Maternity and Neonatal Services in Wales
Assessment, Assurance and Exception Reporting Tool

This tool has been developed to support provider health boards to assess their current position against the recommendations made within recently published reviews, reports and audit documents. The tool should be used to assess compliance with the recommendation and exception report and action plan for those recommendations which are **AMBER** and **RED**. It is recommended that an evidence log be created to support the document.

As of May 2022 the following reports and audits have been included. This document can be amended when other reports are published.

Key

Abbreviation	Author	Report Title
R	RCOG / RCM / IMSOP	Review of Maternity Services at Cwm Taf Health Board / Thematic Maternal Category Report / Thematic Stillbirth Category Report / Review of Neonatal Services at Prince Charles Hospital
O	Ockenden	Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospitals NHS Trust / Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust
H	HIW	Phase 1. National Review of the Quality and Safety of Maternity Services
M-MD	MBBRACE-UK	Saving Lives, Improving mothers' Care: Lessons Learned to Inform Maternity Care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-2018
M-SND	MBRRACE-UK	Perinatal Confidential Enquiry. Stillbirths and Neonatal Deaths in Twin Pregnancies. Recommendations Identified from Existing Guidance Required to Reduce Stillbirth and Neonatal Death in Twin Pregnancy

1. Safe and Effective Care

Maternity care provision has seen growing levels of complexity over the last decade with rising rates of obesity and chronic medical conditions. To ensure that services are sustainable and provide the best care it is imperative that women and families are cared for within the most appropriate pathways and by the professionals who best meet their needs.

Governance Processes			
Abbrev.	**No.**	**Recommendation**	**RAG Rating**
O	1.1	Patient safety specialist should be in post at each health board.	
O, R	1.2	Any clinician with the responsibility for clinical governance must have sufficient time within their job plan to deliver their duties. They should also receive training in human factors, causal analysis and family engagement. Have appropriate clinical risk and governance processes and training in place, including a consultant lead. A governance framework from ward to board must be evident ensuring joint ownership form maternity and neonates.	
O	1.3	Regular progress reports presented at Board level to review progress against improvement plans.	
R, O	1.4	Processes are in place for data collection and accuracy checking, clinical validation and monitoring of clinical practice and outcomes. Clinical change where required must be embedded across health boards with regional clinical oversight in a timely way. Health boards must be able to provide evidence of this through structured reporting mechanisms.	
R, H, M-SND	1.5	Identify named midwife/obstetrician to lead on updating policies and procedures, ensuring staff are aware of updates to maintain the delivery of safe and effective care.	
O	1.6	Systems must be in place to ensure appropriate management of women with high risk of pre-term birth, including: • Counselling of parents • Appropriate monitoring of pregnancy • Mode of delivery • Tertiary discussion • Continuous audit of In-utero transfers	
R, O	1.7	Midwifery, neonatal and obstetric co-leads identified for audit, clinical guidelines, mortality and morbidity.	
O	1.8	Processes are in place to provide assurance that adherence to guidance is being achieved. Where guidance is not being followed evidence should be available to outline the reasons why	
R	1.9	Support a full program of clinical audit.	

R, H, M-MD	1.10	Ensure appropriate staff training is available, including CTG, emergencies, NLS and Develop an effective department wide multi-disciplinary teaching program. This must include clinical governance, skills and drills for obstetric emergencies, CTG interpretation, human factor training, NLS and psychological safety; incorporating learning from audits. Ensure that staff have timely access to the training that is required for them to carry out their roles. Compliance should be monitored.	
O	1.11	Health Boards should appoint a dedicated Lead Midwife and Lead Obstetrician for fetal surveillance who will run regular fetal surveillance meetings, cascade training and lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	
O	1.12	Clinicians working on labour ward or delivering intrapartum care must be trained in CTG and emergency skills. This must be mandated	
O	1.13	Local guidelines should be in place for: • When Consultant Obstetrician presence is mandatory • When Consultant Obstetrician and Mangers need to be informed of situations • Escalation to a tertiary unit is required	
H	1.14	Ensure medicines management policies in place which include safe storage of medicines and the prescription and administration of medication for the induction of Labour	
R	1.15	Have process in place to facilitate MDT debrief after an unexpected outcome	
R, O, H	1.16	Health Boards must work collaboratively to ensure that local investigations into National Reportable Incidents (NRIs) are reported as per Welsh Government Framework. All significant learning should be shared across Wales. Lessons from clinical incidents must inform local multi-disciplinary training	
R, H	1.17	Ensure that steps are taken to encourage staff to speak up and report incidents without fear of reprisal or repercussion.	
R, O, H, M-SND	1.18	External clinical specialist opinion from outside the Health Board, must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. This should include the use of the PMRT where applicable.	
R, O, M-SND	1.19	Ensure learning and service improvement actions are implemented following incidents, concerns or audit, is effectively shared with staff across all sites. Mechanisms will be in place to capture this information to close the loop.	
O	1.20	There must be robust pathways in place for managing women with complex pregnancies. Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.	
H	1.21	Ensure that a high standard of documentation is maintained, in particular ensuring that the standard of patient records is improved and prescribing.	
H	1.22	Ensure the ongoing monitoring in line with health board policy of neonatal resuscitaires and emergency medical equipment.	

Clinical Pathway			
Abbrev.	**No.**	**Recommendation**	**RAG Rating**
O, M-MD	1.23	Development for high-risk pregnancies including rapid referral for neurology review, an epilepsy team, rapid specialist stroke care, specialist multidisciplinary care for pregnant women who have had bariatric surgery	
O, M-MD	1.24	Regional integration of maternal mental health services should be considered	
O	1.25	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional and must include ongoing review of the intended place of birth	
O, M-MD	1.26	Ensure early senior involvement in the care of women with extremely preterm prelabour rupture of membranes and a full explanation of the risks and benefits of continuing the pregnancy. This should include discussion of termination of pregnancy.	
O	1.27	Robust pathways of care in place between hospital and community setting	
O	1.28	Complex pregnancy pathways must be in place for • Preconception advice and management of women with pre-existing conditions • Multifetal pregnancies • Pre-existing conditions e.g. Diabetes, cardiac, chronic hypertension	
O	1.29	Systems must be in place to ensure appropriate management of women with high risk of pre-term birth, including: • Counselling of parents • Appropriate monitoring of pregnancy • Mode of delivery • Tertiary discussion • Continuous audit of in-utero transfers	
O	1.31	During labour and birth women must receive a full clinical assessment on presentation, including a review of risk factors. Women who choose to birth outside of a hospital setting must receive documented information on transfer times to an obstetric unit.	
O	1.32	Pathways must be in place for induction of labour, that includes the management of delays	
O, M-MD	1.33	Centralised CTG monitoring must be mandated	
O	1.34	There must be clear pathways of care for the provision of neonatal care. Activity outside of the agreed pathways must be supported by NICU advice on resuscitation and management, with all cases outside of pathway exception reported.	
O	1.35	Neonatal staff should have the opportunity for secondment to other units to maintain clinical expertise. Units should maintain Network contacts to share best practice, learning and education	

R, O	1.36	Bereavement care must be available on a daily basis to ensure compassionate, individualised, high quality bereavement care is consistently offered to all families experiencing perinatal loss. This should be included as part of regular training updates.	
O	1.37	Obstetric Anaesthetic assessments must be robustly documented in line with Good Medical Practice GMC recommendations. Follow up care should include but not be limited to: postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia. Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.	
O	1.38	Postnatal care must include systems in place to ensure a consultant review of all readmissions within 14 hours of readmission, including daily review of unwell postnatal women regardless of clinical setting.	

2. Family Centred Care

Respect and compassion are core values underpinning the care women and their families receive. Respectful family-centred care enables women to have control over their behaviour, surroundings and the treatment they receive. This supports meaningful discussions and shared decision making about their pregnancy, Labour, birth and postnatal care. Maternity services also have a key role in promoting the health and wellbeing of the mother and her family, and in preparing families for parenthood.

Abbrev.	No.	Recommendation	RAG Rating
R	2.1	Maternity and neonatal services must ensure that women and their families are listened to with their voices heard.	
O	2.2	Service users (ideally through the MVP / MSLC) must be involved in the complaints process, ensuring responses are caring and transparent	
R	2.3	Develop and strengthen the role and capacity of the MSLC/MVP to act as a hub for service user views and involvement of women and families to improve maternity care:	
H	2.4	Improve the ability of birth partners or family members, to be able to support women, in line with a woman's wishes	
O	2.5	All Health Boards will have pathways in place to provide timely emotional and specialist psychological support	
O	2.6	Psychological support for the most complex levels of need, should be delivered by psychological practitioners, who have specialist expertise in maternity care	
O	2.7	A framework for Family Integrated Care should be implemented and its impact evidenced.	

O	2.8	Peer support networks should be developed for families when using and after discharge from the neonatal services.	
H	2.9	All Health Boards must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery. All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care. Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care. Women's choices following a shared and informed decision-making process must be respected.	
H	2.10	Ensure that women are aware of how they can request information or support in their language of choice	

3. Skilled Multi-professional Teams

Professional groups who work together must develop strong inter-professional working skills to ensure that they share clear aims, language and culture in order to deliver safe and effective care. Multi-professional training should be a standard part of professionals' continuous professional development, both in routine and emergency situations

Governance Processes

Abbrev.	No.	Recommendation	RAG Rating
O	3.1	Health Boards must implement a robust preceptorship programme for newly qualified midwifes	
O	3.2	Midwives responsible for coordinating labour ward must attend a funded and nationally recognised labour ward coordinator education module. This must be a specialist post with an accompanying Job Description	
O	3.3	Health Boards must ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs.	
O	3.4	Health Boards must train a core team of midwives to deliver high dependency maternity care, sufficient in numbers to ensure one midwife is available each shift	
O	3.5	Competing workloads in obstetric staffing must be risk assessed and discussed at Board (where no separate rota is in place)	
R, O	3.6	Ensure the Medical Director has effective oversight and management of the consultant body by: making sure they are available and responsive to the needs of the service, urgently reviewing and agreeing job plans to ensure the service needs are met, clarifying what is to be covered as part of SPA activity (audit, governance, teaching, guidelines, data assurance, train more consultant obstetricians as appraisers), ensuring the most unwell women are seen initially by a consultant and all women are seen by a consultant within 12 hour NCEPOD recommendation4 (national standard).	

R	3.7	Ensure obstetric consultant cover is achieved in all clinical areas when required by: • reviewing the clinical timetables to ensure that 12-hour cover per day on Labour ward is achieved, • undertake a series of visits to units where extended consultant Labour ward presence has been implemented • Ensure the consultant on-call for the labour ward has ownership of all patients in the maternity unit for the period of call. This must involve the antenatal ward round being performed by the consultant.	
R	3.8	Neonatal consultant of the week 09:00-17:00 with a minimum of 4 weeks service per year.	
R, O	3.9	Clinical supervision and consultant oversight of practical procedures must be in place for all staff including specialist midwives and staff doctors.	
R, O	3.10	Support training in clinical leadership. The Health Board must allow adequate time and support for clinical leadership to function. Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.	
R, H	3.11	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.	
H	3.12	Consider implementation of positive initiatives to recognise the good work carried out by staff within the midwifery and medical teams.	
H	3.13	Ensure all midwives complete appropriate training before being required to assist in theatre	
O	3.14	Bereavement training must be offered to all staff	
O	3.15	Rotation of neonatal staff into exemplar units to ensure competence in key clinical skills and decision making.	
R, O	3.16	Investment in neonatal nursing staff, part matron part improvement. Nurse in charge to be supernumerary, ANNP should be expanded to ensure career progression. Nurse consultant roles to be explored. AHP in line with national recommendations including an expansion of pharmacy services.	

4. Continuity of Carer

Continuity of carer affords women and Midwives / Obstetricians the opportunity to build a trusting relationship over the pregnancy journey and into parenthood. It is acknowledged that women often have very individualised journeys through pregnancy from straight forward to complex and requiring multiple specialist inputs

Governance Processes

Abbrev.	No.	Recommendation	RAG Rating
H	4.1	Take steps to ensure that women have contact with a consistent group of healthcare professionals, to improve continuity of care.	

5. Sustainable Services and Workforce Planning

Maternity services in Wales should provide equity across health boards to ensure all women and families have individualised care appropriate to their needs. This will require key resources to ensure sustainable future delivery of services.

Staffing			
Abbrev.	**No.**	**Recommendation**	**RAG Rating**
H	5.1	Multiyear workforce planning process in place, incorporating the whole perinatal team	
H	5.2	Nationally agreed minimum staffing levels based on acuity and complexity of pregnancies, vulnerable families and mandatory training requirements	
H	5.3	When staffing levels cannot be achieved a process of escalation to the highest level of senior management in the organisation	
H	5.4	Staffing uplift to be representative of the previous 3 years data on sickness, maternity leave, mandatory training and annual leave	
H	5.5	The feasibility and accuracy of the Birthrate+ tool and it associated methodology must be reviewed nationally	
H	5.6	A strategy is in place to support a succession planning programme for the maternity workforce and develop future leaders and senior managers. This must include a gap analysis of all leadership and management posts in midwifery and obstetric	
H	5.7	Obstetric anaesthesia staffing guidance to include: • The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave. • The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity. • The competency required for consultant staff who cover obstetric services out of hours, but who have no regular obstetric commitments. • Participation by anaesthetists in the maternity multidisciplinary ward rounds	
O	5.8	RCOG guidance on locum management is to be followed	
R, H	5.9	Neonatal units must be staffed according to BAPM guidelines.	

Specialist Services			
Abbrev.	**No.**	**Recommendation**	**RAG Rating**
R, H	5.10	Consider the introduction of smoking cessation leads to strengthen their approach.	
H	5.11	Consider working with Public Health Wales to further promote healthier living and lifestyles.	
R, H	5.12	Ensure the appropriate level of breastfeeding advice, guidance, and support is provided at all times.	
O, H	5.13	Review the adequacy and availability of perinatal and postnatal mental health support for women.	
O, H	5.14	Ensure effective and timely access to dedicated perinatal mental health service is available to all women who require it.	
H	5.15	Consider how water birth options can be made available across all units.	
H	5.16	Consider the implementation of champion midwives to support further innovation and research.	

Exception Reporting Tool

Recommendation Number	
Area assessed as amber / red	
What is currently in place to meet this recommendation?	
How will we evidence that we are meeting this recommendation?	
How do we know that these are effective?	
What further action do we need to take?	
Who and by when?	
What resource or support do we need?	
How will we mitigate risk in the short-term?	