AIMS For a better birth...

Things are different in Wales

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Gill Boden discusses the Welsh NHS and maternity services

Over many years I have found myself popping up in meetings in England and arguing that things are done differently in the NHS in Wales, and feeling a bit like Pollyanna. So following much hostile criticism in the press and House of Commons over the past few months, I feel that I have to justify my case about the Welsh NHS and apply that to our maternity services.

First of all, the health system in a devolved nation where the provisions of the Health and Social Care Act do not apply is now very different. In contrast to England, where the Health Secretary no longer has responsibility to secure a comprehensive health ser vice, there is one minister with overall responsibility for both the NHS and Social Ser vices, (currently Mark Drakeford, a professor of social work, experienced in government and described by senior civil servants as clear and decisive). There are also Local Health Boards (LHBs) and the role of the Chief Medical Officer is still a powerful one and, importantly, there is no split between purchaser and provider.

The Assembly government and, it seems to me overwhelmingly, the public, believe that public services should be centrally coordinated, and planned towards shared social goals. If a local hospital is performing badly, and of course some do, people in Wales expect state action to improve it and do not want (especially in rural areas) to exercise personal choice to go to a competing hospital elsewhere.

Shared responsibility for both NHS and Social Ser vices through LHBs has made it far easier to deliver integrated services. David Sissling, chief executive of NHS Wales and director general of health and social services, said of LHBs, *'They don't have any allegiance to hospital-bed care and you can think about designing a care pathway without having to think about it in terms of transactions that bring two or three different organisations into the equation.'*[1] Interestingly in May 2013, NHS England announced its intention to integrate all NHS and social care ser vices by 2018, without any mention of the fact that Wales was already doing this.

I won't attempt to say whether patient care and outcomes are broadly better in Wales. This is impossible to do and the argument has now become a political football, but the independent Nuffield review this year suggested that outcomes were broadly similar.[2] Of course there is plenty of genuinely bad news about health in Wales, and some (though much less) good news about health care in Wales. The Welsh have been poorer and sicker than the English for at least 300 years. They have more of the principal causes of ill health and premature death: more heavy industry, more unemployment, and lower average

earnings, and money is a major issue. Most people agree that Wales has been underfunded for years under the Barnett formula, which is the method for working out how much of the 'tax take' will be returned to Wales and Scotland: the NHS takes 40% of this block grant: there is a spend per patient of £1900 compared to the best comparator in terms of 'need', which is the North East of England, which receives £2100, 10% more.

All of this applies to maternity: *'the overarching principles in a National Health Ser vice that is cash strapped are first to do no harm, use evidence-based treatments and coproduce'*[users of the ser vice must be integrally involved in the design and delivery of the ser vice].[3] All of these absolutely apply to maternity, particularly after the draft NICE intrapartum guideline of May 2014, which recognises the need to reduce medical intervention in birth.[4]

The underlying commitment is to an integrated service, which, with all of its faults and shortcomings, can feel very enabling in such a small country. Good leadership is possible, in a situation where Heads of Midwifery can and do meet regularly, and in turn meet with public health practitioners and obstetricians: vision and agreement can potentially be achieved.

Shortages of midwives have never been quite so damaging as in some parts of England: the Assembly government ensures that the whole of Wales is birth-rate plus compliant,[5] but despite that there is no spare capacity and midwives are, in my view often overstretched. As a result there is little room for initiatives involving training the workforce, although some initiatives have been implemented. 'Future proofing of super vision', for example, is the Welsh attempt to improve and safeguard midwifery supervision by employing fulltime supervisors of midwives who were appointed in early 2014. Like everywhere else in the UK there is much reduced antenatal education and postnatal care, but still on average three postnatal visits from a midwife compared with one in London.

There are huge on-going problems, for instance, of data collection where sometimes not enough is collected, or what is available is not helpful, patient episode data are not appropriate for maternity; and provision of specialist services in the rural north and west is difficult and expensive. Also dealing with a population comparatively poor, and suffering from the problems that arise from that, including complications of smoking, obesity and malnourishment, has its own challenges for midwives.

Nevertheless there is much optimism and commitment to women within midwifery and one of the first demarcating moves by the new devolved government was to set a 10% target for home birth in Wales to be met by 2009, before the Birthplace Study,[6] and well before the new NICE draft guideline; and this, I think, showed the clear commitment to a belief in normal birth. The target was missed by a long way but the rise in homebirth was the fastest in the UK for a considerable time and it served to change the culture to some extent. Quietly, and often in rural areas midwives have found ways to provide quality woman-centred care.

In June 2010 I visited the Glan-y-mor team, in the quiet seaside town of Porthcawl. This is a long established team with a marvellous local record, which included a home birth rate of 25%: despite radical

reorganisation they had managed to retain a working environment that they felt was successful in giving women what they needed, while safeguarding their own family life. They did this by working hard to support one another with some stunning examples of high morale and loyalty in the team. They asserted that flexibility is the key, and they described sharing the 'same brain' that is decision-making, accomplished often by phone calls from the bath at home when they were feeling creative.

'We're there to promote the best care for women in what could be the best or the worst experience of their lives, we don't know in advance what the outcome will be'. This is a group practice characterised by continuity, knowing the women and supporting them. Parents in Partnership was a new project of theirs, whereby 80 local mothers had recently been peer support trained for breastfeeding; covering preconception, diet, contraception, obesity and weaning.

Midwives in the team are socially close: they often go walking together; for many years, they have cooperated by picking up each other's children and now they are repeating that with their grandchildren.

There are other examples across Wales: the West has taken pride in its high home birth rate and the large, sparsely populated county of Powys has for many years had no obstetric unit - so women have birthed at home or in tiny MLUs and considered it the norm. In Cardiff, a dedicated home birth team was set up at the end of 2013 with the aim of raising the rate from only around 1% to 3% within the year.

Things are not rosy in Wales but a commitment to a communitarian philosophy with pooling of risk to protect the vulnerable means that for the moment at least it feels as if shared action for the common good is possible. Over 30 years ago, Welsh Valleys GP Julian Tudor-Hart, saw that areas of social deprivation, containing high proportions of people from lower social groups, tend to have access to less good health services, even though their need for such ser vices is greater than that of higher groups. His conclusion was summed up in the 'Inverse Care Law', which states that: *'The availability of good medical care tends to var y inversely with the need of the population served.'*[7] The Welsh Government is battling against the UK and European trend to reduce universal care, a trend that results in targeted facilities for some groups and a two-tier health ser vice. Instead the driving force underlying policy is to remember that health inequalities are not simply, or even mainly, due to failings in the Health Ser vice, nor individual failings, but rooted in poverty and inequality in material wellbeing, and to create a politics that can counter the inverse care law.

Gill Boden

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