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Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: SF/MD/0713/15

David Rees AM
Chair
Health and Social Services Committee

30 March 2015

Dear David,

Stillbirths in Wales – progress report

In response to your letter of 26 February, I enclose a progress report on implementation of the nine recommendations following the one-day inquiry into stillbirths in Wales in February 2013.

While there is still further work to be done to fully implement the recommendations, I am pleased to report the considerable progress made to date and the engagement of clinical professional staff across NHS Wales.

Best wishes,

Mark

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HSCC One Day Enquiry into stillbirths in Wales.
Welsh Government update against recommendations March 2015

Recommendations	Committee Comments on Progress	Welsh Government Response
Recommendation 1: Public awareness of stillbirth and its risk factors is essential to reducing stillbirth rates in Wales. We recommend that the Welsh Government take an active lead - via the recently established National Stillbirth Working Group – in developing key public health messages as a matter of priority. This will raise the awareness of expectant parents and those planning to start a family of the risks of stillbirth and allow them to make more informed choices about their health and pregnancy.	Stakeholders noted that there was a lack of clarity about the Welsh Government's view on the consensus document which includes core messages on stillbirths. The Committee urges Welsh Government to work with relevant partners to clarify the position.	The draft document developed by SANDS at the UK Committee will be an agenda item at the next National Stillbirth Working Group (NSWG) meeting in March 2015. The Chief Nursing Officer for Wales is the chair of this group. Welsh Government will fully endorse the opinion and advice of the NSWG members. Through the Maternity Network, health boards will be asked to agree on the best way to promulgate these messages to all pregnant women in Wales.
Recommendation 2: We recommend that the Welsh Government work with professional bodies and health boards in Wales to ensure that all expectant parents receive adequate information from clinicians and midwives about stillbirth and its associated risks. Discussion of stillbirth should form a routine part of the conversation held between health professionals and expectant parents during the course of a pregnancy. Welsh Government should work with health boards to monitor training needs and competence of health professionals in relation to stillbirth.	Clarification on how the Welsh Government is working with professional bodies and health board managers to ensure stillbirth becomes a normal part of discussions with prospective parents would be welcomed.	Once there is agreement at the meeting in March on what messages will form part of the "routine conversations", the Maternity network plans to launch this work with midwives and obstetricians in Wales. Guidance on this will then be added to the NHS Wales Governance e-Manual. As part of the 1000 Lives National Learning Event in June, a master-class will be held about promoting these messages to women. It will then be the responsibility of health boards to ensure that, through continuous professional development, the messages become a normal part of discussions with prospective parents.

Recommendation 3: We recommend that the Welsh Government work with professional and regulatory bodies and relevant academic institutions to ensure that stillbirth, its associated risk factors and interventions and bereavement training are more prominently featured in welsh midwifery and obstetric curricula.	The Welsh Government may wish to provide further clarification on how it is working with health boards to review training needs and competence of health professionals in relation to stillbirth.	Welsh Government has had assurances from the RCOG and the All Wales Midwifery Education group that the curriculum content is appropriate. It is now the responsibility of health boards to review the training needs and competence of health professionals and to work with higher education institutions to refresh curriculum content to ensure that competencies are maintained.
Recommendation 4: We recommend that the Welsh Government scope the viability of establishing a maternity network to drive the standardisation of care across Wales. We believe that at least a virtual clinical network should be established within the next 12 months.	The Committee would welcome further information about: • When the National Stillbirth Working group will meet • How its progress will be monitored • Whether its minutes will be published • Whether one of the core functions will be to collect data on stillbirths.	The NSWG plans to meet on March 18, April 15, July 8 and October 14. Progress will be monitored via the Maternity Network Steering Group, which reports to the 1000 Lives Steering group and then to the Chief Executive of Public Health Wales. The Maternity Network will discuss how minutes of the meetings could be made public at the next NSWG on March 18. The All Wales Perinatal Survey (AWPS) is a key member of the NSWG and data on stillbirths will continue to be monitored and published through the AWPS.
Recommendation 5: We recommend that the Welsh Government undertake a review of the number of women who deliver more than thirteen days after their due date. The outcome of those pregnancies and the factors that led to the decision not to induce within the recommended guideline	The Committee urges Welsh Government to ensure that this work is monitored closely to ensure that progress is made as soon as possible.	The Chief Nursing Officer for Wales is the chair of the National Stillbirth Working Group and in that role will ensure that this issue remains on the agenda. The AWPS has made an analysis of the numbers which failed to show any increase in incidence of stillbirth in the post 40+13. This will be fed back to the NSWG in March.

time should be considered in every case. Further consideration ought to be given to whether women with other high risk factors such as advanced maternal age, smoking or weight should be induced closer to their due date.		
Recommendation 6: We recommend that the Welsh Government investigate and report on evidence presented at the Committee that having to seek specialist fetal medicine consultations outside wales now exceeds the cost of providing the services within Wales. The Welsh Government should also explore the proposal that specialist fetal medicine services should be commissioned at the tertiary rather than secondary level.	Further information about how to address the needs of women in North or mid-Wales would be welcomed.	As part of Health Board reconfiguration plans, fetal and maternal services have been/are being located alongside high risk Obstetric services. In BCU, the location of high risk Obstetrics is part of the current Sustainable Services Review. Services will be networked to support the Sub Regional Neonatal Intensive Care Centre which will be sited in Ysbyty Glan Clwyd. Women in mid-Wales, who require specialist fetal medicine services would be under the care of a consultant obstetrician and would be referred to appropriate services via the Health Board that is responsible for their care. It is also recognised that local fetal medicine services continue to be strengthened to avoid the specialist centre being over burdened with work that is more appropriately dealt with by fetal medicine leads in local services and that plans are reviewed by WHSSC in six months time to ensure progress continues to be made.

Recommendation 7: We recommend that a national minimum standard for reviewing perinatal deaths should be developed and rolled out across Wales. We also recommend that a wider, more imaginative approach to funding for medical research and investigation is adopted and that the Welsh Government seek detailed costings for a national perinatal audit for Wales from the All the Wales Perinatal Survey. We believe that the initial investment in this audit could yield significant benefits in the future detection and prevention of stillbirth.	The Welsh Government seek detailed costings for a national perinatal audit for Wales	It has been agreed that the four UK governments and NHS England will work together to facilitate the introduction of standardised perinatal mortality reviews. The introduction of these reviews will follow a three stage process that enables: i Individual clinical teams to understand where things have gone wrong and inform discussion with parents; ii Trusts to compare themselves against other units; iii Review at national level. This review is on-going and will be discussed through the NSWG. The NSWG will monitor progress in the development and implementation of a UK standardised review.
Recommendation 8: We recommend that the Welsh Government publish a detailed plan of how it proposes to tackle the problem caused by low rate of post-mortem for stillborn babies. The plan should include: • Details of how training will be delivered to health professionals in order that they re better equipped to raise this very difficult issue with grieving parents. • Details of what improved information will be developed for parents so that they are able to make more informed decisions.	The Committee urges Welsh Government to keep this under close surveillance. If improved timescales are not achieved over the next six months, the Committee believes that the remit of the Perinatal Pathology Sub Group should be extended to include work on how post mortem reports are returned to parents.	Train the Trainers day will be available in Spring 2015. Cascade training in health boards is planned to start within the last 6 months of 2015. The Perinatal Pathology Sub Group are keen to work on developing a standard for the giving parents post mortem reports once they have completed their work on the consent training and patient information leaflet.

• An assessment of the actions needed to improve the provision of perinatal pathology		
Recommendation 9: In the absence of large charities and interested industry that fund the bulk of research for other health conditions, we recommend that Welsh Government, through National Institute for Social care and Health Research's Clinical Research Centre, commission a comprehensive piece of work on the underlying causes of stillbirth. This work should be undertaken in cooperation with health professionals and academics with expertise in this field, and should draw on international knowledge of stillbirth. This work should be completed by the end of this Assembly.	The Committee continues to believe that further research into the underlying causes of stillbirth is still needed.	The Welsh Government and the Maternity Network will take every opportunity to collaborate in and encourage health professionals and others to develop research proposals in this field and to target existing schemes, for example those of the National Institute for Social Care and Health Research.