mentorship for medical staff was in place, and staff we spoke with across all health boards said that the training, support and guidance was of a very high standard. However, we were also told by midwifery staff that the preceptorship programme[59] required some improvements to ensure new staff felt adequately trained and supported when newly registered.

Induction and preceptorship are important processes to integrate staff into their new roles. These allow for increased productivity, professional development and competent working when introduced at the right time, with the appropriate content and support available to all new staff.

Recommendations

Welsh Government should:

- Consider an all Wales approach to appraisals to ensure a consistent approach
- Consider a review of the preceptorship programme to improve the experience for newly qualified staff.

[58] https://gov.wales/sites/default/files/publications/2019-03/clinical-supervision-for-midwives-in-wales.pdf

[59] https://www.nmc.org.uk/standards/guidance/preceptorship/

Can the quality of services be sustained?

Health boards should aim to consistently deliver high quality care. However, a key factor in sustaining quality of services is ensuring a strong workforce, who are skilled and trained to undertake their roles effectively.

Staffing, work and job plans

It is critically important for maternity services to have a workforce in place that is sufficient in both number and in capability. We found that there are risks around the ability of health boards to ensure that sufficient levels of staff are in place to enable the safe delivery of care at all times.

Birth Rate Plus

Birth Rate Plus[60] is a staffing methodology used in maternity services, based on an assessment of clinical risk and the needs of women and their babies during labour, delivery and the immediate post-delivery period.

We found that overall, services were working in line with Birth Rate Plus. We were able to see that adequate staffing levels were were in place in all unit establishments across all health boards, and in line with Birth Rate Plus requirements. The NICE recommends that a Birth Rate Plus review is conducted at least every three years, and we found evidence that this was consistently carried out within all the services inspected. However, within our staff survey, only 40% said there are 'always' or 'usually' enough staff for them to do their job properly. This response varied considerably, with the health boards across south Wales having the most negative comments about staffing ratios.

40% said there are 'always' or 'usually' enough staff for them to do their job properly.

[60] https://www.rcm.org.uk/media/2367/birthrate-plus-what-it-is-and-why-you-should-be-using-it.pdf#:~:text=The%20Birthrate%20Plus%C2%AE%20methodology%20is%20based%20on%20an,pathway%20using%20NICE%20guidance%20and%20acknowledged%20best%20practice.

"The culture in the unit I work is awful, it's punitive, there is sadly lots of bullying and there is a huge blame culture. The senior management team are unsupportive and sometimes you feel like it's a witch hunt to pin blame on you. I feel scared to go to work in case I lose my pin as the staffing levels aren't safe and we aren't supported as midwives...."

"The safety of our patients and the care we give is always our main priority as midwives working out on the wards. There is a huge impact on the midwives and support workers due to staffing levels and lack of senior management support in our organisation."

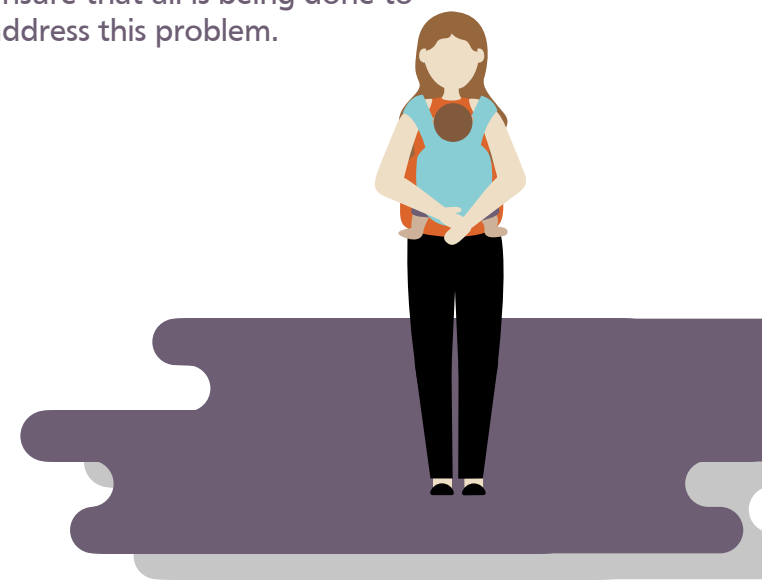
"Sometimes on shift I feel I am unable to give the care patients/babies deserve due to staffing and very busy ward. Also having to give ladies to other members of staff to look after whilst taking on elective section because of staffing, then having to return, look after a fresh section, complete deliveries on computer, as well as picking up with other patients I had to leave."

Views from staff who work in the service

Medical cover

A strong theme from our review is that staff perceive there to be a heavy reliance on the good will of doctors to cover shortages in the medical staffing rota. We saw evidence that during twilight shifts (between the hours of 2100 hours and 0200 hours), consultants would often undertake the role of a registrar in some health boards, to cover the deficit in registrar on-call duties. This was a concern due to compliance with the working time directive[61], and the amount of hours staff were actually working.

It was clear in our discussions with health boards that fragility of the medical staffing workforce is evident, although the executive and board team members we spoke with felt assured that this situation is being managed operationally on an ongoing basis. Continued monitoring of this situation and its sustainability is required to ensure that all is being done to address this problem.



[61] A law in which staff are not allowed to work more than 48 hours in a working week to maintain staff safety and well-being.

Staffing levels

During our inspections we reviewed the midwifery and medical rotas and establishments for each unit, and found they were comprehensively managed as highlighted above in relation to Birth Rate Plus. Where short or long term staff absences were identified across Wales, for example due to sickness, departmental escalation processes were in place to address the shortfall in staffing. The staff we spoke with were all aware of the local procedures on how to address and escalate such issues.

Throughout our review we found issues in many units, with staff from all disciplines working in excess of their contracted hours. This was to cover unfilled vacancies and unplanned absences.

As highlighted earlier, this also impacted on last minute cancellation of arranged training sessions. To maintain staff well-being, prevent fatigue and improve morale, health boards should monitor staff working hours locally, and review their current workforce plans. This should include a review of recruitment strategies to help address the current shortfall in staffing and cancellation of planned training within some units.

Where shortages were reported in acute hospital units, we were informed that some health boards temporarily deployed community midwives to cover the shortfall. Senior managers told us that they would also provide clinical cover when required.

> "Patient care and safety is always a priority for all staff and management."
>
> "When sufficient staff are on duty, I would generally be happy with the standard of care, but frequently there aren't enough staff, particularly on the postnatal ward and skill mix is sometimes an issue to demands of other areas of the unit."
>
> **Views from staff who work in the service**

Compliance with working time directives

Within a number of units across Wales, we found issues in relation to shortages in staff numbers as a result of vacancies or unplanned absences. Such shortages are not sustainable where there is a reliance on staff working in excess of their contracted hours, often not compliant with working time directives. In addition, this can have an effect on continuity of care if the use of temporary staffing was required. There is also a risk of care and patient safety being compromised as a result of fatigue, when staff are working excessively.

Some units did not monitor the number of hours individual staff members were working, and did not take steps to ensure staff had adequate rest time between shifts. In our staff survey, less than half the respondents agreed their job was good for their health, although the majority said their immediate manager took a positive interest in their health and well-being.

The issue of staff shortages, and staff working excessive hours is a concern across all health boards. Each unit should carefully monitor the hours its substantive staff are working throughout their health board. This is to ensure that patient safety and the quality of care can be maintained by reducing the risk of fatigue, along with maintaining staff well-being.

Recommendations

All health boards should:

- Review their workforce plans to ensure appropriate actions are being taken to address the impact of staff working excessive hours, and any shortfall across staff groups.

Maintaining staff morale

Celebrating staff success

Celebration of staff achievements, good work or general care and kindness can promote more success, and will add to the satisfaction of staff in the workplace, as well as that of women and their families. During our fieldwork, we noted a number of good initiatives across Wales to recognise and commend good practice and care within units. Some examples we found during our inspections include the following:

- Kindness boards displayed in staff areas
- Greatix electronic database for recording of good practice/care
- Caring for you Campaign[62] (improving the health, safety and well-being of members in their workplaces)
- Employee of the month
- Feedback Friday cards
- Letters from supervisors highlighting areas of good practice
- Recognition awards for volunteers.

These were positive initiatives and all health boards should consider introducing some or all of them in their maternity units.

Recommendations

All health boards should:

- Consider implementation of positive initiatives to recognise the good work carried out by staff within the midwifery and medical teams.

[62] https://www.rcm.org.uk/supporting/getting-help/caring-for-you/

How well are maternity services led and managed?

Strong leadership and management is essential to the delivery of safe, and effective care. Well-led and well-managed services contribute to safer, and more effective care for those using the services. The better a maternity unit is run, the more positive the experience is for women and their families. When issues are identified relating to poor care, whether these are individual concerns or systematic issues, it is often the case that these matters are rooted in poor leadership, management or governance arrangements.

Leadership

The effectiveness of how maternity services are led and managed, has a significant bearing on the overall quality of care provided, and consequently upon the experience of those using the services. Overall, we have seen services and units led by a hugely committed workforce, striving to provide the best level of care, and provide a positive experience for women and families. As our public survey has demonstrated, the majority of women were pleased with the level of care and support that they received at each stage of their pregnancy.

Our programme of inspections have nonetheless highlighted some concerns over the effectiveness of the management of the maternity units. It has been striking to note how consistently we identified patient safety issues, which gave rise to concerns over local management and governance arrangements of these units. It is clear that there is room for improvement, to ensure that safe and effective care is being provided consistently across Wales.

Executive and board leadership

Our review has considered the findings from our inspections, document analysis, surveys and discussion with key leaders of health boards. Overall, we have found executive and board leadership across Wales to be good. Through review of the minutes and actions from executive meetings, where audit and governance responsibilities are addressed and monitored, we concluded that there is clear oversight of maternity services.

During our governance interviews, the executive and board members told us that they take the opportunity to visit maternity units to meet with staff, women and their families. During our fieldwork, this was confirmed by staff, the majority of which were well aware of the senior management teams and executive team members for their directorates and health board. We were also assured that where improvements were needed, good relationships have been fostered with the maternity service teams, which allow for effective communication to take place. This was confirmed by the teams during our inspection programme.

Senior leadership

Our review has found medical leadership throughout Wales to be effective, supportive and focused on the care being given to women and staff well-being. We found a number of good examples of successful medical leadership, and this was also confirmed through the discussions we held in our governance interviews with executive Medical Director's across Wales. Staff also told us throughout our inspection programme that support and engagement from medical staff and the clinical director to be very positive.

Senior midwives and ward managers were also seen to play a vital part in management and leadership or maternity services, with their main focus being on patient care and staff well-being. During our inspections, most staff told us that they felt fully supported by their direct leaders, with some comments received in our staff survey stating they felt their manager can be counted upon. However, we also received some negative feedback during interviews, suggesting a perceived lack of effective communication and engagement with more senior staff, which was noted to have a detrimental effect on working relationships.

"I have been very impressed with the level of personal support provided, especially with respect to serious incidents at work. Having previously worked in England, I was astonished to see the difference and how in Wales the staff care for each other and support each other."

Views from staff who work in the service

We saw good examples of work undertaken by consultant midwifes to facilitate and achieve expert clinical practice, provide leadership and management support, undertake education and practice development research and implementing service improvements. This included the development of the new VBAC protocol mentioned in an earlier section, increased user engagement in service development and producing and implementing numerous training programmes to develop the knowledge and skills of staff. These posts were in place in each health board and are key to the further development of maternity services across Wales.

"Excellent line manager – fosters a culture of openness and team work. Supportive and encouraging."

"I have had full support and encouragement from my manager (matron). She has always been positive with my practise and CPD and makes me feel valued."

"My immediate manager works in an office adjacent to the staff office and always has an open door policy. She is approachable and always happy to help out in a clinical way as well as managerial."

"Ward managers show very little concern for staff well-being. They are only concerned with their office work – never cover staff for meal breaks or help on wards voluntarily, often can't be found on the wards."

Views from staff who work in the service

Unit leadership

We found that most units across Wales were well led and had good governance processes in place. However, it is clear from the sheer number of consistent patient safety issues to have emerged from our programme of inspection, that there is room to strengthen these arrangements. For instance, our inspections identified that the governance processes and leadership of the free-standing birth units of Betsi Cadwaladr required improvement due to a lack of oversight on key areas such as audit, checking of medical equipment and IPC. As highlighted earlier in the report, we consistently uncovered issues regarding the checking of emergency equipment in line with health board policies. These issues are not down to individual failures, rather they represent a need to strengthen certain aspects of management and governance of these units to ensure that all measures are taken to ensure the safety of those using the services.

During our inspections, governance interviews and from the completed executive team self-assessments, we found that good governance processes were in place in most units. However, where we identified issues locally as highlighted above, we have received assurance through our Immediate Assurance process and inspection recommendation action plans that improvements have been made or are in progress. This was also confirmed during our governance interviews with executives and board members, who felt such improvements were being prioritised as a result of strong and committed heads of midwifery and medical leads, along with senior midwifery teams, who strive to lead dedicated and hardworking staff teams.

Throughout our inspections, most staff reported that leadership within the units was excellent with leaders being involved in clinical practice when required. However, some of the comments received within our survey suggested that staff felt senior manager visibility could be improved, due to their office location being away from the units. Senior staff we spoke with confirmed that they addressed this by frequently attending the units. Whilst some clinical staff confirmed this, others felt this could further be improved in some units, which would allow for stronger working relationships.

"I know all of the senior managers on the unit, but I am unsure if they know their staff. There is very poor communication between senior management and staff and senior management are very rarely visible during the day."

"I know what they do and how they cascade information, but a general member of staff may not even know what they look like, as they rarely walk the floor to see staff and patients."

"I know managers' names and faces, but senior managers have made no effort to get to know staff or the daily workings of the unit. With the exception of the (manager) who is always supportive, visible and available to contact, the other senior managers are invisible. On several occasions when managers on call have been contacted, they don't answer their phone out of office hours."

Views from staff who work in the service

Culture of maternity services

Culture is an incredibly powerful force, and can be simply described as 'how we do things around here'. A negative culture can have a significant and detrimental impact upon the quality and safety of care, and most significantly can pose a real risk to outcomes for women and babies. Conversely, a positive and open culture can contribute to effective and safe care being delivered, with women and families having a positive experience of using the service.

Generally, across all of our inspections we found the culture to be positive. It was often described to us that the teams were more 'like a family', with positive working relationships witnessed by us. This was supported by the responses in our staff survey, with a majority feeling there is a culture of openness and learning that supports staff to identify and solve problems.

Organisation's priorities

Throughout our review and inspections we have seen staff who are compassionate, committed and keen to promote the work they do. This was not only supported by comments received from women and their families, it was also seen in the staff survey results, where 84% agreed that the care of women and their families is the organisation's main priority. This positive result was common across all health boards.

However, 16% of survey responses were more negative regarding this issue. Responses were more negative from staff working within Cardiff and Vale, Cwm Taf Morgannwg and Hywel Dda, where inadequate staffing levels and poor communication from management teams were highlighted as having a detrimental effect on individual and personalised care given.

"Any feedback we receive is mostly negative. There is a blame culture within our organisation and it appears that some senior members of the team thrive on putting staff down."

"The Trust does take near misses/incidents very seriously but I feel there is very little support afterwards for staff involved. Also poor feedback."

"Lack of support for staff from management, culture of blame towards midwives and concerns raised are often dismissed by upper management."

Views from staff who work in the service

Quality governance systems and processes

Effective quality governance is a requirement to support the safe delivery of care. Health boards must have in place systems and processes that allow them to monitor their services, identify issues at the earliest possible moment, and learn from them.

Audit

We saw that each maternity service regularly monitors the quality of care being delivered through their quality governance processes. This was done mainly through audit activity, and key meetings, such as quality and safety, infection, prevention and control meetings and clinical incident reviews. In addition, we saw evidence that there were regular departmental meetings, which included; ultrasound screening, labour ward activity, postnatal and neonatal forums and weekly multidisciplinary team meetings.

Record keeping

Throughout our fieldwork, we considered the arrangements for patient confidentiality and compliance with Information Governance and General Data Protection Regulations (GDPR) 2018. In all health boards other than Powys, we found patient information was not always being managed or stored securely, to maintain patient confidentiality. This included unlocked cupboards, notes trolleys, and doors left open to areas containing multiple patient records. These issues were dealt with under our Immediate Assurance process and we have since received assurance from the relevant health boards, through improvement plans.

Across Wales we generally found an acceptable standard of documentation throughout the multidisciplinary teams. However, across all health boards, we found some examples of patient records being disorganised and difficult to navigate. Improvements were required to rectify this issue, to prevent any adverse outcomes in the delivery of care.

Risk assessment, clinical incident reporting and lessons learned

Across our inspections we found, in general, that risk assessments and risk registers were completed and maintained, and were updated regularly. We saw that risk mitigations were actioned throughout. We also found during our governance work that executive teams and boards monitored higher risks regularly, with each health board holding monthly governance meetings which considered risks and clinical incidents. Through these meetings, any trends or themes are identified, and any actions allocated to teams to address areas requiring improvement.

Through our discussions, we were informed that lessons learned following incidents within maternity units were shared and circulated to staff throughout all units within a monthly newsletter. However, although we saw evidence of this on staff notice boards, staff we spoke to during our inspections stated that often they did not see this communication. It is clear that health boards need to identify more effective or additional mechanisms for sharing this information.

We did not identify any concerns regarding under reporting of clinical incidents in any health board. However, as noted earlier in the report, and where we made a recommendation, there is significant room for improvement for all health boards in ensuring that trends and themes arising from incidents are effectively shared with staff in order to improve quality of care.

Learning from independent review

In response to the RCOG and RCM independent review of maternity services at the former Cwm Taf University Health Board, and the publication of the report in April 2019, the Minister for Health and Social Services required all health boards to consider their own maternity services. Health boards were asked to consider the recommendations within the report, and provide rapid assurance to Welsh Government in this regard.

We discussed with multiple staff from all grades and disciplines throughout our review, the learning that has taken place since publication of the report. We explored how each health board considered the findings of the report and the recommendations within it. We found that each health board's aim was to address any issues identified and to become confident that the concerns raised in the report were not present within its maternity services. Where improvements were identified, plans were immediately made and actions implemented to address the issues.

We saw across all health boards that action planning had taken place following the independent review, with improvements implemented in line with the recommendations made. We found where issues identified could not be addressed immediately, action plans were in place with appropriate timescales to address these. We saw evidence that actions and progress for improvement were regularly discussed within services across Wales, and also within the HOMAG meetings.

Recommendations

All health boards should:

- Ensure that a high standard of documentation is maintained, in particular ensuring that the standard of patient records is improved.

Conclusion

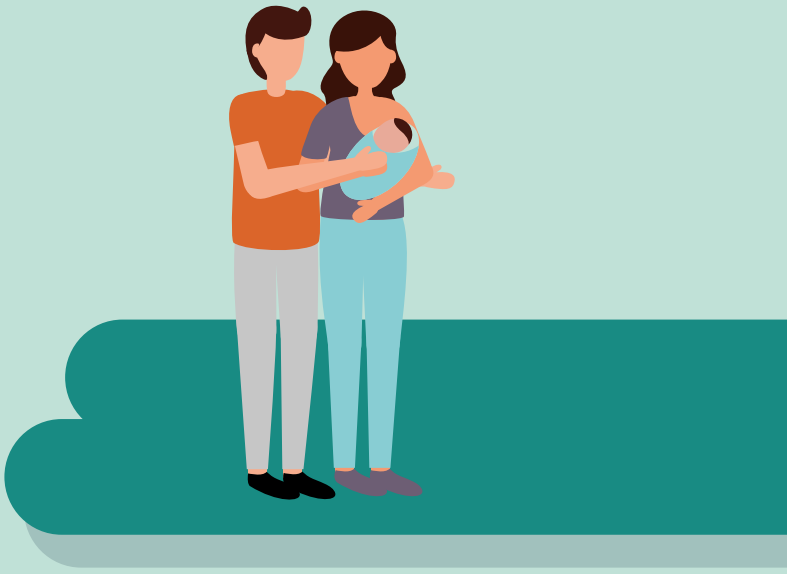
This report highlights the key themes and findings from the first phase of our national review, with Phase Two due to commence in late 2020. It is clear from our findings to date that the quality of care that is being provided across Wales is generally good, and that the majority of women and families who use maternity services report positive experiences, delivered by a hugely committed and dedicated group of professionals.

Nonetheless, there are some clear messages for heads of service to note. In particular, more needs to be done to ensure that women are heard and listened to. The arrangements for the safe and effective management of maternity units requires improvement, as does ensuring the presence of an open and transparent reporting culture demonstrating effective learning.

It has been a challenge to undertake this review due to the scale of activity required against a backdrop of the RCOG report regarding the former Cwm Taf Health Board. The report undoubtedly caused repercussions for all maternity services across Wales, and as a consequence we have striven to build positive relationships with all stakeholders, to ensure that services understood why, and how we were to undertake our review.

This has culminated in a positive relationships being built with all stakeholders throughout this review. It is clear that there is a strong will amongst both those working in, and those leading services, to continually improve the standard of care being provided. Each individual inspection has seen health boards respond positively to the issues raised, and we have been assured that relevant improvements have already been made as a consequence of our work.

We are confident therefore that the findings and recommendations from Phase One of our review will also be acted upon, improving the experiences of women and families on their journey along the maternity pathway.



What next?

We expect all health boards across Wales to carefully consider the findings from this review and our recommendations set out in Appendix C.

We hope that this information will be used to further improve services being provided to women, and to inform further work across Wales, as highlighted within the report. Welsh Government recommendations are also detailed within Appendix D for consideration.

Three months after the publication of this report, each health board and Welsh Government, will be required to submit an improvement plan in response to the recommendations. This is to ensure that the matters raised by our review are being addressed.

As previously mentioned, the findings within the review so far have enabled us to review the scope and direction of Phase Two. Detail regarding what Phase Two will include can be found in Appendix A.

Appendix A – Phase Two

Phase Two (November 2020 to spring 2021 – subject to change)

Further planned activity

Phase One of the review identified some issues in relation to aspects of maternity care that were outside the original scope of the national review. Consequently, we feel there is value in focusing our attention on developing a further understanding of these specific issues during Phase Two. These key areas to focus upon relate to:

- Antenatal care – to consider the quality of care provided by community midwifery teams
- Postnatal care – to consider the periods after the birth and up to the stage of health visitor engagement
- Follow-up on some of the inspections undertaken as part of Phase One, to understand what progress is being made.

Phase Two will seek again to explore in relation to the above:

- The experiences of women, their partners and families.

It will also explore the extent to which health boards across Wales:

- Provide safe and effective maternity services
- Understand the strengths and areas for improvement within their community maternity services.

Approach and methodology

The antenatal and postnatal periods during pregnancy and following the birth are important times for both the mother and the baby, and at times can be complex. For Phase Two, we will gather intelligence and review antenatal and postnatal services across Wales.

We will listen to the accounts of women, their partners and families to gain further insight, and understand their experience of using services.

To inform Phase Two, we will review the information and evidence obtained through our work to date. In addition, follow-up assurance work will be undertaken for a selection of inspections undertaken during Phase One of our review, in order to determine completion or progress of actions in line with recommendations made during inspection. To obtain this assurance, we may be required to undertake some onsite follow-up inspection activity. Decisions to undertake these inspections will be subject to risk assessment and intelligence, in view of the current COVID-19 pandemic.

In undertaking Phase Two, we will consider:

- A range of information and data regarding antenatal and postnatal maternity services across Wales, including any concerns intelligence held by HIW and Welsh Government
- Information provided by each health board regarding community maternity services
- Evidence obtained during Phase One fieldwork, along with both public and staff surveys
- Information obtained through various data collection methods, including attending antenatal and postnatal classes and holding focus groups on themes such as antenatal classes, breast feeding support groups and mother and baby groups.

Working with others

HIW will continue to work with a range of stakeholders, including the Community Health Councils and third sector organisations, in order to engage with women, their partners and families to understand their experiences of maternity services across the communities of Wales.

HIW will liaise with these stakeholders at key intervals throughout the review to share plans and ensure any joint working opportunities are explored to avoid unnecessary duplication of efforts and to share findings following completion of fieldwork.

Planning and timescales

It is our intention at this stage to conduct Phase Two of the national review between November 2020 and March 2021, with a view to reporting our findings by summer 2021. We are aware that these timescales may be contingent upon the impact of the COVID-19 pandemic, and winter pressures.

Reporting

We hope to produce a final National Maternity Review report by summer 2021. This will be a single report capturing the findings of Phase Two, and progress made by services since Phase One.

A dedicated webpage for the maternity review will continue to be found on HIW's website, sharing updates on the key findings from the review. Following publication of the Phase One national report, follow-up activity will be considered and a Welsh Government learning event will also take place in December 2020.

Out of scope

We have noted a number of areas during the national review which may warrant further examination in the future. However, it is not possible to include them within the scope of this review:

- Obstetric theatre environment, procedures and pre-assessment
- Neonatal care.

Appendix B – Glossary of terms

Anaesthetist	Doctor who specialises in giving anaesthetic
Antenatal	Term that means 'before birth'
Birth choice	Decision on birthing method in line with the services available for individualised care
Caesarean section delivery	Surgical procedure in which a baby is delivered through a cut in the abdomen and uterus (also called a 'C-section')
Entonox	A gas which is inhaled to help reduce pain
Epidural	An injection in your back to stop you feeling pain in part of your body
Fieldwork	Refers to the period when maternity unit inspections were undertaken
Forceps delivery	Forceps are smooth, curved metal instruments that look like large tongs. They're placed around the baby's head to help in delivery
Gynaecologist	Doctor who has undertaken specialist training in women's health
Haemorrhage	Excessive bleeding
Home birth	Labour and delivery that takes place at home, under the supervision of a midwife
Hypnobirthing	A complete antenatal programme focussing on a combination of education, self-hypnosis and deep relaxation to help achieve a more comfortable birth
Intrapartum	Term meaning childbirth or delivery
Labour	Process a woman's body goes through when her baby is born
Midwife	A person who has been specially trained to care for women during pregnancy, labour, birth and after the birth

Multi-faith room	A multi-faith room is a quiet location within busy environments such as hospitals where people of differing religious beliefs, or none at all, are able to spend quiet time
Neonatal resuscitaire	A medical devise to have on standby during labour and delivery procedures. Combining effective warming therapy with components needed for clinical emergency and resuscitation of babies
Obstetrician	A doctor who has undertaken specialist training in pregnancy and childbirth
Perinatal	Period before and after birth. The perinatal period, starting the 20th to 28th week of gestation and ends between the 1st and 4th week after birth
Perinatal and postnatal mental health	Condition that affects some women in early pregnancy, early days following birth and weeks or months after giving birth
Post-dural puncture	Post-dural puncture headache is a complication of puncture of the dura mater, one of the membranes around the spinal cord. A common side effect of lumber puncture and spinal anesthesia
Postnatal	Term meaning after the birth
Postpartum haemorrhage	When a woman loses more than 500 ml of blood after birth
Spontaneous delivery	A vaginal delivery that happens on its own, without requiring doctors to use tools to help deliver the baby
Theatre	An operating room in a hospital or other health facility
Vaginal Birth after Caesarean (VBAC)	When a woman has a vaginal birth after having had one or more previous caesarean sections
Venous Thromboembolism (VTE)	Term referring to blood clots in veins, an under diagnosed and serious, yet preventable medical condition that can cause disability and death
Ventouse delivery	A procedure were a vacuum cup is attached to the baby's head by suction to aid in delivery
Water birth	Where a baby is born fully submerged in water.

Appendix C – Health board recommendations

As a result of the findings from this review, we have identified the following recommendations in the table below. Where applicable, the health boards should:

Recommendation		
1. Ensure that women are aware of how they can request information or support in their language of choice.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
2. Ensure that wherever possible, women are able to communicate in their language of choice.		
Action	**Responsible Officer**	**Timescale**

Recommendation		
3. Consider how water birth options can be made available across all units.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
4. Take steps to ensure that women have contact with a consistent group of healthcare professionals, to improve continuity of care.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
5. Consider the introduction of smoking cessation leads.		
Action	**Responsible Officer**	**Timescale**

Recommendation		
6. Consider working with Public Health Wales to further promote healthier living and lifestyles.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
7. Ensure the appropriate level of breastfeeding advice, guidance, and support is provided at all times.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
8. Review the adequacy and availability of perinatal and postnatal mental health support for women.		
Action	**Responsible Officer**	**Timescale**

Recommendation		
9. Consider the introduction of PRAMS across its services.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
10. Ensure that staff are able to access bereavement training in a timely manner.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
11. Consider what steps can be taken to ensure that learning from women's experiences can be improved, with a particular focus on sharing what has changed in response to feedback.		
Action	**Responsible Officer**	**Timescale**

Recommendation		
12. Consider strengthening arrangements for sharing patient stories at board and quality and safety committees.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
13. Ensure the ongoing monitoring in line with health board policy of neonatal resuscitaires and emergency medical equipment.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
14. Ensure staff awareness of procedures and responsibilities to follow in the event of a medical emergency.		
Action	**Responsible Officer**	**Timescale**

Recommendation		
15. Ensure staff awareness of procedures and responsibilities to maintain the safety of the women using water birthing facilities.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
16. Ensure that a clutter free and safe environment is maintained across units.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
17. Ensure adequate infection control measures are in place, and adhered to.		
Action	**Responsible Officer**	**Timescale**

Recommendation		
18. Ensure the safe storage of COSHH substances at all times.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
19. Ensure that staff are aware of their responsibilities in relation to the safe storage of medication.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
20. Ensure that the prescription and administration of medication for the induction of labour is done in line with health board policy.		
Action	**Responsible Officer**	**Timescale**

Recommendation		
21. Ensure women have access to Female Genital Mutilation clinics.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
22. Ensure learning and service improvement actions are implemented following incidents, concerns of audit, is effectively shared with staff across all sites.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
23. Ensure that steps are taken to encourage staff to speak up and report incidents without fear of reprisal or repercussion.		
Action	**Responsible Officer**	**Timescale**

Recommendation		
24. Ensure the timely implementation of a single maternity dashboard across Wales.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
25. Ensure that policies and procedures are updated, ensuring staff are aware of updates to maintain the delivery of safe and effective care.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
26. Ensure all midwives complete appropriate training before being required to assist in theatre.		
Action	**Responsible Officer**	**Timescale**

Recommendation		
27. Consider the implementation of champion midwives to support further innovation and research.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
28. Consider the introduction of live stream CTG monitoring in all units.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
29. Ensure that staff have timely access to the training that is required for them to carry out their roles effectively.		
Action	**Responsible Officer**	**Timescale**

Recommendation		
30. Review their workforce plans to ensure appropriate actions are being taken to address the impact of staff working excessive hours, and any shortfall across staff groups.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
31. Consider implementation of positive initiatives to recognise the good work carried out by staff within the midwifery and medical teams.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
32. Ensure that a high standard of documentation is maintained, in particular ensuring that the standard of patient records is improved.		
Action	**Responsible Officer**	**Timescale**

Appendix D – Welsh Government recommendations

As a result of the findings from this review, we have identified the following recommendations in the table below. Where applicable, Welsh Government should:

Recommendation		
1. Ensure that the implementation of an electronic record is achieved as soon as possible.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
2. Consider the benefits of a consistent approach across Wales to prevent baby abduction.		
Action	**Responsible Officer**	**Timescale**

Recommendation		
3. Ensure the timely implementation of a single maternity dashboard across Wales.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
4. Consider an all-Wales approach to appraisals to ensure a consistent approach.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
5. Consider a review of the preceptorship programme to improve the experience for newly qualified staff.		
Action	**Responsible Officer**	**Timescale**

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