A Strategic Vision for Maternity Services in Wales

September 2011
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Foreword from the Minister for Health and Social Services

It is now well understood that the foundations for health and well-being start in pregnancy. From heart disease to obesity, educational achievement and economic status, the months before and the years immediately after birth are crucial to the life chances of the mother, her child and her family.

We know that the health and happiness of future generations can be enhanced through the provision of high quality maternity services and that pregnancy is a powerful motivator for change. It is a time when women and their partners, often for the first time, make positive lifestyle changes and choices in order to provide the optimal conditions to ensure the health and wellbeing of their unborn baby. This is particularly important, not just in the context of the pregnancy, but also because we know that when women make these changes, they significantly influence the lifestyle choices of their children and wider family. Pregnancy therefore presents a golden opportunity to impact on the health and wellbeing of individuals, families and communities.

The health of children is influenced by what happens throughout pregnancy and even before, so it is vitally important that efforts to ensure that mother and child are safe and healthy need to start well before the birth.

This document sets out the results I want for women and their babies during pregnancy and childbirth. The effectiveness and quality of NHS maternity services clearly has a fundamental role to play in delivering these results. This document and other work going on at an all Wales level, therefore, also sets out my expectations of NHS Wales in transforming maternity services so that a real difference can be made to families in Wales.

As all the Local Health Boards review the full range of services they secure for their resident populations to ensure they are safe and effective for the future, I will expect each of them to take full account of this document.

Investing efforts to improve maternity services now and in the future is imperative if Wales is to build healthy and happy families and communities.

Lesley Griffiths AM
Minister for Health and Social Services
1. Introduction

In Wales, over 35,000 babies are born each year. Each baby deserves the best possible chance in living a healthy and happy life. The purpose of this document, supplemented by future all Wales work, is for the Welsh Government to set out:

- its strategic vision and the results it wants for women and their babies during pregnancy and childbirth;
- its expectations of NHS maternity services in delivering these results, and
- how success will be measured.

While this document is primarily directed at the NHS and its partners to inform the planning and delivery of its maternity services, we hope that women and their families will also read this to have an understanding of what services and care they can expect from NHS Wales.

2. Strategic context

While many of the standards for maternity services in the National Service Framework for Children, Young People and Maternity Services (2005) have been achieved, and women in Wales report a high level of satisfaction with maternity services, there is no room for complacency. It is now time to focus on those maternity service improvements that have presented challenges.

There are also new challenges. The social and economic context within which the maternity services operate is constantly changing and given the high level of social inequality in Wales, action must now focus on reducing these inequalities to make sure that all families receive the best care possible.

Tackling inequities in terms of access to and the outcomes from maternity services in Wales is the cornerstone of this document. Ensuring every woman in Wales, irrespective of her location, social background, circumstances or ethnicity, has access to and receives safe high quality care, as close to home as possible is paramount.

3. Our strategic vision and desired results

The Welsh Government’s strategic vision and the results it wants for women and their babies during pregnancy and childbirth are set out below.

The Welsh Government’s vision for maternity services in Wales is a service that promotes pregnancy and childbirth as an event of social and emotional significance where women and their families are treated with dignity and respect. For every mother wherever they live and whatever their circumstances, pregnancy and childbirth will be a safe and positive experience so that she, her partner and family can begin parenting feeling confident, capable and well supported in giving their child a secure start in life.
Vision to reality - five key themes for action

For this vision to become a reality, the NHS clearly has a fundamental role to play by providing safe and high quality maternity services. The Welsh Government expects the NHS to take action to deliver maternity services which:

- place the needs of the mother and family at the centre so that pregnancy and childbirth is a safe and positive experience and women are treated with dignity and respect;
- promote healthy lifestyles for pregnant women which have a positive impact on them and their family’s health;
- provide a range of high quality choices of care as close to home as is safe and sustainable to do so, from midwife to consultant-led services;
- employ a highly trained workforce able to deliver high quality, safe and effective services;
- are constantly reviewed and improved.

We need a meaningful and appropriate way of measuring how well the results we want for women and their babies during pregnancy and childbirth are delivered and how well the NHS delivers against the above expectations. The Welsh Government has established an All Wales Maternity Services Implementation Group, co chaired by a service user and the Chief Nursing Officer, which is tasked with developing a formal set of indicators against which maternity services will be measured. More about this is set out later in this document.

4. Current position and what is needed next

Changes in the health, social and economic status of people in Wales over the last decade are influencing the shape and delivery of NHS Wales’ services. For maternity services, the Royal College of Obstetricians and Gynaecologists and Midwifery 2020 refer to demographic and social changes in the population and recognize them as the drivers that will result in changes to the organisation and delivery of maternity services in Wales.

These drivers are set out below, supplemented by a broad discussion on the public health context for maternity services at Appendix 1.

4.1 Health Factors

There are significant public health challenges for people living in Wales. To make a positive impact for the future, a particular focus is needed in the following areas.

- Teenage pregnancies
  There is well accepted evidence that teenage pregnancy is associated with poor health and social outcomes for both the mother and the child. Young mothers are more likely to suffer postnatal depression and less likely to complete their education. Children born to teenage parents are less likely to be breastfed, more likely to live in poverty and more likely to become a teenage parent themselves’.
A recent review acknowledges that sex education and sexual health services are not on their own effective strategies for encouraging teenagers to defer parenthood; they need to be complemented by early childhood and youth development interventions that tackle social disadvantage.\(^\text{vi}\)

The Welsh Government supports the continuous improvement of universal provision of sex and relationships education and sexual health services. This must sit alongside targeted intervention for those most vulnerable to teenage pregnancy as recommended by the National Institute for Clinical Excellence (NICE).\(^\text{vii}\) Both of these approaches must complement our efforts to address the wider determinants of teenage pregnancy through the reduction of child poverty, raising the standard of education and the provision of good quality youth services.

- **Perinatal and Infant mental health**

  The promotion of emotional health and well-being is extremely important to both the woman and baby; supporting the mother will inevitably benefit the baby and promote the development of secure attachment relationships.

  National guidelines for healthcare professionals recommend that at a woman’s first contact with maternity services and postnatally, she should be asked about any past or present severe mental illness and previous treatment by psychiatrist/specialist mental health team.

  Whilst midwives now discuss mental health needs with pregnant women, access to appropriate secondary mental health services as identified in NICE guidelines must be available, so that women who require specialist advice, treatment and care planning have effective care assured. Each local area should ensure a care pathway is in place, which should be agreed and implemented by maternity services and mental health services.

- **Obesity, smoking and alcohol**

  Obesity - All opportunities should be used to provide women who are overweight with information about the health benefits of losing weight before becoming pregnant.

  Guidance on weight management before, during and after pregnancy stresses the importance of ensuring that all relevant health professionals understand the importance of women achieving a healthy weight before pregnancy.

  GPs, health visitors, midwives, practice nurses, pharmacists and other health professionals working in weight management, fertility, pre-conception advice and gynaecology and contraceptive services could all play their part.

  During a pregnant woman’s initial assessment it is important to discuss both eating habits and physical activity so that evidence based advice can be given and myths dispelled about ‘eating for two’.

  To maximise impact midwives and obstetricians may need more training to be able to discuss this and other sensitive and challenging public health issues and to motivate women to seek support.
Smoking - Guidance on quitting smoking in pregnancy advises that all women who smoke are identified early in pregnancy and offered focussed support to quit rather than to cut down. Studies have shown that structured self-help and support from NHS smoking cessation services and motivational interviewing are effective in helping pregnant women to quit smoking.

Alcohol - Advice for women planning a pregnancy is to avoid alcohol in the first 3 months. During pregnancy, if women choose to drink alcohol, the advice is that women drink no more than 1 to 2 UK units once or twice a week and avoid getting drunk or binge drinking.

During a women’s initial assessment it is important that alcohol consumption of the woman and her partner is discussed and recorded and a written plan made if support in reducing alcohol intake is needed.

4.2 Education and information

Good antenatal education helps women and their partners to support each other during pregnancy and the postnatal period. It increases self-esteem and confidence in participants and promotes friendship and support within a local community. However research suggests improvements are needed because:

- midwives are not adequately prepared for or supported in the delivery of antenatal education;
- it is not recognised as being of high priority and that it does not address the needs of women or their partners in terms of access or content;
- it is directed at women and therefore limits the participation of men;
- it should include the transition to parenthood, preparation for parenthood and the impact of a baby on existing relationships;
- consideration needs to be given to the best methods of supporting and engaging with parents from minority ethnic groups including asylum seekers and refugees, gypsies and travellers;
- consideration needs to be given to the best methods of supporting and engaging with parents:-
  - who are young teenagers,
  - with alcohol and drug-abuse problems, serious mental health problems or
  - who are in prison, during pregnancy and the immediate postnatal period.

4.3 Breastfeeding

A particular priority is optimising nutrition from birth. Initiation of breastfeeding in Wales between 2005-2010 increased from 67% to 71% but lags behind England and Scotland. Further action needs to be taken to increase the number of women who breastfeed, and innovative ways in which services are provided should be developed to further increase breastfeeding initiation and continuation.
Engagement with The Baby Friendly Initiative (BFI) is one mechanism for achieving this. BFI is a World Health Organisation and UNICEF programme to ensure that best practice is adopted in relation to breastfeeding. NICE identifies BFI as a minimum standard for encouraging breastfeeding.

4.4 Social circumstances

Evidence suggests that the lower a person’s social position, the worse his or her health will be. This social gradient in health is particularly acute in Wales. A proportionate approach to addressing health inequities is reflected in the Welsh Government’s “Fairer health outcomes for all”, which includes a focus on giving every child a healthy start in life and making health and social services more equitable.

A number of Government policies are in place that can support this approach including:

- A framework for a school nursing service for Wales
- Healthy Start
- Welsh network of healthy schools schemes
- Sexual health and wellbeing action plan
- Child poverty strategy
- Communities First
- Flying Start

To ensure as far as is possible health is protected and promoted before, during and after pregnancy, it is vital the focus on maternity care be extended to include involvement from others e.g. school nurses, social services and the third sector. The public health skills of health professionals working in maternity services need to be reviewed to ensure that they are able to fulfill this role effectively. This will be particularly relevant for midwives and obstetricians as they work most closely with women and their partners.

4.5 NHS Workforce Issues

There are a number of key workforce issues influencing the delivery of maternity care. These are as follows:

4.5.1 Safe services

Providing safe maternity care is everybody’s business. This requires focus on the workforce development and modernisation which will affect the whole workforce including midwives; doctors; support workers; housekeeping, administrative, estates, portering and security teams. Ensuring that mothers and babies have the right staff to meet their needs will require the appropriate use of expert skills of the whole maternity service team with appropriate delegation of responsibilities to qualified support staff. Skill mix changes will need to reflect the needs of local communities, sensitive to equality matters, with access to education and training to ensure that all carers have the necessary competencies.
4.5.2 Availability and access to services

The right place for care is dependent upon need. Whilst care should normally be provided as close to home as possible, specialist skills may need to be centralised and staffed accordingly. Access to different approaches to care may necessitate role development and expansion across professional boundaries whilst retaining a commitment to continuity of care and carer. Specialist units also have additional responsibilities around teaching and supervision of the future workforce, and promoting research and academic excellence. Clinical academics, educationalists and researchers within each of the professional groups help make up the wider team.

Providing the right type of care is dependant upon the needs of mothers and babies. Working from the acceptance of normal childbirth as a social and emotional event needs staff to support and advocate independence and an informed choice about care by mothers and families. To direct women into the right type of care requires midwives to have a visible place in community settings to ensure easy access and where possible become the first point of contact.

To achieve the vision and results we want for women and their babies before, during and after pregnancy, the identification of a lead professional will ensure that women have their care planned and led by obstetricians, GPs or midwives, each with the necessary skill mix of support staff. Whilst midwives will be the lead professional for women with no complications, they will also need to become the named midwife for all women including obstetric and GP led services.

4.5.3 Review of roles

Achieving this vision and desired results set out in this document will require a review of the roles of staff providing the current service, to consider opportunities for new and extended roles. Reviewing existing models that determine the skill mix within maternity services may be possible as part of the review of local service provision and development of new service models. Whilst Birthrate Plus is a valuable tool for workforce planning in midwifery, as services change other tools may need to be developed and used to develop the whole maternity care team. It will be essential that workforce data collection and planning for education and training comply with the current integrated process of workforce, service and financial planning reflecting new models of service provision. This will necessitate agreement on the assessment of need and acuity of care required, with the development of a multidisciplinary acuity methodology as necessary.

4.5.4 Education of the workforce

Education and training from pre registration to continuing education must reflect the cultural shift in the philosophy of care, with a focus on the public health agenda, midwives as the first point of contact for women accessing services, together with clinical leadership skills to support appropriate career frameworks for all staff groups.

So, to deliver the results we want, it will be essential to plan for the whole maternity services workforce. Workforce planning must be integral to service change and financial planning, and must capture those workforce implications which may need to be addressed at an all Wales or UK level.
4.6 Service Planning Considerations

Recognising that the majority of care, if not necessarily the birth, will be provided within the community, the following must inform future service planning and delivery:

4.6.1 GPs

The role of the GP in providing maternity care will vary throughout each Local Health Board and this must be clarified to ensure that there is no duplication of care and that mothers, midwives and GPs are clear about who is the lead professional for each woman’s care and what the role entails.

4.6.2 Rural Communities

Services provided in deeply rural areas may need to have some different arrangements, for example, to take advantage of differing technologies, including telemedicine. Whether Midwife led units are co-located alongside consultant led units or stand-alone will have to be considered by each Local Health Board, depending upon geography, existing service provision and access for women.

4.6.3 Midwife Led Care and Birth at Home or in a Midwife Led Unit

The following criteria should be met:

- Ensuring consistent application of appropriate criteria for antenatal and intrapartum care to use this service;
- Provision of comprehensive health promotion and public health advice to enable women to support a healthy lifestyle approach to their pregnancy;
- Sufficient staffing levels to ensure all women are able to see a midwife as their first point of contact with services;
- adequate support to enable increased rates of breastfeeding;
- ongoing Continuing Professional Development arrangements are in place so that midwives can deliver their enhanced public health role;
- arrangements and capacity to work with hard to reach groups;
- adequate capacity to enable women to give birth at home, in a birth centre or midwife led unit where that is their choice;
- ensuring all midwifery staffing levels comply with Birthrate Plus;
- establishing appropriate skill mix balance between midwifery and support staff;
- 24 hour administrative support;
- appropriate transport.
4.6.4 Consultant Led Care and Birth in a Consultant Led Unit

The following criteria should be met:

- Ensuring consistent application of appropriate criteria for antenatal and intrapartum care to use this service;
- Provision of comprehensive health promotion and public health advice to enable women to support a healthy lifestyle approach to their pregnancy;
- Access to consultant led obstetric services without undue delay;
- All modalities of analgesia available on a 24 hour basis;
- The provision, on site, of at least level 2 neonatal services;
- Establishing appropriate skill mix balance between medical, midwifery and support staff;
- Ensuring appropriate ratio of time consultants spend on obstetric as opposed to gynaecological work through job planning mechanisms;
- Compliance with European Working Times Directives (EWTD);
- Services comply with the RCOG guidance for 40 hours of consultant labour ward presence per week, depending on the number of deliveries per year;
- A middle grade doctor (level ST3 or higher or SAS grade) will cover the labour ward at all times that a consultant is not present;
- Arrangements to specialised services if required.

5. Delivery requirements of the NHS

For the vision and results for women and their babies set out in this document to become a reality, the NHS clearly has a fundamental role to play by providing safe, sustainable and high quality maternity services.

5.1 The role of Local Health Boards

Planning and providing local maternity services and getting these right on a daily basis is the responsibility of Local Health Boards. To work well, their services must interact effectively with partner organisations to meet the needs and expectations of the local community.

In addition, there must be continuous engagement with the local population and key interest groups around how services are being managed and developed.

To deliver the expectations set out in this document, Local Health Boards will now need to review current services and use the outcome to inform local delivery plans to improve access to and the quality of maternity services.
Five Key Themes for Action by NHS Wales

The Welsh Government expects the NHS to take action in 5 key areas as follows:

1. Placing the needs of the mother and family at the centre so that pregnancy and childbirth is a safe and positive experience and women are treated with dignity and respect

Support for new families

All new families should be offered support in adapting to the changes needed to love and nurture a new member of the family. Antenatal preparation with a skilled educator has a vital role to play in supporting families to make this transition.

To ensure a successful start in life for the whole family, specific forms of support may be needed. Initial assessment and preparation will need to start early, with clear lines of communication established between midwives, GP’s, health visitors and all members of the maternity team. Care should be coordinated and planned antenatally and revised following birth to ensure that each new mother is offered individualised postnatal care, consideration should be given to achieving the child poverty indicators during this process (WAG 2010). Consistent advice and support should be available for women who choose to breast feed their babies.

Information should be given to women on local postnatal/parenting advice and support groups. Third Sector organisations and other agencies can have an important role in the planning and delivery of services to support vulnerable people and communities by maximising the outcomes for pregnant women, their babies, the wider family and the community.

The following provide examples of the outcome, actions and suggested performance measures associated with this theme. The indicators and performance measures will be fully developed by the implementation group.

Outcome:

• Healthy and well supported new families

Actions to include:

• Provision of needs based antenatal and postnatal education

• Provision of support for mothers wishing to breast feed

Examples of indicative performance measures

• Quantifiable evidence of the specific benefits gained by attending antenatal and postnatal classes

• Quantifiable evidence of the value of the Third Sector’s contribution to vulnerable families

• Level of uptake of breast feeding
Women’s experience of care

Women themselves are best placed to judge the performance of services in this most sensitive of services. The Welsh Government and Local Health Boards are aware that services need to be improved in certain specific areas such as for those preferring to use the Welsh language.

Therefore the Welsh Government will require that women’s views of their care are regularly collected and published and responses seen to be used in the development of services. Evidence-based information on local services will be made easily available to women.

As well as using women’s views to shape services it is important that users of the services are able to contribute to the strategic direction of maternity services.

Local Health Boards must maintain their Maternity Service Liaison Committees to ensure effective service user engagement with all user representatives being trained and supported so they are able to contribute fully.

The following provide examples of the outcome, actions and suggested performance measures associated with this theme. The indicators and performance measures will be fully developed by the implementation group.

Outcome:

• Effective engagement with service users

Actions to include:

• Establish local Maternity Services Liaison Committees

• Actively seek and respond positively to service users’ views

Examples of indicative performance measures:

• Published report that demonstrates how the Local Health Board has responded to women’s views of their care

• Percentage of service users who have received specific preparation enabling them to effectively discharge their role on the Maternity Services Liaison Committee

2. Promoting healthy lifestyles for pregnant women which have a positive impact on them and their family’s health

Maternity services are delivered chiefly by midwives, obstetricians, anaesthetists, neonatologists and general practitioners assisted by maternity care support workers. The services aim to be cohesive, providing care for healthy women with normal pregnancies and for those with risk factors or more complex needs.

To ensure as far as possible that health is protected and promoted before, during and after pregnancy, it is vital to create and capitalise on opportunities that provide public health information. The focus on maternity care must be extended to include involvement from others e.g. school nurses, social services, schools and the third sector. The public health skills of those health professionals delivering maternity care will need to be reviewed to ensure that they are able to fulfil this role effectively.
The following provide examples of the outcome, actions and suggested performance measures associated with this theme. The indicators and performance measures will be fully developed by the implementation group.

**Outcome:**
- Healthy mothers and babies with fewer premature and low birth weight deliveries

**Actions to include:**
- Provision of healthy lifestyle education to mothers and their families
- Provision of public health skills training for health professionals

**Examples of indicative performance measures:**
- Percentage of midwives that have had training in motivational interviewing
- Number of women referred for smoking cessation support; percentage of women smoking during pregnancy

3. ** Providing a range of safe high quality choices of care, from midwife to consultant-led services**

The midwife will be the first point of contact for the majority of women who access maternity services to ensure women receive relevant information, advice and support about pregnancy services and are referred to the appropriate lead professional.

GPs will also have a vital role to play in supporting women and their families. They may have known them for many years and will have a detailed understanding of their health and social issues. Because of this, some women may choose to have maternity care from their GP. In these instances it is important that there is clarity about who is the lead professional for each woman’s care and what that role entails.

Each Local Health Board is expected to provide access to a range of services for women to give birth including at home, in a birth centre or consultant led obstetric unit. For women with complex needs and high risk pregnancies, obstetric services will be provided without due delay. Local Health Boards will need to implement their Caesarean Section Toolkit plans and report on progress.

Local Health Boards will need to ensure that the different needs of their local community are kept under review and that no group is neglected in planning services, including hard reaching groups such as the homeless, gypsies and travellers. The particular needs of black and minority ethnic groups must be understood, provided for and respected.

The following provide examples of the outcome, actions and suggested performance measures associated with this theme. The indicators and performance measures will be fully developed by the implementation group.

**Outcomes:**
- Women have access to a range of safe high quality maternity services that meets their needs
- Midwives are the first point of contact for the majority of women
Actions to include:

- Review of current organisation and delivery of maternity services against the vision and themes set out in this document, reflecting the needs of their local communities, to inform the development of local service improvement delivery plans
- Implementation of the Caesarean Section Toolkit plans

Examples of indicative performance measures:

- Percentage of women who are able to access a midwife as a first point of contact
- Percentage of women who know who their lead professional is
- Progress on implementing the Caesarean Section Toolkit plans
- 24/7 compliance with the criteria set out in sections 4.6.3 and 4.6.4 on page 9

4. Employing a highly trained workforce which delivers high quality services

Workforce planning

The Welsh Government supports an integrated process for workforce planning which incorporates the whole workforce. Data and information is then utilised to inform education and training arrangements for all staff involved in maternity services. Maternity service specific workforce modelling at a national level, assuming different birth rates, working practices, and skill mix would be available to support local workforce modernisation and changes to training arrangements.

Research and development

Local Health Boards in association with Higher Education Institutions will actively engage in the research and development of the evidence base that will lead to future service/care improvements for the benefit of mothers and babies.

This will include the facilitation of staff to contribute to the respective Local Health Board’s research agenda and will include participation in research fellowships, supported by the Academic Health Science Collaboration. It will also include supporting staff to actively review evidence and where appropriate implement research findings in practice.

Academic appointments and university links will be encouraged where appropriate as clinical standards will be raised and recruitment facilitated. We want NHS Wales to be known to be a place where any member of the maternity team can come to train and practice to the highest standard.

The following provide examples of the outcome, actions and suggested performance measures associated with this theme. The indicators and performance measures will be fully developed by the implementation group.

Outcomes:

- Local Health Boards have highly trained and educated workforces able to deliver safe, high quality maternity care
- Evidenced based maternity care is developed and implemented
Actions to include:

- Review of current workforce numbers, skill mix and skills against the vision and themes set out in this document to inform the development of local workforce and service improvement delivery plans

- Create and implement research and development plans in partnership with Higher Education Institutions

Examples of indicative performance measures:

- Evidence that workforce plans demonstrate an appropriate skill mix balance between medical, midwifery and support staff, ensuring compliance with current Birth Rate Plus recommendations

- Education and training programmes are in place to enable staff to deliver an enhanced public health role with focus on the principles of respect, well being, choice and dignity

- Evidence of consultant job plans that distinguish between time spent in obstetrics and gynaecology

- Compliance with the RCOG guidance for hours of consultant labour ward presence per week, ensuring that a middle grade doctor (level ST3 or higher or SAS grade) is available to cover the labour ward at all times that a consultant is not present

5. Maternity Services are constantly reviewed and improved

Local Health Boards must carry out clinical audits and routinely use the results to inform the planning and delivery of maternity services.

A new impetus for improving the quality and safety of care provided to women and their babies is happening as a result of extending the 1000 Lives Plus Programme to this area of care. In addition, following a review of the evidence, a number of focussed interventions to improve safety and reduce the risk of avoidable harm have been identified as a priority to take forward. A new initiative, the Transforming Maternity Services collaborative, was launched in March 2011 and is a powerful support for achieving the vision in this document.

The following provide examples of the outcome, actions and suggested performance measures associated with this theme. The indicators and performance measures will be fully developed by the implementation group.

Outcome:

- Maternity services provide safe, high quality care

Actions to include:

- Carry out regular clinical audits, including participating in national audit activity

- Implement the 1000 Lives Plus Transforming Maternity Services Collaborative

Examples of indicative performance measures:

- The number of high risk women who have had a deep vein thrombosis risk assessment

- Perinatal and maternal mortality rates
These 5 themes for action must form the basis of Local Health Board delivery plans. These plans must contain key milestones to map the journey against which progress can be reported.

5.2 The role of Welsh Government

The Welsh Government sets the vision and the desired outcomes it wants at population level. It must show strategic leadership by setting out clearly what its expectations are of NHS Wales and to provide support where appropriate. That is the purpose of this document.

Welsh Government will support Local Health Boards by developing a maternity service specific workforce modelling projection, assuming different birth rates, working practices and staffing arrangements to ensure that robust whole workforce planning can be achieved.

The Welsh Government will hold NHS Wales to account for the delivery of their local services.

5.3 The role of the All Wales Maternity Services Implementation Group

In fulfilling its role of strategic leadership and to support NHS Wales in delivering high quality maternity care Welsh Government has established the All Wales Maternity Services Implementation Group. This Group is co-chaired by a service user and the Chief Nursing Officer and is made up of health professionals and Local Health Board Executive Leads for Maternity Services.

This Group is tasked with the following;

- agree a set of indicators on which Local Health Boards will base the development of local performance measures;
- undertake work at an all Wales level to support Local Health Boards;
- facilitate the sharing and promulgation of best practice;
- identify constraints and solutions to specific clinical and operational issues.

A key early priority for this Group is to identify a formal set of indicators for measuring the effectiveness and quality of maternity services in terms of clinical outcomes and women’s experience. These indicators, based around the 5 Themes For Action, will form the basis of a monitoring tool for Local Health Boards to monitor their own services and there will be a small set of key or national indicators which Local Health Boards will report performance against to the Welsh Government.

The Welsh Government will issue the final set of national and local indicators early in 2012 together with the level of performance we expect delivered by 2015 for the national indicators.
6. Reporting and monitoring

It is the responsibility of Local Health Boards to plan and deliver maternity services that match the Welsh Government’s vision. It is the responsibility of the Welsh Government to hold Local Health Boards to account through a meaningful mechanism of monitoring the quality of maternity care across Wales.

The Welsh Government will formally hold Local Health Boards to account by means of their performance against the national indicators and the performance required for each indicator by 2015 developed by the All Wales Maternity Services Implementation Group. We will publish an annual report based on these indicators.

The Chief Executive of NHS Wales will establish and maintain a regular dialogue with Local Health Boards as part of the mainstream performance management mechanisms. To inform this dialogue, Local Health Board Chief Executives and their Lead Executives for Maternity Services, will report progress against their local delivery plans each quarter on their websites.

The Chief Executive for NHS Wales and his Executive Team will review these progress reports and require action in case of any poor or slow performance.

The Welsh Government will develop and maintain a robust and regular dialogue with the NHS to monitor progress with delivering the vision.

7. Conclusion

A Strategic Vision for Maternity Services in Wales sets the direction for transforming services.

This vision will become a reality through working in collaboration across health, social services and the third sector to ensure that a real difference can be made to families in Wales.

Summary of Key Actions

There are a number of actions identified throughout this document that are key to delivering the vision and desired results Welsh Government wants for women and their babies during pregnancy and childbirth. These Key Actions are to be implemented over the period 2011 to 2015.
<table>
<thead>
<tr>
<th>Key Action</th>
<th>By Whom</th>
<th>By When</th>
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</thead>
<tbody>
<tr>
<td>Establish an All Wales Maternity Services Implementation Group.</td>
<td>Welsh Government</td>
<td>Achieved in July 2011</td>
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<tr>
<td>Develop a set of national indicators to measure effectiveness and quality of maternity services.</td>
<td>All Wales Maternity Services Implementation Group</td>
<td>December 2011</td>
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<tr>
<td>Issue final set of national indicators and future levels of performance for each indicator to Local Health Boards.</td>
<td>Welsh Government</td>
<td>February 2012</td>
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<td>Complete review of current organisation and delivery of maternity services and use the outcome to inform a local delivery plan for the 5 Themes for Action. Report formal progress against the delivery plans and national milestones to Boards and Welsh Government. Report progress against delivery plan milestones via website reports. Review and update delivery plans and milestones.</td>
<td>Local Health Boards working in partnership with other Local Health Boards, NHS trusts and Third Sector</td>
<td>March 2012, Annually, starting with period 2012-13, Quarterly, starting with quarter ending June 2012, At least annually</td>
</tr>
<tr>
<td>Publish annual all Wales report on effectiveness of maternity services in Wales based on national indicators.</td>
<td>Welsh Government</td>
<td>September 2013, for period 2012-13</td>
</tr>
</tbody>
</table>
Reference List


ii Wales Audit Office (2009)


Healthy Start Available at: http://www.healthystart.nhs.uk


Public Health Context for the Maternity Services

The beginning of life continues to become safer. Wales has a comparatively low maternal, perinatal, neonatal and infant mortality rate. However, we continue to face significant public health challenges with health inequities evident around Wales, for example, Blaenau Gwent, Newport and Merthyr Tydfil had the highest percentage of low birth weights.

In order to increase the accumulation of positive effects on health and wellbeing, and reduce the accumulation of negative effects (Fig 1), action to reduce health inequities must start before birth and be followed up through infancy, the school age and working years, and into later life.

Figure 1: Cumulative positive and negative effects on health

Source: Adapted from the Mermot Review. ‘Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010’ February 2010
Whilst our genes play an important role, health and wellbeing is influenced by a complex range of social and environmental factors. To deliver the vision of this strategy, we must maximise opportunities to further improve the physical, mental and emotional health outcomes for women and baby’s, and tackle inequities in line with the ‘Our Healthy Future’\textsuperscript{iii} (Welsh government’s strategic framework for Public Health in Wales), Local Health Boards need to deliver services within the context of the wider determinants of health (Fig 2).

**Figure 2: Dimensions of Health and Wellbeing**

To effectively work across these wider determinants of health and have a holistic impact on health and wellbeing at a population level, engagement with a variety of partners across organisational boundaries within the public and third sector will be necessary. Ensuring that strong links are established with local partnerships developed from local Children and Young People Plans, Health Social Care and Wellbeing Strategies, and Local Public Health Strategic Frameworks are a mechanism for making this happen.

**Births and Deaths**

Local authority population projections for Wales published in May 2010\textsuperscript{iv} project that, between mid-2008 and mid-2023, there will be an increase in their overall population. Five local authorities are projected to see increases of 10 per cent or more between mid-2008 and mid-2023. In 2007/08, there were 13 local authorities in Wales who had more births than deaths.

The total fertility rate in Wales has risen year on year from 2001-10 with the exception of 2009. It is projected that between 2008/09 and 2022/23, birth numbers will be highest in Cardiff, Swansea and Rhondda Cynon Taf. This is a reflection of the fact that these are the largest local authorities in Wales. Birth numbers in Swansea are projected to increase from 2,700 in 2008/09 to 3,100 in 2022/23, while birth levels in Cardiff are projected to increase from 4,600 in 2008/09 to 5,900 in 2022/23.
These growths in birth numbers are mainly a result of an increase in the population of women of fertility age, which is likely to be caused by a high in-migration of women of this age group. Cardiff in particular is projected to see a high net in-migration of women aged 15-49, at around 1,500 each year. Birth numbers are projected to be lowest in the Isle of Anglesey, Ceredigion and Merthyr Tydfil, at around 700 to 800 births from 2008/09 to 2022/23. Birth levels in Ceredigion are projected to remain fairly constant, while birth levels are projected to decline between 2012/13 and 2022/23 in the Isle of Anglesey and Merthyr Tydfil. This decrease in the number of births is a result of a decrease in the number of women of fertility age in these local authorities.

**Maternal Mortality**

The Centre for Maternal and Child Enquiries (CMACE) report for 2006-2008 shows that the maternal mortality rate was 11.39 per 100,000 maternities compared to 13.95 per 100,000 maternities for the previous triennium, 2003-05. For the first time there has been a reduction in the inequalities gap, with a significant decrease in maternal mortality rates among those living in the most deprived areas and those in the lowest socio-economic group.

Key recommendations from the report stressed the importance of:

- **Pre-pregnancy counselling** - Women with pre-existing medical illness, including psychiatric conditions, whose conditions may require a change of medication should be informed of how this may relate to their pregnancy.

- **Pre-existing medical conditions** - Women whose pregnancies are likely to be complicated by potentially serious underlying medical or mental health conditions, and women who develop these problems should be immediately referred to appropriate specialist centres where care can be optimised. Referrals should be made a priority.

- **Specialist clinical care** - There remains an urgent need for the routine use of a national modified early obstetric warning score (MEOWS) chart in all pregnant or postpartum women who become unwell and require either obstetric or gynaecology services. This will help in the recognition, treatment and referral of women who have, or are developing, a critical illness during or after pregnancy.

- **Genital tract infection/sepsis** - All pregnant and recently delivered women need to be informed of the risks and signs and symptoms of genital tract infection and how to prevent its transmission and all health care professionals should be aware of the signs and symptoms of sepsis.

Inequalities in health and wellbeing between areas and social groups are proving extremely resistant to policies which seek to narrow the gaps. The significant public health challenges are described in the following sections.

**Perinatal Mortality**

Perinatal, stillbirth, neonatal and infant mortality rates in Wales have remained static in recent years, following a gradual reduction over the previous 10 years.
Preterm birth is the largest cause of death, following live birth and once again, studies have found an association between poor outcome and life style and behaviour factors such as young maternal age, smoking and alcohol use as well as access to antenatal care.

Challenges for Maternity Services in Wales

Pregnancy is a powerful motivator for change and a time when women and their partners, often for the first time, make positive lifestyle changes and choices in order to provide the optimal conditions to ensure the health and wellbeing of their unborn baby. This is particularly important, not just in the context of the pregnancy, but also because we know that when women make these changes, they significantly influence the lifestyle choices of their children and wider family. Pregnancy therefore presents a golden opportunity to impact on the health and wellbeing of individuals and communities.

The health of children is influenced by what happens throughout pregnancy and even before, so it is vitally important that efforts to ensure that the mother and child are safe and healthy need to start well before birth.

The strength of the evidence for preconception care is varied. However, the evidence to support lifestyle changes in areas such as diet, physical activity, smoking and alcohol consumption is well established, and will make a positive contribution to healthy uncomplicated pregnancies and healthy babies. It is important not to forget that this is not just applicable to the woman; positive lifestyle changes in these areas, for example, can affect the quality of the man's sperm.

Pre-conception care involves assessment of lifestyle, health and fitness in order to identify areas for improvement. It provides opportunities to ensure that vaccinations and routine screening tests are up to date, such as rubella immunisation and cervical screening, and the importance of pre-conception folic acid can be re-enforced.

For women with certain conditions there is strong evidence to support specific pre-conception advice information and support, for example;

- Chronic health problems such as diabetes, asthma, depression or other mental illness, epilepsy and thyroid disease, increase the risk of complications developing for both mother and baby during pregnancy, labour, birth and the post natal period. Medication used to treat such conditions may be harmful and need to be changed or monitored closely.

- Women who are obese or have conditions such as cardiac problems or previous thromboembolic conditions, may need advice to ensure that their treatment and care is optimised to ensure that risk of developing complication are minimised as much as possible.

- Where there is a family history of genetically inherited conditions prospective parents may need specialist counselling and advice in order to make informed choices when planning their pregnancy.
More effort to ensure that women and their partners have access to pre-conception information and advice will support action to reduce health inequalities preconceptually, which can be followed up during the ante, intrapartum and post natal periods, through infancy, the school age and working years, and into later life.

**Obesity**

Obesity in pregnancy is associated with an increased risk of a number of pregnancy-related complications and adverse outcomes and the babies of obese women have an increased risk of perinatal mortality compared with the general maternity population in the UK. In addition neonatal unit admissions (within 24 hours of birth) correlate directly with maternal obesity.

Given that obesity is more common in areas of high social deprivation it is no surprise that Wales has the highest overall prevalence of maternal obesity in the UK.

**Smoking**

The Centre for Disease Control identified that women who smoke before pregnancy have a 30% chance of being infertile and are more likely to experience delay in conception. Those women who smoke during pregnancy are about twice as likely to experience premature rupture of membranes and placental abruption during pregnancy. Babies born to women who smoke are 30% more likely to be born prematurely, are more likely to be born with low birth weight (less than 2500 grams), weigh an average of 200 grams less than babies born to mothers who do not smoke, and are 1.4 to 3 times more likely to die of Sudden Infant Death Syndrome (SID).

Smoking is the largest single cause of avoidable ill health and early death in Wales. Adults in more deprived areas (as defined by the Welsh Index of Multiple Deprivation) are more likely to smoke than those in less deprived areas (Fig 3. on following page). The 2010 Infant Feeding Survey demonstrated that:

- A third of mothers (33%) in Wales smoked at some point in the 12 months immediately before or during pregnancy, more than in the other UK countries. Of mothers who smoked, about 50% gave up at some point before the birth, compared to 54% in the UK as a whole.
- One in six of all mothers (16%) in Wales continued to smoke throughout their pregnancy.
- The highest proportions of mothers who smoked before or during pregnancy were found among mothers in routine and manual occupations and among those aged 20-24.

ASH reported 22% of women in Wales continue to smoke throughout pregnancy.
Alcohol

Drinking during pregnancy will have a significant impact on the physical and mental health of the woman and can result in Fetal Alcohol Syndrome (FAS). This disorder leads to lifelong intellectual and behavioural problems for the child.

According to the Department of Health Hospital Episode Statistics\textsuperscript{XVI} the number of cases of FAS in England was 95 in 2000-01, 90 in 2001-02 and 128 in 2002-03. In Scotland, there were four cases of FAS in 2000, five in 2001, four in 2002, two in 2003 and ten cases in 2004. This equated to 0.21 per 1,000 live births in 2004. In Wales, the Congenital Anomaly Register and Information Service (CARIS)\textsuperscript{XVII} has been collecting data since 1998. 27 confirmed cases have been reported between 1998 - 2009, giving a rate of 0.07 per 1000 live births. The diagnosis of FAS is difficult and requires a geneticist to confirm, hence in Wales there are suspected but unconfirmed cases and probable under reporting. There is no data available for the incidence of FAS in Northern Ireland. In the USA, the incidence of FAS is reported to be between 0.5 and 2 per 1,000 live births.

The reported worldwide incidence of FAS is 0.97 cases per 1,000. It is important to note, however, that this estimate is based almost entirely on data from the USA. FAS, although not a common condition, is nevertheless regarded as the leading known cause of non-genetic intellectual disability in the Western world.
Key findings for the UK as a whole from the UK Infant Feeding Survey 2005 are:

- Over half (54%) of mothers drank alcohol during pregnancy. However, among mothers who drank during pregnancy consumption levels were low. Only eight per cent of all mothers drank more than two units of alcohol per week on average.

- Almost three-quarters of mothers (73%) who drank during pregnancy received advice about drinking, with midwives being the most common source.

**Teenage Conception**

The 2006 Health Behaviour in School-aged Children Study showing that Wales had one of the highest proportions of 15 year olds in the 34 European and North American participating countries reporting having had sexual intercourse, at 41% of girls and 30% of boys.

Encouragingly, the latest update on the Child Poverty Milestones suggests a reduction in inequality between the most deprived fifth of Wales and the middle deprived fifth in relation to underage conceptions. Despite the latest provisional figures for 2009 showing teenage conception rates (age under 18) to be 21% lower than they were in 1999, recent progress has been slow. (See Fig 6 for 1992-2009 trends). It is estimated that 20% of under 18 births are to previous teenage mothers therefore ensuring that the contraceptive needs of new teenage mothers are met is an important factor in reducing rates of teenage conception.
The Welsh Assembly Government’s Sexual Health and Well-being Action Plan for Wales, 2010-2015, is committed to improve the sexual health and wellbeing of the population, reduce inequalities in relation to sexual health, and to develop a society that supports open discussion about relationships, sex, and sexuality. One of the key objectives of the Sexual Health and Well-being Action Plan is to reduce the rates of teenage pregnancy. A grant scheme will be targeting areas with high rates of teenage conception. Funding will be used to provide evidence based interventions amongst those most vulnerable to teenage pregnancy and strengthen the capacity of existing services to tackle young people’s sexual health.

Breastfeeding

Breastfeeding gives babies protection from disease and infections and breastfed babies are less likely to develop asthma, eczema and diabetes. There are advantages for the mother too, as a breastfeeding mother is less likely to develop ovarian and pre-menopausal breast cancer.

The Infant Feeding Survey 2010 shows that whilst Wales lags behind other parts of the UK in sustaining breastfeeding through infancy, the rates of breastfeeding at birth rose in 2010 compared with previous years - 71 per cent of babies were breastfed at birth - an increase from 67 per cent in 2005. Routine breastfeeding initiation data suggests that the more deprived areas of the Welsh Valley’s have the lowest initiation.

More detail from the 2010 Infant Feeding Survey will be published in summer 2012 but information on duration of breastfeeding is available from the previous survey in 2005. Breastfeeding rates for Wales from the Infant Feeding Survey 2005 showed an initial incidence
rate of 67%. This was less than in England (78%) and Scotland (70%) but more than in Northern Ireland (63%).

In 2005, 48% of all mothers in the United Kingdom were breastfeeding at six weeks, while 25% were still breastfeeding at six months. In Wales 37% of mothers were breastfeeding at six weeks and 18% at six months, lower proportions than in England (50%, 26%) or Scotland (44%, 24%) but higher than in Northern Ireland (32%, 14%).

In 2005, 38% of all mothers in Wales were breastfeeding exclusively at one week, while 15% were feeding exclusively at six weeks. This compared to 45% of all mothers in the United Kingdom breastfeeding exclusively at one week, and 21% feeding exclusively at six weeks. At six months the proportion of mothers who were breastfeeding exclusively in all UK countries was negligible (<1%). (NB. Incidence refers to all babies who were breastfed initially; prevalence refers to the proportion of babies who were wholly or partially breastfed at specific ages).

Birth Interventions

Of the 36,033 live births to Welsh residents in 2010, 3.4% took place at home (Fig 6.) Caesarean section rates rose from 23% in 1999-00 to 27% in 2009-10; this is more than 10% above the 15% rate determined by The World Health Organisation (WHO).

Figure 6: Live births to Welsh residents by place of birth, 2010

![Pie chart showing live births to Welsh residents by place of birth, 2010]

**Total live births: 36,033**

Source: National Community Child Health Database
Figure 7 below indicates the number and type of interventions during the year 2009-10, i.e. out of 31,583 deliveries there were 15,317 without intervention (48.5%). The interventions include: caesarean section (emergency and elective), ventouse (vacuum), forceps and intervention for breech presentation. Caesarean section is the most common intervention.

**Figure 7: Deliveries in hospitals in Wales by method of delivery, 2009-10**

- **Total deliveries:** 31,583
- **Deliveries without intervention:** 15,317
- **Inductions:** 6,644

*Source: Patient Episode data Wales*

The high levels of induction of labour described in Figure 8 below, coupled with other interventions such as ventouse and forceps birth can all impact negatively on the birth experience and can lead to similar morbidity issues as described above.
Figure 8: Induced deliveries, Wales 2003-04 to 2009-10

Figure 9 below shows the percentage of instrumental deliveries by forceps or vacuum (ventouse) over a ten year period 1999-00 to 2009-10. This indicates a steady rise in use since 2003-04.

Figure 9: Instrumental deliveries, Wales 1999-00 to 2009-10
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