Public Accounts Committee
PAC(4) 25-12 – Paper 1

Date: Monday 12 November 2012

Venue: Senedd, National Assembly for Wales
Title: Maternity Services in Wales

Purpose

1. This paper provides evidence for the Public Accounts Committee's short inquiry into Maternity Services in Wales with particular focus on caesarean section rates

2. The evidence paper looks at:

- The Welsh Government's leadership in improving maternity services; and
- Caesarean section rates

Other areas for examination on a secondary basis are:

- Staffing levels in maternity services; and
- The impact of maternity services on breastfeeding rates

WELSH GOVERNMENT'S LEADERSHIP OF MATERNITY SERVICES

Policy lead

3. The Chief Nursing Officer (CNO) was made the policy lead for maternity services in June 2011.

The Strategic Vision for Maternity Services in Wales

4. The strategic vision for maternity services was launched in September 2011 and is currently being used to guide NHS maternity service reconfiguration work that is currently underway in Wales (see section 6 below for timelines). It sets out a programme of action at both a national and local level to deliver our vision and it specifies the results we want for women and their babies during pregnancy and childbirth.

5. The Vision document that the Welsh Government expects the NHS to take action on includes the following key principles for maternity services:

i. 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;

ii. Promote healthy lifestyles for pregnant women which have a positive impact on them and their family's health;

iii. 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;

iv. Employ a highly trained workforce able to deliver high quality, safe and effective services; and are constantly reviewed and improved.

6. Service Reconfiguration Plans

There are three programmes ongoing at different stages at present:

Betsi Cadwaladr University Health Board launched its public consultation *"Healthcare in North Wales is changing 2012"* on 20 August, which contained its formal proposals for the future of health services in North Wales. The formal consultation process concluded on 28 October and the Minister expects the comments of all stakeholders to be taken into account as part of the evaluation and analysis that will now follow. The Health Board is expected to publish its final plans towards the end of the year.

Hywel Dda Health Board launched its public consultation *"Your Health, Your Future – Consulting our Communities"* on 6 August, which contains its formal proposals for the future of health services in Mid & West Wales. The formal consultation process concluded on 29 October and the Minister expects the comments of all stakeholders to be taken into account as part of the evaluation and analysis that will now follow. The Health Board is expected to publish its final plans towards the end of the year.

South Wales launched their engagement programme on the 26 September and will not enter their formal consultation process until the New Year.

Implementation of the Maternity Services Vision

7. An all-Wales Implementation Group has been leading and overseeing this process. It is co-chaired by Jean White, Chief Nursing Officer and Claire Foster, a user representative.

8. The following sub-groups have been set up to take forward the key principles described in the Maternity Services Vision document:

1. Setting outcomes, indicators and performance measures
2. Workforce
3. Informatics
4. Direct access to a midwife
5. Reporting for quality and safety

9. This work is progressing well and will be completed by March 2013. Table 1 below describes the tasks set for each of the five sub groups. More detail on the outcomes, indicators and performance measures that have been issued to NHS organisations, is in the section following the table.

Table 1: Main tasks per subgroup

Sub Group	Tasks
1. Setting outcomes, indicators and performance measures	Using the Results Based Accountability (RBA) methodology and terminology, to identify a set of outcomes and indicators for measuring nationally how well Wales is achieving the results it wants for women, their babies and families.

	This group has finished its work - see section 10 & 11 on measuring success below for specific action taken.
2. Workforce	Workforce Skills, Education and Development – to recommend minimum standard of skills, education and development for all staff, supported by the development of pan-Wales programmes where appropriate. Staffing Levels – to assess the organisational compliance with all recommended staff levels (Birth Rate Plus/RCOG etc) to identify areas of shortfall. To identify potential workforce opportunities and constraints on future service models. Skill Mix – to review opportunities to re-balance skill mix, drawing on best practice. Develop a staffing/skill mix model for all staff groups to support the delivery of workforce changes. Workforce Planning – to recommend inclusions to the workforce planning process and guidance which reflect the outcomes of the work undertaken on the three work areas above.
3. Informatics	The Informatics sub group has been established to take forward into practice the informatics requirements of the Strategy.
4. Direct access to a midwife	To consider the definition and components required to ensure that pregnant women have direct access to a midwife and to develop a toolkit and operational framework for LHB implementation. The sub-group has now completed the second draft of the toolkit document which was finalised in August.
5. Reporting for quality and safety	To review and evaluate existing surveys, audits and other reporting mechanisms for quality and safety in maternal and neonatal services. To determine the appropriateness and robustness of existing reporting and identify overlaps and gaps. To ensure the reporting systems are integrated with service provision and audit loops are routinely closed to promote ongoing quality and safety

Measuring success

10. Focussing on improving health, 5 outcome indicators were issued to the NHS in July 2012, these will be used to measure progress in transforming services. All Health Boards are required to provide baseline data on the indicators by July 2013 so

that performance measures can be set for future years. These outcome indicators are:

I. Percentage of women who:
   a. Smoke during pregnancy
   b. Drink 5 units of alcohol or more a week, during pregnancy
   c. Have a BMI of 30 or more at the initial assessment
   d. Misuse substances during pregnancy

II. Proportion of babies with a birth weight below 2.5 kgs (live births)
III. Proportion of babies exclusively receiving breast milk at 10 days following birth
IV. Proportion of women and their partners who felt confident to care for their baby
V. Proportion of normal births

11. The above outcome indicators will be used to measure and track how well over time the services is doing. There is a need to reduce inequalities in health, and therefore Welsh Government will also examine how well the services are reducing the gap between the most and least deprived parts of Wales and between age groups. There is also a need to compare ourselves internationally wherever we can.

EXAMPLE OF WELSH GOVERNMENT LEADERSHIP: Development of All Wales Training for Interpretation of Electronic Foetal Heart Rate Monitoring (Cardiotocograph)

12. Cardiotocography (CTG) is a technical means of recording the foetal heartbeat and the uterine contractions during pregnancy and labour. The challenge of interpreting CTG recordings in labour can result in failure to act appropriately when a foetus is in distress. Current guidance sets out the need to be competent in the use and interpretation of CTG and whilst regular training is provided to medical and midwifery staff this could be improved with the inclusion of an assessment of competence.

13. In response to these concerns the Chief Nursing Officer is chairing all Wales CTG Interpretation Task and Finish Group. The group will be developing an all Wales evidence based e-learning package for midwives and obstetricians, which will include an assessment of competence, based on the Royal College of Obstetricians and Gynaecologists/Royal College of Midwives guidance. The training package is being developed and will be available in 2013.

CAESAREAN SECTION RATES

Background

14. Caesarean Section rates have been steadily rising over the last 15 years and in 2011 around a quarter of all births in Wales were by Caesarean Section. Across the UK the picture is similar.

	England	Scotland	Northern Ireland	Wales
Rates 2010	24.8 %	26.6%	30%	26.6%

15. There is no one factor that contributes to the rise in rates and it is a real challenge to reduce them particularly as repeat caesareans account for approximately a quarter of the total rate.

16. The number of women with complex medical complications is rising as well as the number of pregnant women who smoke or are obese. These factors all contribute to the rise in Caesarean Section rates.

17. Health Boards are reporting that the recent NICE Guidance on Caesarean Section (2011) has resulted in more women requesting a Caesarean Section. The guideline recommends that when a woman requests a Caesarean Section because she has anxiety about childbirth she should be offered referral to a healthcare professional with expertise in providing perinatal mental health support to help her address her anxiety in a supportive manner.

18. For women requesting a Caesarean Section, if after discussion and offer of support (including perinatal mental health support for women with anxiety about childbirth), a vaginal birth is still not an acceptable option she should be offered a planned Caesarean Section.

Introduction of the Caesarean Toolkit

19. During 2009 -10, in response to Wales having the highest reported Caesarean Section rates in the UK, Welsh Government funded the implementation of the Caesarean Section Toolkit across all Health Boards in Wales.

20. The toolkit is a practical approach to reducing Caesarean rates but also has relevance to all aspects of care.

21. The toolkit encouraged Health Boards to:-

- Share good practice across Wales
- Facilitate reflection on the culture of an organisation or team
- Stimulate discussion about the strengths and weaknesses of services
- Show up any differences in perception between staff groups, managers or users
- Help to understand how a service with a more progressive approach might look
- Identify practices or behaviours a team would like to change
- Provide the team with tools and case studies to share good practice and resources
- Question current practices.

22. Each Health Board was asked to develop a plan to reduce Caesarean Section rates and to provide an update a year later, on progress.

Rates over the last 5 years

	2007	2008	2009	2010	2011
ABMU	Pre re-organisation	23.06%	24.18%	23.74%	25.68%
Aneurin Bevan	25%	25%	24%	23%	23.73%
Betsi Cadwaladr	24.4%	26.7%	25.3%	24.9%	25.47%
Cardiff & Vale	23.3%	23.67%	23.91%	21.25%	20.43%
Cwm Taf	28.8%	28.4%	30%	29.8%	29.2%
Hywel Dda	25.7%	23.7%	26.8%	27.1%	25.96%
Powys	18%	17%	19.9%	18.7%	22.4%

STAFFING LEVELS IN MATERNITY SERVICES

Background

23. Providing safe maternity care requires focus on the workforce development and modernisation of the whole workforce including midwives, doctors, support workers, housekeepers, administrative and portering teams.

24. As part of the Strategic Vision for Maternity Services in Wales a sub-group was set up to develop workforce guidelines for delivering safe effective services in Wales. The group is due to conclude its work by February 2013 and will be proposing a hub and spoke model – a hub of specialist practice (consultant delivered obstetric and neonatal services supported by anaesthetics and diagnostic services), with spokes of midwife-led birth centres supporting the hub.

25. Detailed analysis and forecasting of the workforce requirements to staff the hub and spoke model cannot be made until specific size, specification and location of the units is agreed by the Health Boards. However the sub-group have identified the principles that should guide workforce developments.

Midwifery Workforce

26. The number of midwives (Whole-time Equivalent) has fluctuated during the last 5 years, as illustrated on the table below. Health Boards are required to be Birthrate Plus (nationally accepted workforce tool) compliant and all have confirmed that they work to ensure compliance.

27. Annual education training numbers also fluctuate, which is due to the Integrated Workforce Planning Process which asks Health Boards to identify their future requirements. Health Boards have to consider birth rates against issues such as the age profile of their staff. Currently Wales has the youngest midwifery workforce in the UK. The workforce plans are then used to calculate the number of midwife training places that are commissioned across Wales.

Numbers of Midwives

Whole-time equivalent	2007	2008	2009	2010	2011
Registered midwives	1,247	1,323	1,227	1,196	1,165 .

Maternity Support Workers

28. A specific maternity support worker role was launched by the Minister in February 2009 and since that date an all Wales curriculum to train staff has been rolled out to every Health Board. The training programme takes up to 18 months to complete and the first cohort from Aneurin Bevan Health Board completed their training in July 2011. Maternity support workers work under supervision of a midwife and provide advice to women before and after birth on a range of subjects including breastfeeding, baby and mother nutrition as well as carrying out routine tests such as blood pressure and blood tests.

29. Organisations identify the numbers entering training in their workforce plans. In 2012 a further 12 Maternity Support Workers (MSW) commenced their course, with 12 currently identified to begin in 2013. The 2012 assessment date for MSW numbers in training and due dates for completion of training is in December. Estimation of numbers pre this data collection suggest there are over 50 MSWs in training or having completed their training in Wales

Medical Workforce

30. The number of medical staff within obstetrics and gynaecology (Whole-time Equivalent) has increased by 15 since 2007.

Whole-time equivalent	2007	2008	2009	2010	2011
All grades	315	313	324	329	336

31. The latest complete set of vacancy data across NHS organisations in Wales for the medical staff group in June, records that the only vacancies in the obstetrics and gynaecology speciality were 2 in Abertawe Bro Morgannwg University and 1 in Betsi Cadwaladr University Health Boards. All vacancies were in Specialty Training grades.

32. Whilst vacancy levels are relatively low, the medical rotas for Obstetrics and Gynaecology are spread across multiple sites. They are therefore vulnerable to risk in terms of service continuity. Discussions between the Wales Deanery and Health Boards are focussing on the opportunities that reconfiguration of services will bring to develop more robust rotas which will deliver high quality and appropriate training.

THE IMPACT OF MATERNITY SERVICES ON BREASTFEEDING RATES

33. There is good quality evidence that quantifies the short term and long term health risks of not breastfeeding for both mothers and babies. A recent report highlighted the cost to the UK of low breastfeeding rates both in terms of an

increased incidence of illness and health service costs of treatment for those illnesses. Therefore, although rates in Wales are only slightly lower that England, the low breastfeeding rates in Wales continue to be a cause for concern and an important public health issue to be addressed.

Baby Friendly Initiative

34. The UNICEF UK Baby Friendly Initiative provides accreditation to maternity and community health services that have successfully undergone an external assessment.

35. The initiative provides training for health professionals to enable them to give breastfeeding mothers the help and support they need to breastfeed successfully.

36. The Welsh Government encourages all NHS hospitals and community health services in Wales to take part in this initiative.

Progress towards accreditation for maternity services

Health Board	Status
Cwm Taf	Full accreditation of both maternity units
Powys Teaching	Initial plans made but progress slow
Hywel Dda	Initial plans made but progress slow
Aneurin Bevan	Full accreditation of both maternity units and birth centres
Cardiff and Vale	Full accreditation
Abertawe Bro Morgannwg University	Full accreditation
Betsi Cadwaladr University	Stage 2 assessment passed – all staff trained – working towards full accreditation
All Wales	69% of births in Baby Friendly maternity services

Plans for the development of the breastfeeding programme

37 There is now a new national coordinator for the breastfeeding programme in post, a review of the programme is underway and work includes:

- supporting fast progress to complete all Wales breastfeeding data introduced in Sept 2012 as part of the Strategic Vision for Maternity Services in Wales;
- working with those maternity units and health visiting services that are making slow progress to address barrier to implementing change; and
- developing the programme to include additional evidence based mechanisms for increasing breastfeeding rates.

Glossary of Terms /Procedures

Birthrate Plus

Birthrate Plus is based upon the standard on one to one care from a midwife for a woman during labour and delivery, together with the care of the newborn infant(s)

A classification system was developed which uses clinical indicators to place mother and baby in one of five outcome categories.

Cardiotocography (CTG)

Cardiotocography is a technical means of recording the foetal heartbeat and the uterine contractions during pregnancy and labour.

Direct access to a midwife

Most UK maternity policy over that last 20 years has recommended that women are able to access a midwife directly without having necessarily to go through another health professional. The rationale for this is that women are able to access care more quickly at a time when early intervention, advice and information is essential in improving outcomes. Duplication of care is also reduced.

External cephalic version (ECV)

External cephalic version is a process by which a breech baby can be turned to head first and is usually performed around 36 weeks. This is to avoid the woman needing a Caesarean as women are now advised that should their baby be in a breech position, this is the safest way of giving birth.

In this procedure hands are placed on the mother's abdomen around the baby. The baby is moved up and away from the pelvis and gently turned in several steps from breech, to a sideways position, and finally to a head first presentation.

It has a 40-60% success rate.

NICE Guidance on Caesarean Section 2011

Recent NICE guidance (2011) recommends that when a woman requests a Caesarean Section because she has anxiety about childbirth she should be offered referral to a healthcare professional with expertise in providing perinatal mental health support to help her address her anxiety in a supportive manner.

For women requesting a CS, if after discussion and offer of support (including perinatal mental health support for women with anxiety about childbirth), a vaginal birth is still not an acceptable option she should be offered a planned Caesarean Section

Vaginal Birth after Caesarean Section (VBAC)

NICE guidance (2011) recommends that pregnant women who have a previous Caesarean Section and who want to have a vaginal birth should be supported in this decision.

References

NICE 2011Caesarean section NICE clinical guideline 132