Contents

Vision h-4

Definition h-4

Principles / Parameters h-5

The key principles consistent within configuration of Maternity & Newborn services are: h-6

Current model A profile of Maternity, Neonatal and Gynaecology Services h-9

Maternity Services h-10
Princess of Wales Hospital, Bridgend h-11
Birth Centre, Neath Port Talbot Hospital h-11
Midwifery Led Unit, Singleton Hospital h-12
Antenatal clinics h-12
Neonatal Services h-12
Gynaecology Services h-14

Future Model of Care for Maternity and Newborn Services h-15

Maternity Services h-15
Neonatal Services h-16
Gynaecology Services h-17
Maternity and Obstetric Services h-17
Neonatal Services h-19
Anaesthetic and Critical Care Issues: h-20

Options for future models of care h-21

The preferred model identified by the Maternity and Newborn Workstream: h-22
Midwives (Standards for Maternity Care) h-26
Obstetricians (Standards for Maternity Care) h-27
Anaesthetists (Standards for Maternity Care) h-28
Neonatologists (Standards for Maternity Care) h-29

Communications requirements for delivering the maternity care Pathway h-31
Clinical Service Interdependencies:  

Transfer routes during labour and delivery  
Draft Service Model as identified by the South Wales Programme  
Clinical Reference Group  
Clinical Service Interdependencies:  
The typical key patient flows through a Neonatal Intensive Care Unit  

Gynaecology Services  

Draft Service Model for Gynaecology Services  

Maternity and Newborn Workstream Summary  

Service Model – Maternity and Newborn  
Service Model – Neonates  
Service Model – Gynaecology Services  
Quality and Performance Measures  
Prevention  

Next Steps  

Measuring success  

Proposed Projects  

Draft Project Identification for Maternity & Newborn Workstream  
Project managers next step  
Actions  
Further Actions  
Demand  
Productivity & Efficiency  

Conclusion
Vision

The vision for Maternity and Newborn services is to ensure safe, high quality integrated, and sustainable care, delivered by a workforce, who are trained to the highest standards for the care of women and their babies during pregnancy, childbirth and postnatal care in a clinically appropriate location, recognising their clinical acuity and personal choice, to deliver the best achievable outcomes. We need to ensure that babies requiring specialist Neonatal services wherever possible are delivered in a unit which can offer this care and produce results which are comparable to the best in the world. We need to continue to provide high quality and evidence based specialist neonatal intensive, high dependency and special care to serve our ABMU, Hywel Dda and the rest of the neonatal network.

Definition

Maternity and Newborn – Maternity and Newborn services are primarily delivered by Midwives, Obstetricians, Anaesthetists, Neonatologists, Paediatricians, Neonatal Nurses and General Practitioners. The services aim to be cohesive, providing care for healthy women with normal pregnancies and for those with risk factors or more complex needs.
Principles / Parameters

The Maternity and Newborn workstream has identified the following principles to be achieved in the future model of care:

• The highest possible quality of care whilst still providing value for money

• Driven by an enthusiastic, committed and caring workforce who is proud of their services.

• Improved communication and engagement across all the clinical workforce enabling clinicians to develop and shape clinical services.

• Zero tolerance to avoidable perinatal mortality (constant real time analysis of adverse events to ensure a reduction in mortality).

• Empowering patients to actively influence service delivery and change (informal groups of staff, patients & carers, involve underrepresented groups, mechanism for empowering patients, complaints as a tool for change, virtual suggestion box on line, use of patient diaries etc.).

• Greater involvement of the 3rd sector in service planning and provision.

• Sustainability.

• High quality services with outcomes comparable with the best in the world.

• Excellent provision for midwifery, nursing and medical education to ensure high quality midwives, doctors and nurses of the future.

• High quality facilities for parents and families to stay.
The key principles consistent within configuration of Maternity & Newborn services are:

• Safe services should be provided as locally as possible, not local services provided as safely as possible.

• Service delivery should be evidence based and be consistent with national quality standards.

• The workforce must be fit for purpose, sustainable and affordable.

• The emphasis of the service model should be on maintaining normality whilst ensuring easy access to services for women with complications and Obstetric / medical needs.

• The service model should provide choice for women.

• Women receive appropriate care by the appropriate person in the appropriate place.

• Local services should be developed as part of a wider network to ensure that patients can be “escalated” to more specialist care where necessary.

• There must be robust and effective intra-partum transfer protocols for patients who require more specialist services.
Maternity and Newborn

• Services should be provided in comfortable and fit-for-purpose care environments.

• Services should provide optimum efficiency and be deliverable within the existing resource envelope.

• The service model must be supported by patients, parents, the public, our partners and other key stakeholders.

The South Wales Programme has identified the following Service objectives to improve the quality and safety of care for patients by:

• Ensuring that services meet agreed National UK and Welsh standards which achieve the principles and recommendations of the Maternity Strategy.

• Delivering services in environments of care which are fit for purpose in both acute and primary care settings.

• Reducing risk as far as possible for patients by developing robust clinical policies and procedures that meet the requirements for each model of care.

• Ensuring that clinical staff have the appropriate skills and experience to provide effective assessment, advice and/or intervention.

• Ensuring effective intra-partum transfer capacity and pathways to ensure that appropriate support and/or specialist services are available in a safe, high quality and timely manner.
The South Wales Programme has identified the following Service objectives to improve the sustainability of services to patients by:

- Providing robust staffing arrangements that comply with employment legislation (e.g. European Working Time Directive) and meet the professional regulatory body requirements such as Deanery/General Medical Council/RCOG/RCOA/NMC for clinical training and supervision where appropriate.
- Developing clinical roles to provide future workforce flexibility e.g. midwifery support roles.
- Improving efficiency.
- Ensuring sufficient flexibility to meet fluctuating peaks and troughs of Maternity and Neonatal service demand.

The South Wales Programme has identified the following Service objectives to improve access for patients by:

- Optimising the opportunity for women to give birth at home
- Ensuring that the majority of Maternity care is provided as locally as possible.
- Optimising the number of Midwifery led cases
- Planning capacity to meet demand and requirements of service model standards
Current model
A profile of Maternity, Neonatal and Gynaecology Services

• Safe services should be provided as locally as possible, not local services provided as safely as possible.

• Service delivery should be evidence based and be consistent with national quality standards.

• The workforce must be fit for purpose, sustainable and affordable.

• The emphasis of the service model should be on maintaining normality whilst ensuring easy access to services for women with complications and Obstetric / medical needs.

• The service model should provide choice for women.

• Women receive appropriate care by the appropriate person in the appropriate place.

• Local services should be developed as part of a wider network to ensure that patients can be “escalated” to more specialist care where necessary.

• There must be robust and effective intra-partum transfer protocols for patients who require more specialist services.
Maternity and Newborn Services

The current maternity and newborn services are provided across 3 of the main 4 Acute Hospital Sites in ABMU, namely: Singleton Hospital, Swansea, Neath Port Talbot Hospital, Baglan and Princess of Wales Hospital, Bridgend. The Maternity service also provides a full range of community based midwifery care. Currently, Morriston Hospital only provides acute and community paediatric services.

Maternity Services

Singleton Hospital, Swansea

The Maternity Unit consists of:

- Labour Ward (Central Delivery Suite)
- Ward 19 – Antenatal Ward
- Midwifery Led Unit
- Ward 18 – Postnatal Ward

The Labour Ward has a triage area for assessment on arrival and eight individual rooms for women to give birth in. There are also two theatres where Caesarean Sections take place. Following a Caesarean Section women are transferred to the five-bedded low dependency area for 12-24 hours. There is also a high dependency area for women who require additional care following the birth of their babies.

Mothers requiring intensive care are transferred to Morriston Hospital.

The Neonatal Intensive Care Unit (NICU) in Singleton Hospital is able to look after babies from 23 weeks gestation.
Princess of Wales Hospital, Bridgend

The Maternity Unit consists of:

- Ward 12 – Maternity Ward
- Labour Ward
- Bluebell Room (midwifery led room)

The Labour Ward has six individual rooms for women to give birth. There is a birthing pool for women who would like to use water for pain relief or experience a water birth. There are also two theatres where Caesarean Sections take place. The Bluebell Room is a room off the Labour Ward where healthy women experiencing an uncomplicated pregnancy can give birth with a midwife. This room is a homely environment with a double bed and en-suite. If there are complications arrangements will be made and mothers can be transferred to the obstetric unit. Deliveries are planned for babies over 32 weeks gestation, or over 34 weeks if there are twins. Mothers requiring HDU or Intensive care remain on site where there is HDU/IC provision. Where time allows deliveries of less than these gestations are transferred in utero to a level three unit to allow access to neonatal intensive care. If babies less than these gestations are delivered who require intensive care, the baby is stabilised and then arrangements are made for transfer to a level three unit.

Birth Centre, Neath Port Talbot Hospital

There are seven single-bedded rooms with en-suite bathroom and tea making facilities. Double beds are provided in some rooms should partners wish to stay. A ‘pool room’ is also available for women who choose to labour or birth in water. The Birth Centre is managed and run by midwives. The midwives are experts in normal birth and no doctors are present.
**Maternity and Newborn**

**Midwifery Led Unit, Singleton Hospital**

At Singleton Hospital there is an alongside Midwifery Led Unit where healthy women experiencing uncomplicated pregnancies can give birth. The Unit is managed and run by midwives with no doctors present. It consists of two birthing rooms and a ‘pool room’ for women who choose to labour or birth in water. Many women go home within two hours of giving birth. Transfer to Postnatal Ward is possible in certain situations.

**Antenatal clinics**

All sites have a full range of consultant led antenatal clinics with local access to ultrasonography and specialised clinics in diabetes, medical disorders, substance misuse.

**Neonatal Services**

**Neonatal units are classed into 3 types:**

- Level 3– Neonatal Intensive Care Unit (IC)
- Level 2 – Neonatal High Dependency Unit (HD)
- Level 1 – Special Care Baby Unit (SC)

Singleton Hospital level three unit is the tertiary centre for Neonatal care in South West Wales. Princess of Wales neonatal unit is a level 2 unit. These two units work together with shared protocols and resources. There are combined ward rounds at POW with consultants from Swansea. Nurses work flexibly across the two sites.

Neonatal services provided within units can be classed into 3 acuity levels:

- Intensive Care (IC)
Maternity and Newborn

- High Dependency (HD)
- Low Dependency (LD)

The funded current neonatal cot provision within ABMU is as follows:

<table>
<thead>
<tr>
<th></th>
<th>Singleton Hospital</th>
<th>Princess of Wales Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>IC</td>
<td>7 (2 partly funded)</td>
<td></td>
</tr>
<tr>
<td>HD</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>SC</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>12</td>
</tr>
</tbody>
</table>

In addition, one stabilisation cot (equipped but without funded nurse cover) is provided in both units to be used if there is a baby born who unexpectedly requires intensive care, when the unit is full. This is according to the Welsh and BAPM standards.

In 2012, the tertiary neonatal unit in Swansea cared for over 100 very low birth weight (<1500g) birth weight babies, an increase of 20% from the previous year, provided nearly 1971 days of intensive care and 1346 days of high dependency care and over 3000 days of special care. This was a substantial increase in activity from the previous year.
Maternity and Newborn

Gynaecology Services

In 2010 the Directorate of Women and Child Health implemented a number of changes to the provision of inpatient Gynaecology Services. At the time there were particular pressures with the quality and standards of pregnancy advisory care. There was also a significant proportion of inpatient bed capacity that was either under utilised or accessed by other specialities. Ensuing developments resulted in following changes:

- Change of inpatient Gynaecology at Neath Port Talbot Hospital to an Ambulatory Gynaecology Unit;
- Closure of Ward 5 in Singleton Hospital;
- Development of a dedicated Pregnancy Advisory Unit on Ward 16 in Singleton Hospital;
- Reduction of beds on Ward 20 in Singleton Hospital and inclusion of a ward based day surgery unit.

The table below summarises these changes:

<table>
<thead>
<tr>
<th>Clinical Area</th>
<th>Previous Service Model Resources</th>
<th>Current Service Model Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 5 (Singleton)</td>
<td>12 beds</td>
<td>Ward 16 PAS Unit</td>
</tr>
<tr>
<td>Ward 11 (POW)</td>
<td>15 beds</td>
<td>14 beds</td>
</tr>
<tr>
<td>Ward B1 (NPTH)</td>
<td>15 beds</td>
<td>Ambulatory Gynaecology Unit</td>
</tr>
<tr>
<td>Ward 20 (Singleton)</td>
<td>26 beds</td>
<td>22 beds &amp; 6 DOSSA Trolleys</td>
</tr>
<tr>
<td>Total/Summary</td>
<td>68 beds</td>
<td>PAS Unit / Ambulatory Gynaecology Unit / 36 beds / 6 Trolleys</td>
</tr>
</tbody>
</table>
Future Model of Care for Maternity and Newborn Services

Maternity Services

‘A Strategic Vision for Maternity Services in Wales’ published by Welsh Government in 2011 identified 5 key themes:

- 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.

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

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

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

- Maternity Services are constantly reviewed and improved.
Neonatal Services

The British Association of Perinatal Medicine (BAPM) issues national guidance, the most recent of which includes: ‘Service Standards for Hospitals Providing Neonatal Care 2010’, and, ‘Neonatal support for Stand Alone Midwifery Led Units (MLUs) 2011’. The neonatal taskforce document also provides standards for neonatal services. Recently the Wales neonatal network has issued new standards which have been modelled on the BAPM standards 2010.

The Maternity and Newborn Workstream identified the following issues:

BAPM service standards for Hospital Providing Neonatal Care 2010 guiding principle is that babies who require intensive care should be delivered in facilities which meet the full standards, including dedicated neonatal cover at consultant, middle grade and first on tier

- At risk babies do best when born at a unit which can offer on site neonatal intensive care facilities. In 2010 less than half very low birth weight infants born in Wales were born in level 3 units.

- Linkages with and impact of changes to South Wales Model.

- Sharing of vision and joint planning required with Hywel Dda in particular to providing a solution to South West capacity problems.
Gynaecology Services

The Royal College of Obstetricians and Gynaecologists (RCOG) report on ‘Standards for Gynaecology Care 2008’ outlines standards which are aimed at facilitating the development of equitable, safe and high-quality services. The following sections are particularly relevant when considering future options for the gynaecology service model within ABMU Health Board:

• Section 2 – Early Pregnancy Loss;
• Section 3 – Ectopic Pregnancy;
• Section 4 – Recurrent Miscarriage;
• Section 7 – Induced Abortion;
• Section 9 – Diagnostic & Operative Hysteroscopy;
• Section 10 – Laparoscopic Surgery.

Maternity and Obstetric Services

The development phase of Changing for the Better has identified key deficits and challenges in the current model as documented in the “part 1 Case for Change document”. These include:

• Increasing numbers of very preterm births and demand for neonatal specialist care
• Changing Demographics and Complexities of women and Neonatology care
• Capacity and Demand Management
Maternity and Newborn

- Workforce sustainability in a multi disciplinary context
- Public Health Challenges e.g. teenage conceptions, ethnic minority populations, obesity, substance misuse and smoking in pregnancy
- High incidence of social deprivation - some of the worst in Europe
- Social Factors e.g. safeguarding, parenting, domestic abuse, smoking cessation
- Rising Demands and Public Expectations relating to quality and experience outcomes for mothers/babies
- Static stillbirth rate in Wales
- Need to increase consultant cover on labour wards in line with RCOG Standards
- Meeting recognised national standards of care currently and sustainably in the future

Our Health Board should provide a woman with a choice of where she gives birth, at home in a standalone midwifery led unit, a midwifery led unit that is situated alongside an obstetric unit or within an obstetric unit.

*NHS Member of Staff written response to engagement 2012*
Maternity and Newborn

Neonatal Services

• Insufficient neonatal capacity and ad hoc closures of the neonatal unit at Singleton Hospital. This situation has improved since 2 intensive care cots were transferred from Princess of Wales Hospital in October 2012, but there is still a deficit (as identified by the network) of 1 stabilisation cot and 3 more high dependency cots requiring provision at Singleton Hospital.

• Insufficient labour ward capacity at Singleton Hospital impacting on ability to accept high risk in utero transfers. This might be improved if more midwives were appointed.

• In Singleton Hospital, Medium to long term risk of insufficient junior grade and middle grade doctors.

• Paediatric middle grade cover at Princess of Wales Hospital is difficult. There is a prospect that trainees may be withdrawn by the Deanery in the near future because of insufficient paediatric doctors in training and the need to sustain rotas elsewhere. It is not feasible to provide any neonatal special or high dependency care in a unit where there is no paediatric cover on site. There is a need to increase the neonatal middle grade rota at Singleton which is currently 7 person rota to 8 person rota in line with network guidance and to improve training.
Anaesthetic and Critical Care Issues:

- Obstetric Units should have a minimum of 10 anaesthetic consultant sessions provided. This is the case in Singleton, but not in Bridgend which currently has 8 sessions allocated; Ideally, weekends should also be covered by consultant anaesthetic sessions as set out in the Association of Anaesthetists/OAA guidance.

- Duty anaesthetist should be immediately available with no other duties. Not the case in POW as also involved in theatre cases.

- Moving obstetrics to Morriston will result in a bigger pool of anaesthetic trainees on the Morriston site and therefore better cover as a whole. In addition, while not critical at the moment, anaesthetic junior staffing is likely to become a problem in the future due to a reduction in training numbers in Wales. There are already deficits on the Morriston site.

- With the absence of a level 3 intensive care unit in Singleton there is the risk of ventilated patients possibly requiring transfer to Morriston. This supports the model of co-locating ICU and Obstetrics in Morriston.

- Interventional Radiology is available on an ad hoc basis in POW but not available in Singleton.

It is essential that any future model of Maternity and Newborn is developed in line with the principles identified, and that a future model also addresses the possible deficits identified within the Case for Change document.
Options for future models of care

The Maternity and Newborn Workstream identified the following options:

All options include:

1. Provision of a tertiary neonatal unit and tertiary obstetric unit integrated within an acute tertiary Hospital

2. One Consultant Led Obstetric Unit supported with network of Midwifery Led Units.

3. Two Consultant led Obstetric Units with network of Midwifery Led Units (stand alone or alongside) ; One unit with level 3 neonates and the second unit covering low risk births >36wks gestation and no twins

4. One or Two Consultant Obstetrics Units with no free standing Midwifery Led Units with an enhanced home delivery service

5. Integrated Women’s Hospital on an existing acute hospital site

6. One unit dealing with acute obstetric cases and a second unit dealing with elective cases on a 5 day per week (Mon-Fri) basis with inpatient gynaecology services for the HB.
The preferred model identified by the Maternity and Newborn Workstream:

Integrated Women’s Hospital on Morriston acute hospital site. This would have excellent state of the art facilities for patient care and parent accommodation for those who have to travel for care.

- Easy access from West Wales and Bridgend along M4, and from Heads of Valleys road
- Co-located with emergency care
- High level adult ITU
- Radiology
- All other key specialties e.g. adult renal, cardiac, trauma, enabling complex obstetric cases to be optimally managed
- Meets all RCOG and BPAM standards
- Excellent training available at obstetrics, gynaecology and neonatal level
- Elimination of staffing pressures
- Quality of clinical care will improve because it will become a more attractive place to work
- Potential of model being more cost effective
- Co-locates neonatal paediatrics with general paediatrics enabling shared access to services e.g. paediatric dietetics
- Improves post natal care pathways
- Merger of outreach services
Maternity and Newborn

- Enhanced MDT working
- Enhanced patient experience through clearer patient pathways
- Needs to be an A&E on site with an obstetrics service
- Single point of access for obstetrics and neonates emergencies from Midwifery Led Units or community care
- Part of a network of Midwifery Led Units and an alongside unit
- Referral pathways for Midwifery Led Units and stand alone birth centres(within and outside the Health Board)
- Facilities meeting the RCOG labour ward cover standards

The preferred service model identified by the Maternity and Newborn workstream will enable truly integrated care and partnership working, maximising the contribution of the entire workforce. The principles of this model will also enable:

- Service focused on individual needs and choice
- Localise where possible, centralise where necessary
- Prevention is better than cure
Integration of service delivery with Gynaecology needs has also been considered from a workforce perspective. Consideration needs to be given to the following:

- Timescale and training lead time to operationalise reconfigured service models including redeploying and/or training workforce, redesigning and redeveloping facilities.

- Concentration on some sites of acute hospital care element of the model may require capital infrastructure affecting timeliness of implementation.

- Revised clinical models on Hospital sites which were obstetric led will attract a capital requirement to make them suitable to be either a hospital care (non acute) model or a community model.

- Persuasion of public that flows are acceptable and necessary to access high quality services

- Capacity of Welsh Ambulance to provide required emergency transport service for timely transfers between local acute and major acute facilities. In addition to this consideration must be given to the requirements for nonemergency transport which will not tie up scarce emergency resource.

- Demographic changes affecting birth rate trend and conurbation growth distorting demand patterns.

- Impacts on theatre workload and workforce will need to be considered in the redesign.
There is much evidence that women are the pivotal factor to the health and wellbeing of the rest of the family. As such shaping services for this client group is essential.

Member of Public Written response – engagement 2012

Excellent Maternity and Newborn care must be comprehensive and flexible to respond to the clinical and social needs of women and their families. For the majority of women, pregnancy and childbirth is a totally normal and uncomplicated experience but the service must be able to respond appropriately to those who may require highly specialised care for existing medical problems, social circumstances and complications that may develop.

The Royal College of Obstetricians and Gynaecologists, Obstetric Anaesthetic Association, Royal College of Midwives and Royal College of Paediatrics and Child Health have comprehensively defined the standards for the organisation and delivery of care in labour. The National Institute for Clinical effectiveness (NICE) has also produced guidelines for ante-natal, intrapartum and post natal care which must be considered. Welsh Risk Pool (WRP) has also devised a number of standards contained within Standard 15 that Health Boards need to demonstrate compliance with. There are also All Wales Standards for Midwife Led Units (MLUs) irrespective of whether the Unit is an alongside unit or a freestanding unit.
Maternity and Newborn

Summarised below are the key standards relating to the provision of acute hospital obstetrics and midwifery led units.

• Consultant Obstetric units require a 24-hour anaesthesia and analgesia service with consultant supervision, adult high-dependency and access to intensive care, blood transfusion and other district general hospital support services and an integrated Obstetric and Neonatal care service.

• Complex intra-partum cases require integrated, multi-professional specialist management and direct consultant involvement.

• Maternity care providers must ensure that all healthcare professionals directly involved in childbirth are competent and expert in basic adult Obstetric, Neonatal resuscitation and immediate care.

• In order to provide junior doctor training in Obstetrics, the hospital must ideally provide more than 2,500 deliveries per annum (Future of Small Units: RCOG 2008) as any number of births below this figure is deemed to be unlikely to benefit trainees out of hours.

Midwives (Standards for Maternity Care)

• Every woman should have a named midwife and be booked before 10 weeks of pregnancy.

• Every woman should have a designated midwife to provide one-to-one care for them when in established labour for 100% of the time.

• LHBs should ensure that for all transfers in to hospital with complications, midwives can refer directly to the most senior Obstetrician on call.
Maternity and Newborn

- LHBs should ensure that in all out-of-hospital labours/births, the midwife is responsible for transfer and continues to care for the woman on transfer where possible.

- There should be a lead midwife for child protection.

- All other intrapartum care standards require consideration.

**Obstetricians (Standards for Maternity Care)**

The role of the Consultant Obstetrician on the labour ward is to ensure a high standard of care for women and their babies with complex medical or obstetric needs and to be available for the acute, severe and often unpredictable life-threatening emergencies which are a feature of obstetric practice.

One of the key considerations for future service configuration will be the requirement for consultant presence in an Obstetrics-led Unit (OU). The RCOG recommends that Consultant is related to the number of deliveries per annum. This is discussed in more detail under the workforce section below.

The main components of the Obstetrician Standards are set out below:

- It is expected that, during the consultant’s session on the delivery suite they would have no other clinical commitments.

- Outside the recommended minimum 40 hours of consultant obstetrician presence, the consultant should conduct a physical ward round as appropriate at least twice a day during Saturdays, Sundays and bank holidays, with a physical round every evening, reviewing midwifery-led cases on referral.
Maternity and Newborn

• A consultant obstetrician should be available within 30 minutes outside the hours of consultant presence.

• Complicated births in obstetric units should be attended by a consultant obstetrician.

• Any planned delivery earlier than 27–28 weeks of gestation requires review, as early as possible, by staff with appropriate expertise in the interpretation of foetal wellbeing tests. Women in this group should be seen within 24 hours of admission by a consultant obstetrician and their plan of care reviewed.

• The RCOG in collaboration with the RCM has published standards for safe staffing levels for labour wards and these will need to be considered in the new service models.

Anaesthetists (Standards for Maternity Care)

• There should be a lead Consultant Obstetric anaesthetist with responsibility for the organisation and management of the specialist anaesthetics service within consultant-led units with sessions which reflect the clinical and administrative workload.

• Arrangements should be in place in consultant-led units to ensure that a specialist anaesthetic service is available at all times during childbirth and that service should not have commitments to other parts of the hospital service, for example emergency general surgery or intensive care.

• A duty anaesthetist of appropriate competency and dedicated only to the labour ward must be immediately available.
Maternity and Newborn

• The anaesthetic team’s response time must be such that a caesarean section may be started within a time appropriate to the clinical condition (this requires all team members to be informed of the case appropriately).

• Trainee anaesthetists must be able to obtain prompt advice and help from a designated consultant anaesthetist at all times. They and their consultants must know the limits of their competence and when close supervision and help are needed.

Neonatology (Standards for Maternity Care)

• Consideration of the level of Neonatology input must be made in conjunction with the South Wales Programme Neonatology Clinical Reference Group as part of their service model development to meet British Association of Peri-natal Medicine (BAPM) Standards.

[Diagram: Maternity Care Pathway]
Future service models must be designed to ensure that women are able to access care at any point in the normal pathway or any deviation from that pathway.

<table>
<thead>
<tr>
<th>Out of hospital care</th>
<th>Hospital Care (non acute)</th>
<th>Hospital Care (acute)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Midwifery-led home births for low risk women.</td>
<td>• In some cases, Free Standing Midwifery Led Units (FMLU) or Birth Centre providing midwifery led care for low risk deliveries.</td>
<td>• Consultant-led obstetrics services for medium-high risk deliveries.</td>
</tr>
<tr>
<td>• Community midwifery-led ante natal and post natal services.</td>
<td>• Early Pregnancy (EPAU) and Day Assessment Unit services (DAU).</td>
<td>• Alongside Midwifery Led Units (MLUs) (included in above).</td>
</tr>
<tr>
<td>• Free Standing Midwifery Led Unit (FMLU).</td>
<td>• Inpatient services.</td>
<td>• Early Pregnancy (EPAU) and Day Assessment Unit services (DAU).</td>
</tr>
<tr>
<td>• Access to GP care.</td>
<td>• Consultant led and midwifery-led ante-natal and post natal clinics.</td>
<td>• Obstetrics inpatient care.</td>
</tr>
<tr>
<td></td>
<td>• Non Complex Elective Caesarean Sections (to be clarified)</td>
<td>• Consultant led and midwifery-led ante-natal and post natal clinics.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Emergency and Elective Caesarean Sections</td>
</tr>
</tbody>
</table>
Communications requirements for delivering the maternity care Pathway

<table>
<thead>
<tr>
<th>High level description</th>
<th>Communications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-pregnancy care</strong></td>
<td>GP/midwife (and specialists if appropriate) informed of planning pregnancy and health needs assessment.</td>
</tr>
<tr>
<td>For all women planning pregnancy.</td>
<td></td>
</tr>
<tr>
<td><strong>Antenatal care</strong></td>
<td>GP/midwife (and specialists, if appropriate) informed of pregnancy and dynamic risk assessment.</td>
</tr>
<tr>
<td>First contact with healthcare professional.</td>
<td></td>
</tr>
<tr>
<td>Seven to 10 antenatal appointments according to individual need.</td>
<td></td>
</tr>
<tr>
<td><strong>Labour and delivery</strong></td>
<td>GP/midwife (and specialists if appropriate) informed of birth, dynamic risk assessment, transfer plan and postnatal care plan.</td>
</tr>
<tr>
<td>1:1 support in labour from midwife known to woman.</td>
<td></td>
</tr>
<tr>
<td>Transfer of woman according to individual need, with midwife.</td>
<td></td>
</tr>
<tr>
<td><strong>Postnatal care</strong></td>
<td>GP/midwife (and specialists if appropriate) and health visitor informed of woman’s dynamic risk assessment and postnatal care.</td>
</tr>
<tr>
<td>First visit at home</td>
<td></td>
</tr>
<tr>
<td>Frequency and location of care based on woman’s individual need.</td>
<td></td>
</tr>
</tbody>
</table>

Appropriate level of communications between midwife and GP to meet woman’s needs.
Clinical Service Interdependencies:

In order to clarify the nature and degree of clinical service interdependencies the following framework has been developed by the South Wales Programme Clinical Reference Group based on an approach taken by a report published by the Department of Health in collaboration with the relevant Royal Colleges on Commissioning Safe and Sustainable Specialised Paediatric Services.

A framework has been adapted in order to establish and describe the relative importance of the co-location of specific hospital services to support local birth centres and home births and also major acute hospital obstetrics services.

The relationship between services is colour coded as follows:

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Colour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absolute dependency, requiring co-location on the same hospital site</td>
<td>Red</td>
</tr>
<tr>
<td>Relationship under some circumstances, requiring varying levels of access and contact between specialists, but not necessarily co-location</td>
<td>Amber</td>
</tr>
<tr>
<td>Indirect or no relationship</td>
<td>Green</td>
</tr>
</tbody>
</table>

*If service is MLU only there is no requirement for radiology, however if the model includes full consultant led ante-natal services plus EPAU services the radiology is red.*
<table>
<thead>
<tr>
<th>Service</th>
<th>Out of Hospital Care</th>
<th>Hospital Care (non-acute)</th>
<th>Hospital Care (acute)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obstetrics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulatory Gynaecology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective complex / non complex Gynaecology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency/complex elective Gynaecology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biochemistry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Critical Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiology</td>
<td></td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Paediatric Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paediatrics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neonatal care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anaesthetics</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Transfer routes during labour and delivery

This service model ensures that Neonatal services will be co-located with Level 3 Paediatric services and Level 3 Consultant led Obstetric services. Neonatal Care may be categorised into patterns of care dependent upon the need for nursing and medical support. In August 2011 BAPM published updated Categories of Care which provides definitions for Intensive, High Dependency and Special Care.

**Intensive Care (IC)** formally known as level 3 care: Care provided for babies with the most complex problems who require constant supervision and monitoring and, usually, mechanical ventilation. Due to the possibility of acute deterioration, a neonatal specialist should always be available. Extremely immature infants all require intensive care and monitoring over the first few weeks, but the range of intensive care extends throughout the whole gestation period.
High Dependency Care (HD) formally known as level 2 care: Care provided in a neonatal unit and involves continuing monitoring, for example those who weigh less than 1,000g (2lbs 3oz), or are receiving help with breathing via continuous positive airway pressure (CPAP) or intravenous feeding, but who do not fulfil any of the requirements for intensive care.

Special Care (SC) formally known as level 1 care: Care provided for babies who could not reasonably be looked after at home by their mother. Babies receiving special care need to have their breathing and heart rate monitored, be fed through a tube, supplied with extra oxygen or treated for jaundice; this category includes babies who are convalescing from more specialist treatment before being discharged/ Special care which occurs alongside the mother is called ‘transitional care’ but takes place outside a neonatal unit, in a ward setting.
## Draft Service Model as identified by the South Wales Programme Clinical Reference Group

<table>
<thead>
<tr>
<th>Level 1 – Out of hospital care</th>
<th>Level 2 - Local Acute Hospital services</th>
<th>Level 3 – Major Acute Hospital Services (4/5 Neonatal Units)</th>
<th>Level 3+ - Major Acute Hospital Services (2/3 Specialist Neonatal Units)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Paediatric Community Nursing</td>
<td>• Paediatric Community Nursing</td>
<td>• All Services within a Local Neonatal Unit and Special Care Unit</td>
<td>• All services within a Neonatal Intensive Care Unit</td>
</tr>
<tr>
<td>• Community Therapy Services</td>
<td>• Community Therapy Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatients</td>
<td>• Outpatients</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Clinical Service Interdependencies:

In order to clarify the nature and degree of clinical service interdependencies the following framework has been developed by the South Wales Programme Clinical Reference Group based on an approach taken by a report published by the Department of Health in collaboration with the relevant Royal Colleges on Commissioning Safe and Sustainable Specialised Paediatric Services.

The relationship between services is colour coded as follows:

| Absolute dependency, requiring co-location on the same hospital site | Red |
| Relationship under some circumstances, requiring varying levels of access and contact between specialists, but not necessarily co-location | Amber |
| Indirect or no relationship | Green |

Relationships coded Amber are further differentiated using a scoring system of 1 to 3 to denote both type of and access to medical care required as follows:

<table>
<thead>
<tr>
<th>1</th>
<th>(Most Urgent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant assessment required or transfer of care</td>
<td></td>
</tr>
<tr>
<td>Timescale – within 4 hours</td>
<td></td>
</tr>
<tr>
<td>Visit by consultant/specialist</td>
<td></td>
</tr>
<tr>
<td>Timescale – next working day</td>
<td></td>
</tr>
<tr>
<td>Planned intervention</td>
<td></td>
</tr>
<tr>
<td>Timescale – as required</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>(least Urgent)</td>
</tr>
<tr>
<td>Maternity and Newborn</td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td></td>
</tr>
<tr>
<td>Diagnostics</td>
<td></td>
</tr>
<tr>
<td>Fetal Medicine</td>
<td></td>
</tr>
<tr>
<td>Obstetrics</td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td></td>
</tr>
<tr>
<td>Critical Care</td>
<td></td>
</tr>
<tr>
<td>Gastro</td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
</tr>
<tr>
<td>Cardiology</td>
<td></td>
</tr>
<tr>
<td>Max Face</td>
<td></td>
</tr>
<tr>
<td>Paediatrics</td>
<td></td>
</tr>
<tr>
<td>ENT Airway</td>
<td></td>
</tr>
<tr>
<td>Pathology</td>
<td></td>
</tr>
<tr>
<td>T &amp; O</td>
<td></td>
</tr>
<tr>
<td>Paediatric Surgery</td>
<td></td>
</tr>
<tr>
<td>Paediatrics Radiology</td>
<td></td>
</tr>
<tr>
<td>Anaesthetics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Special Care</td>
</tr>
</tbody>
</table>
The South Wales Programme Clinical Reference Group identified the following risks:

- Reducing training posts combined with inability to appoint sufficient permanent or temporary middle-grade level specialty doctors may result in existing paediatric and neonatal rotas becoming unsustainable before the South Wales Programme Consultation on reconfiguration of acute inpatient paediatrics services is completed.

- Availability of suitably trained workforce to sustain out of hours rotas.

- Timescale and training lead time to operationalise reconfigured service models including redeploying and/or training workforce, redesigning and redeveloping facilities.

- Capacity of Welsh Ambulance to provide required emergency transport service for timely transfers between local acute and major acute facilities which should be a 24/7 service.

- Having the appropriate skill mix of nursing staff.
The typical key patient flows through a Neonatal Intensive Care Unit

- Post-natal ward,
- Delivery suite/theatre
- Tertiary referral from other NNU
- Transfer of local booked baby born out of area

- Admission to neonatal intensive care/ high dependency
- Internal transfer to high dependency/ special care as condition improves

- Transfer to local referring hospital when tertiary service no longer required
- Discharge to Specialists Paediatric wards if long-term in-patient care required/ complex
- Discharge to Paediatric Surgical ward if uncomplicated surgical problem
- Discharge to Mum on post-natal ward
- Discharge Home

Post-natal ward, Paediatric theatres/ radiology
Gynaecology Services

The Planned Care workstream has identified the following principles to be achieved in the future model of care:

- Elective diagnostics available on sites away from major site
- High volume low complexity work away from major site
- Increase utilisation of primary care/community facilities working with GP networks
- Consolidate planned care for elderly patients in a single site specialist unit
- Hot clinics for elements of emergency work away from the major site
- Only planned elective care and rehabilitation at NPTH
- Directorate and localities will need to decide how their individual specialities fit into these principles
- Developing e-health solutions in particular supporting e-mail correspondence between primary and secondary care
### Draft Service Model for Gynaecology Services

<table>
<thead>
<tr>
<th>Services</th>
<th>Hospital Care (non acute)</th>
<th>Hospital Care (acute)</th>
</tr>
</thead>
</table>
| • Specialised clinics:  
  • Vulval clinic  
  • PAG clinic  
  • Urogynaecology  
  • Fertility  
  • Combined (oncology) | • Day case operating:  
  Require medical cover or robust safe pathway for patients still on site in the evenings following an afternoon list | • In patient operating:  
  • Major procedures  
  • Minor procedures on unfit patients  
  • Emergency procedures |
| When planning sites, need to establish baseline activity for number of patients, travel times and frequency of visits, e.g. if large number of patients or frequent visits required, consider provision in 2 sites of the Health Board. | | |
| • Ancillary services  
  • Continence advisor  
  • Physiotherapy  
  • Ultrasound scanning | Outpatient procedures:  
  • Colposcopy | |
| | Hysteroscopy:  
  • Diagnostic  
  • Therapeutic:  
    • Polpectomy  
    • Endometrial ablation  
    • Hysteroscopic myomectomy  
    • Hysteroscopic sterilisation | |
| | ? Emergency gynaecology clinics, e.g.  
  • emergency clinics in afternoons, staffed by SHO and Consultant level.  
  • Consultant also available for phone consultation with GP’s. | |
Maternity and Newborn Workstream Summary

In this section of the report a summary of what will be included in each part of the ABMU Health Board Maternity & Newborn Model will be outlined.

Service Model – Maternity and Newborn

- Maintain Maternity, Neonatal and Gynaecology services at the Princess of Wales Hospital. (Dependent on the outcome of the South Wales Programme)
- Co-locate all inpatient Maternity, Neonatal, Gynaecology and Paediatric services on one Acute Hospital which would be on the Morriston site.
- Midwifery led unit options

Service Model – Neonates

- Service model for Princess of Wales Hospital following the outcome of the South Wales Programme
- Capacity modelling: Level 1, Level 2 and Level 3
- Compliance with BAPM standards
Service Model – Gynaecology Services

- Acute in-patient capacity requirements, complex and non-complex
- Ambulatory care model
- Oncology
- Theatres capacity requirements
- Emergency Gynaecology pathway
- Planned and unscheduled gynaecology care pathway

The Maternity and Newborn work stream have identified a number of improvement, preventive measures and quality outcomes

Quality and Performance Measures

The Maternity and Newborn workstream identified a number of quality and safety performance measures, which include:

- Reduction of % of women smoking during pregnancy and birth;
- Reduction of % of substance misuse;
- Reduction of % of women with a BMI of equal to or more than 25 who gain more than the recommended weight.
- Reduction of % of women who drink more than 1-2 units once or twice a week; % of babies born with a weight below 2.5kgs;
Maternity and Newborn

• Reduction of % of women exclusively breastfeeding at 10 days post natal;

• Satisfaction rates of service users;

• Improved experience for women with elective procedures

Prevention

The Maternity and Newborn workstream identified a number of quality indicators, which included:

• Normal birth rates;

• Initial assessment carried out by 10 weeks;

• Caesarean section rates;

• Care Plan in place for mothers with mental health conditions;

• Rates of women with perineal trauma;

• Rates of women who receive level 3 care on ICU;

• Babies who unexpectedly go to ICU >37/40 with no congenital abnormality.

• Benchmarking of risk adjusted neonatal outcomes of VLBW infants against other level 3 units in developed countries (Vermont Oxford neonatal database). This includes risk adjusted mortality and morbidity such as chronic lung disease, rates of sepsis, Retinopathy of prematurity etc. Also the UK National Neonatal Audit project

• Home birth rates
The model proposes placing maternity services within the wider public health paradigm with an individualised and targeted approach to all care. The model considers care from pre conception to postnatal care with targeted support prioritised for vulnerable women, women with specific needs and women who have been identified as being at a higher risk of poor outcomes. Central to the model is the provision of accessible, timely antenatal care so that all women receive their first health and social care assessment by the end of their 10th week of pregnancy. Early antenatal care provides the foundation of a good pregnancy and allows early detection and management of risks.

Implementing recommendations to provide all women with midwife-coordinated care, continuity of care throughout the pathway and the provision of choice should raise satisfaction and women’s experience of care. Providing excellent care and support to mothers, families and the wider networks of support can help give babies the best possible start in life.
Next Steps

Changing for the better is using programme methodology (Managing Successful Programmes MSP). The Developmental phase of changing for the better has used seven work streams as outlined earlier in this paper. The output from each work stream has demonstrated inevitable cross over / duplication of potential future projects.

Following the engagement process that was completed in December 2012, Changing for the Better (C4B) is moving into the implementation phase. In this phase the Changing for the Better Programme will be made up of a range of projects that each work stream has identified as essential to enabling their proposed future model of service to develop.

Members of the work stream will be incorporated into the project groups. These will either be existing working groups that the Health Board or their Partners have established or where necessary task and finish project groups will be established.

The work stream will also continue to exist as a whole and will perform the quality and assurance function for the relevant identified projects. The frequency of meetings will be agreed by the work stream members.

See diagrams 3 & 4

It is essential that we have a system in place to ensure quality assurance. The quality assurance will be provided by the workstreams and the existing Co-chairs, who will be represented on the Programme Board. The Co-chairs will be responsible for providing rigorous oversight of the project team’s activities and facilitate strong leadership and direction from the top.

A system to give us quality assurance requires a reliable framework including:

- A quality assurance framework which drives improvement and metrics at its core.
- Local action based on constant self assessment and improvement.
- Transparent reporting across the system.
- Swift action where needed when quality or delivery give cause for concern.
Measuring success

is vital for both improvement and assurance. This system will be underpinned by a series of service specific delivery plans which will set out the outcomes that we expect to deliver to agreed time lines. From these service specific requirements we will develop a comprehensive framework of outcome indicators and performance measures to track progress and monitor delivery.

Diagram 4 - The Programme Board will have a range of projects which will deliver the Service Models identified in the Development phase. The current work streams will provide quality and assurance for the Programme Board for each of the appropriate projects. Some Projects will overlap more than one work stream, where this is the case all relevant work streams will be responsible for quality and assurance.
Maternity and Newborn

Proposed Projects

Draft Project Identification for Maternity & Newborn Workstream

Diagram 5 sets out the proposed projects to enable the Maternity and Newborn model to be developed. Each project will require a project lead that with the support of the C4B Project Manager will be responsible for developing a Project Initiation Document.
Maternity and Newborn Gynaecology Service Model

- Acute – patient capacity requirements, complex & non-complex
  - i.e. * Early Pregnancy Loss
  - * Ectopic Pregnancy
  - * Recurrent Miscarriage
  - * Induced / therapeutic/fetal abnormality Abortion
  - * Diagnostic & Operative Hysteroscopy
  - * Laparoscopic Surgery
  - * Pregnancy advisory Service
  - * fertility & Secondary IVF

- Ambulatory care / Office
- Cancer
- Theatre (Planned Care Workstream)
- Emergency Gynaecology Pathway
- Planned & Unscheduled Care Pathway

Quality & Safety Performance Measures – Risk Adjusted Mortality Index

- Initial antenatal assessment carried out by 10 weeks
- Birth mode outcomes:
  1. Normal Birth rates
  2. Caesarean Section rates
  3. Midwifery led Rates (MLU, Home births)
- % of babies born with a weight below 2.5kgs
- Care plan in place for mothers with mental health conditions
- Maternal mortality & morbidity
- Rates of women who receive level 1 care on ICU
- Babies who unexpectedly go to ICU > 37/40 with no congenital Abnormality
- Benchmark of risk adjusted neonatal outcomes of VLBW infants against other level 3 units in developed countries (Vermont Oxford Neonatal database)
- Zero tolerance to avoidable perinatal mortality
- Satisfaction of service users
- Adherence to 1000 lives mini maternity collaboration

Prevention

- Adherence to the antenatal screening/Wales standards
- % of women smoking during pregnancy & birth.
- % of substance misuse
- % of women with a BMI of equal to or more than 25 who gain more than the recommended weight
- % of pregnant women who drink more than 1-2 units once or twice a week
- Breast feeding rates pre term
- Long term conditions, i.e. Diabetes, epilepsy, asthma, depression or other mental health conditions
- Teenage conception
- Preconceptual Counselling
- Perinatal Counselling
- Positive parenting
- % of women given pelvic floor advice/access to Physiotherapy/preconception/during pregnancy post natal

Project Managers next step

Project Managers Next Steps

- Work Stream
  - * Clarity of Function
  - Establish work stream as Q&A
- Finalise Model
  - Identify Projects
  - Project Leads
  - PIDS
  - Incorporate Projects into C4B Programme
- Detailed Planning
  - Finance
  - Workforce
  - Performance & Quality Measures
  - Business Case
  - Capacity Analysis
- Delivering Capability
  - Incorporated into Locality & Directorate Planning
  - Relevant services – Commissioned/ Decommissioned

Consult on relevant Projects

Jan / Feb 13
Jan / Feb 13
Feb - Apr 13
Sept – Nov 13

Ongoing Engagement (staff, patients, carers, partner organisations)
Maternity and Newborn

Actions

VI. Work Stream to agree / modify Midwifery and Newborn Model

VII. Work stream to agree / modify projects

VIII. Work Stream to identify Project Leads

IX. Work stream to agree frequency of meetings

Further Actions

• Collection of epidemiological and relevant demographic data to provide a profile of ABMU Health Boards population likely to be affected by alteration of current service model.

• A comprehensive literature search of publications relating to Maternity & Newborn services.

• A profile of present acute and community services.

• A assessment of current performance against national targets as detailed within the Annual Quality Framework

• An assessment of compliance with national standards.

• An assessment of financial pressures and constraints.
Maternity and Newborn

Demand

• Antenatal demand

• elective/ emergency admissions

Productivity & Efficiency

• Average length of stay elective care/emergency care
Conclusion

The next few years will undoubtedly be characterised by large scale, complex change. ABMU Health Board needs to respond to the unprecedented financial pressures, new medical technologies, a changing workforce and rising demands. Our plans acknowledge the drivers for change and anticipate the need to introduce new integrated models of care, to focus on prevention and health improvements and to utilise our resources effectively and efficiently.

The intention of this case for change has been to present a logical path towards the development of a new model for Maternity & Newborn Services. As identified in this document, a new model of care could incorporate the following elements to drive much needed improvements:

- Fewer hospitals should provide a more comprehensive range of in-house specialised Maternity & Newborn services, and cover defined geographical areas.

- Establish a network that coordinates services in a defined area through the provision of clear pathways based on clinical standards and interdependencies.

- Ensure the most efficient use of resources in the provision of services.

- Determine an appropriate organisation of the workforce that takes into account training needs ensuring that services meet agreed National UK and Welsh standards and which achieves the principles and recommendations of the Maternity Strategy.
• Delivering services in environments of care which are fit for purpose in both acute and primary care settings.

• Reducing risk as far as possible for patients by developing robust clinical policies and procedures that meet the requirements for each model of care.

• Ensuring that clinical staff have the appropriate skills and experience to provide effective assessment, advice and/or intervention.

• Effective collaboration with paediatric services and other co-dependent services.

• Robust and effective transfer protocols for pregnant women and their babies during pregnancy and childbirth requiring more specialist services.

A huge amount of energy and enthusiasm has been demonstrated by the Maternity and Newborns workstream who have shown a dedication to improving Maternity and Newborn services and have clearly contributed their time and knowledge. The challenge will be to carry that energy and enthusiasm forward into implementation. In the coming weeks and months there will be further discussions and further development of the proposals in this report with key stakeholders.