RCPCH Invited Reviews Programme

Design Review

Hywel Dda University Health Board

November 2015

Royal College of Paediatrics and Child Health

Leading the way in Children's Health

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The Royal College of Paediatrics and Child Health (RCPCH) is a registered charity in England and Wales (1057744) and in Scotland (SC038299)

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Executive Summary

A year after reconfiguration of maternity, neonatal services and paediatrics at the Withybush and Glangwili sites, the Hywel Dda University Health Board was required by the Health Minister to conduct an independent assessment of the impact of the changes. They invited the RCPCH in collaboration with four other Royal Colleges to carry out this work.

In many other areas of medical practice, such as cancer and stroke services, there is evidence that centralising specialist care has improved overall outcomes, and increasingly this approach is affecting many regions in the UK with a range of reports and studies providing evidence about the importance of consultant-led and consultant delivered care[1]. Consolidation has become a necessity due to the changing complexity of healthcare and reducing availability of experienced senior health professionals. Within the Hywel Dda area, consolidation of services to meet nationally agreed standards of care for women and children using services had been fully supported as a principle by clinicians from both sites. However when acute services are withdrawn from any locality it is essential that primary and community health care can 'step up' to provide as much local access as possible and that patients and the public are aware of what the changes mean for them and where to seek consistent advice. It is also a prerequisite that staff are prepared and supported to undertake new ways of working.

We found a very dedicated multi-disciplinary team, committed to providing a quality service to women and children in their communities, who welcomed us and answered questions openly to aid the review process.

Despite a strong public lobby which expressed concern about the changes, we see no clinical case for reverting to stand alone hospital provision. We acknowledge that some families have reported harrowing experiences due to additional travelling time and uncertainty about the need for transfers but we did not see evidence of any worsened outcomes in maternity or paediatric care as a direct result of the reconfiguration. There had been improved compliance with national and professional service standards and although more work is needed to consolidate the staffing and systems we see a strong future for a single service increasingly integrated across two[2] sites.

We noted positive feedback about the care in the midwifery led units (MLU) on both sites which should be further encouraged and the midwives who had come together at Glangwili following the reconfiguration were working better together although more could be done in this area to support closer professional working. The "safety net" of consultant obstetricians and paediatricians covering out of hours at Withybush should

[1] See appendix for references
[2] Plus the Bronglais site although this was not included within the scope of this review

be phased out, ideally by April 2016 if appropriate skilled backup is in place, with these roles integrating into a single team of consultants for each speciality across the Health Board. This will allow improved compliance with standards and enhanced recruitment and sustainability.

With regards to emergency care there is good daytime provision in the paediatric ambulatory care centre (PACU) at Withybush with consultant and middle grade paediatricians on site. Out of hours the processes are less clear and need to be reviewed, agreed and communicated clearly. In the immediate future there is a need to ensure ED staff have appropriate paediatric training and anaesthetists have paediatric airway skills. The Dedicated Ambulance Vehicle (DAV) could take on an enhanced role in ambulatory care, initial management and transfer and we strongly support extension of this service as it is seen as a key safety net.

It must be acknowledged that services may continue to evolve. One possibility is that the DAV ambulance could be withdrawn and if this is the case then there would need to be a robust 24/7 PACU service at Withybush. Options to support this are given in 7.2.11 in the main report. One of these would be using Emergency Nurse Practitioners (ENPs) in a network arrangement with Glangwili.

It is important to further develop community paediatric services to tackle waiting times and improve the quality of service received by families.

The consolidated neonatal unit aspires to designation as a local neonatal unit (LNU) but at present it does not fulfil all of the necessary criteria and should currently remain as a special care unit (SCU). It is particularly important that there are clear pathways for transfer, robust monitoring of outcomes, an ongoing programme of training for staff and closer, more integrated working with colleagues in the Neonatal Intensive Care Unit (NICU)at Singleton. The absence of 24 hour neonatal retrieval is a concern although some cover is provided on a ‘goodwill’ basis from the Singleton team.

The planned Phase Two development to develop the infrastructure at Glangwili should proceed swiftly together with improved transport service and parking facilities to promote the quality of patient and family care as well as staff morale.

Many of the staff have engaged positively and with enthusiasm with the changes and this should be supported by strong leadership at Board level. There needs to be better communication both of the benefits of the reconfiguration and pathways to access the services in order to build a secure and confident service with a clear strategy and vision that will attract high calibre staff keen to be part of the new service.

Overarching High Principle Recommendations

Patient Safety: The provision of maternity and children's services must continue to build on the current momentum with the major emphasis on provision of services that provide maximum safety for patients, but are sustainable in the long term, being cognisant of the geographical challenges of the area. We found no evidence that clinical outcomes had worsened since the changes and there is better compliance with professional standards. There is no clinical sense in reversing the major decisions of reconfiguration made one year ago.

Clinical Accommodation: The further development of clinical excellence can only occur if the accommodation to deliver such care is appropriate and adequate for patient safety. Further delay with 'Phase Two' is unacceptable and a potential risk to patient safety.

Community Needs and Access to services: Inevitably some decisions around reconfiguration will make access to safe services more difficult for some people. Alongside such changes, there therefore must be improvements in access to more routine care and the review recommends improved outpatient services at Withybush to demonstrate commitment to patients and the public. The continued provision of a dedicated staffed ambulance for women and children must be supported, but the current consultant on-call arrangements for paediatric and obstetrics/gynaecology out of hours are an inefficient use of resources which are hampering development of unified medical teams and these should be phased out.

Recognition of Staff Commitment: The planning of care must involve all members of the clinical community and build on their professionalism, enthusiasm and commitment to patient welfare.

Organisational Leadership: There needs to be more active and visible clinical leadership of women's and children's services from the Board, and also at divisional and specialty level.

Communication: The Health Board needs to prioritise an active and evidence-based dialogue with patients, advisory groups and clinical staff to mitigate the misunderstandings and anxieties that have arisen in the past.

1 Introduction

1.1 The RCPCH was invited in May 2015 to conduct an evaluation of the maternity neonatal and paediatric services provided by Hywel Dda University Health Board (HDUHB) in Pembrokeshire and Carmarthen following changes to the service reconfiguration which occurred in August and October 2014. As part of approval of the proposals for change by the Health Board, the Welsh Assembly Health Minister, Professor Mark Drakeford, had required HDUHB to conduct a review of neonatal provision after twelve months of operation, and the Health Board wished to combine this with a wider review of all three services.

1.2 The RCPCH is an independent membership organisation, established by the Privy Council as a charity and for this review is working in partnership with four other Royal Colleges which are similarly constituted, including:

- The Royal College of Obstetricians and Gynaecologists (RCOG)
- The Royal College of Anaesthetists (RCoA)
- The Royal College of Midwives (RCM)
- The Royal College of Nursing (RCN)

1.3 This report recognises the strength of feeling amongst Health Board staff and some members of the public about their expectations and anxieties about their local health service. It focusses however on the performance in the current revised situation and the potential for improvement rather than the history but does take into consideration the physical, clinical and emotional impact of the service changes on those who use them.

2 Terms of reference

The RCPCH will conduct an evaluation of the maternity, neonatal and acute paediatric service provided by Hywel Dda University Health Board at the Withybush and Glangwili sites. This will comprise:

- Reviewing services against the benefit criteria identified in “Your Health Your Future” and the rationale for change. These are;
    - Provision of more care for children in their own homes or as close to home as possible;
    - A reduction in the number of pregnant women over 30 weeks gestation who are transferred outside of the Health Board area for possible or actual delivery;
    - Swifter repatriation of babies requiring neonatal care back into HDUHB hospitals;
    - Improved compliance with Royal College of Obstetricians and Gynaecologists Guidance regarding consultant cover on wards and minimum birth levels;
    - Improved support for middle grade doctor training and sustainable rotas by consolidating obstetric care in locations that exceed 2,500 births per annum
    - Improved compliance with British Association of Perinatal Medicine standards where neonatal care is provided;
    - Improved compliance with Royal College of Paediatrics and Child health Guidelines for Acute Paediatric Inpatient Units (Facing the Future) and subsequent revisions
    - Improved arrangements for High Dependency Care for children in the Hywel Dda catchment area to minimise their transfer outside of the Health Board and meet standards developed by the Paediatric Intensive Care Society.
- Review the impact and outcomes of the neonatal service change as required as part of the Ministerial decision
- Determine how the current services meet recognised Royal College and other professional standards not included above.

3 Background and Context

3.1 Demography and Challenges

3.1.1 Hywel Dda University Health Board was established in October 2009, combining primary care with three county-based NHS acute Trusts which merged in April 2008. The combined organisation's clinical catchment covers a population base of 375,000 people spread over three counties which together comprise 25% of Wales, with a mixture of rural and urban living. The Health Board budget of £750 million covers all aspects of health care but does not extend to the social services budget.

3.1.2 Ten per cent of the population in this Health Board are deprived under the Welsh Index of Multiple Deprivation (range for Welsh Health Boards 4% to 39%) 19% of adults smoke, 39% drink more alcohol than the guidelines and 58.5% of adults are overweight. The current life expectancy for women is 82 years. Breastfeeding rates in Hywel Dda are higher than Wales average and low birthweight infants (less than 2.5 kg) is at just over 6%, the lowest level for Wales. These indicators suggest a population less disadvantaged than other areas of Wales[3]

3.1.3 One quarter of the population is below 18 years of age and the profile of the population is increasing to expand those in the elderly age groups. The general fertility rate for Wales has slightly increased of late. A strategic framework for Maternity services in Wales was commissioned and completed in 2011

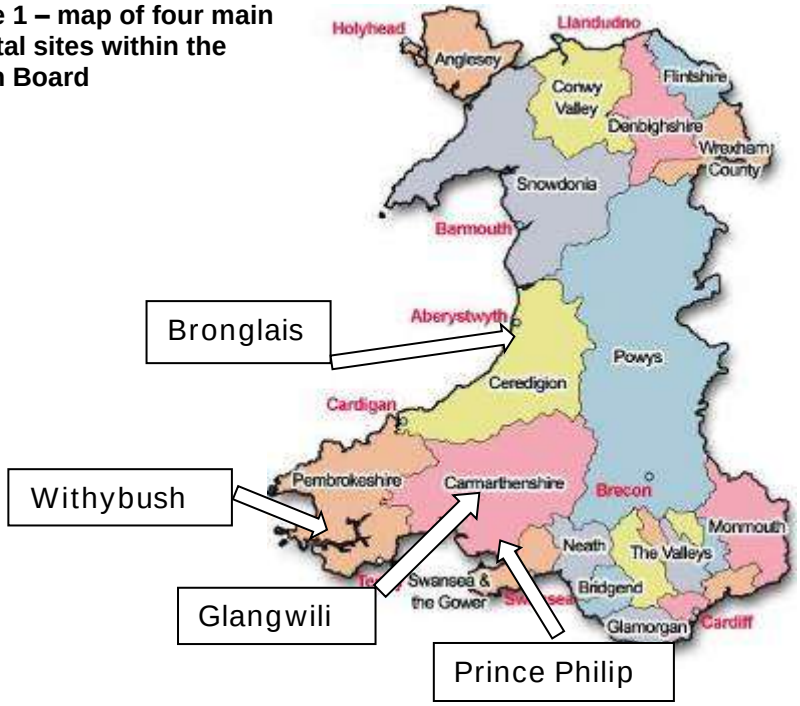
3.2 Service Provision

3.2.1 There are four main hospital sites within the Health Board:

- Withybush General Hospital in Haverfordwest, Pembrokeshire
- Bronglais General Hospital in Aberystwyth, Ceredigion
- Glangwili General Hospital, in Carmarthen, Carmarthenshire
- Prince Philip Hospital in Llanelli, Carmarthenshire

[3] statistics from http://gov.wales/statistics-and-research/births-national-community-child-health-database/?lang=en

Figure 1 – map of four main hospital sites within the Health Board



3.2.2 Maternity and paediatric services are focussed on Withybush, Bronglais and Glangwili and tertiary care is provided by Health Boards in Swansea (Singleton Hospital) and Cardiff; there is no local neonatal unit or specialist (tertiary) paediatric care within this health board.

Table 1 - Distances between acute hospital sites

Bronglais			
1 h 45 min (64.4 miles)	**Withybush**		
1 h 19 min (45.1 miles)	42 min (33.2 miles)	**Glangwili**	
1 h 55 min (73.8 miles)	1h 23 min (57.8 miles)	43 min (29.4 miles)	**Singleton**

3.2.3 In the summer and autumn of 2014, the services provided to the south and west of the Health Board's catchment reconfigured to centralise obstetrics, neonatal care and paediatric inpatients on the Glangwili site, with the Withybush site moving from a consultant-led service with special care unit to a midwife led 'low risk' maternity unit, no special care facility and 12-hour paediatric ambulatory care unit (PACU) replacing the inpatient ward. The Bronglais site in Aberystwyth runs obstetric and midwife led services with all high risk births for the area taking place in Glangwili where the neonatal unit is situated. Paediatric ambulatory care and inpatient services are also provided from Bronglais, but services in this hospital are currently being considered within a Mid Wales Health Review and are hence outside the scope of this review. Prince Philip hospital does not provide inpatient paediatric and maternity services.

3.2.4 The reasons for the change were set out in a consultation document 'Your Health Your Future' and could be summarised as:

- Insufficient activity to retain full training rotas at both sites

- Inability to recruit sufficient consultant staff to both sites to meet standards
- Difficulty maintaining skills and experience when activity levels were low

Insufficient skilled staffing cover poses a clear risk to round-the-clock safe care and the units were not meeting professional standards, relying on short term locum cover to fill obstetric and paediatric rotas.

Supplementary note 1 – Trainee doctors

It takes at least eight years to become a consultant after completing foundation programme training, and doctors below the level of consultant form the backbone of medicine, providing round the clock cover, with clearly defined tasks and supervision to ensure safe care. Paediatric medical staffing forms three 'Tiers':

T1 – those up to the fourth year of postgraduate training (to level 3 speciality training)
T2 – those with at least five years of postgraduate training (from level 4 specialty)
T3 – Consultants – qualified with Certificate Of Completion of Training (CCT) after at least eight years postgraduate training.

Obstetric and gynaecology specialist training similarly requires seven years' training after completion of two years post-graduate foundation training:

Basic Training– Up to ST2 level
Intermediate Training – from ST3-5
Advanced Training– from ST6-7

The Wales Deanery requires rotas to comprise 11 trainees at Tier 1 and Tier 2 to provide 24hr cover including study time and leave. Where training posts are not designated, slots can be filled with appropriately qualified non-training doctors or nurses.

3.2.5 Maternity, neonatal and paediatric services are fundamentally interlinked in terms of pathways of care for families (maternity and neonates) and staffing (neonates and paediatrics) and the changes underwent an extensive and lengthy process of strategic analysis, business case development, scrutiny, public consultation, CHC-led challenge, the appointment of an independent panel and judicial review, culminating in agreement to proceed some six weeks before the changes were implemented in August 2014 (maternity and neonates) and October 2014 (paediatrics).

3.3 Request for review

3.3.1 The agreement by the Health Minister for the Health Board to proceed was conditional on a number of requirements proposed by an independent panel of

clinicians which reported initially in September 2013 and finally, with obstetric input, in January 2014. The independent panel's work focussed on the impact and safety of the changes for neonatal outcomes, and suggested the temporary provision of a 'safety net,' comprising 24 hour on call consultant (or equivalent) cover for obstetrics with a formal evaluation after 12 months of the service change on "the impact of the revised neonatal service on newborn outcomes and patient experience". As part of the implementation the Health Board responded to concerns expressed by the anaesthetic team at Withybush maintaining 24 hour out of hours on-call paediatric cover as a temporary measure pending the review.

3.3.2 RCPCH was approached to conduct the evaluation under its Invited Reviews service The evaluation terms of reference are set out in chapter 2 but the aims are to:

- Assess the services against the benefit criteria identified in "Your Health Your Future" and the rationale for change
- Review the impact and outcomes of the neonatal service change as required as part of the Ministerial decision
- Determine how the current services meet recognised Royal College standards

The Health Board was conscious of the strength of public feeling and requested that user input be sought and considered by the Review team as part of the review.

4 The Review Process

4.1 The evaluation was conducted under an established process, led by the RCPCH but including reviewer input from four other Royal Colleges. The project has four main phases:

a) Setup - comprising

- an initial visit (three reviewers) to clarify the terms of reference, visit both sites and attendance at a 'let's talk health' event at Haverford west
- launch of the patient staff and public survey seeking the views of people who work in or use the services
- broadcast of a 'webinar' and creation of a webpage to explain the review process
- study of background documents, activity data and policies etc. relating to the services and make contact with stakeholders
- planning and setup of the main visit

b) Main fact-finding visit – comprising:

- interviews with staff, and conversations with patients and parents across the three services, including community teams based at both sites
- public meeting to hear the views of staff and those who use the services
- meetings / calls with other individuals who work with the services
- whole-team tour of the services at both hospitals
- driving the journey between hospitals and towards the coast

c) Drafting and delivering the report including:

- checking of facts, and alignment with standards
- seeking clarification on areas of inconsistency
- analysing the survey findings and other correspondence
- drafting the report with full team involvement
- presentation of a summary report to the Health Board meeting in public
- quality assurance and critical challenge (internal) of the report
- Draft report presented to client for accuracy checking
- Full report presented to Health Board meeting in public

d) Follow up including:

- explanation and communications as required to summarise the report
- assistance as needed towards implementation

5 Maternity and gynaecology care

5.1 Services/Background

5.1.1 From August 2014-April 2015 there were 2031 deliveries in the consultant unit at Glangwili, 214 at Glangwili MLU, 106 at Withybush MLU and <78 home births, indicating a midwife-led delivery rate of 16%. The number of deliveries per year between the two units is about 2800. The home birth rate is around 3% after a 'bulge' in August 2014.

5.1.2 The Maternity unit at Bronglais has around 500 deliveries per year. The caesarean section rate across the three sites prior to the changes was around 30% and instrumental delivery rate between 8-9%.

Table 2 – Deliveries by location (August 2014 to September 2015)

	Total number of deliveries	Total obstetric unit deliveries	MLU Deliveries Glangwili (transfers)	MLU Deliveries Withybush (transfers)	Home births	MLC* % of the total
August	271	239	11 (6)	12 (<5)	9	12%
September	304	257	22 (7)	12 (6)	13	16%
October	280	239	24 (8)	6 (<5)	11	14%
November	282	235	26 (8)	11 (5)	10	17%
December	270	225	20 (5)	13 (3)	12	16%
January	276	235	18 (<5)	13 (6)	10	16%
February	254	201	36 (9)	12 (11)	<5**	16%
March	253	207	26 (5)	15 (8)	<5	15%
April	240	193	31 (5)	11 (5)	<5	17%
May	260	202	26 (6)	10 (<5)	5	16%
June	234	215	21 (7)	10 (9)	4	15%
July	246	205	24 (4)	9 (6)	6	16%
August	314	253	24 (4)	17 (7)	7	16%
September	245	198	29 (6)	11 (9)	4	18%
TOTAL	**3729**	**3104**	**338 (58)**	**162 (52)**	**106**	16%

* Midwife led care

** Where numbers are small there is a chance of identification so <5 is used.

5.1.3 Since August 2014 the facilities at Withybush comprise:

- Midwife led unit (MLU)
- Consultant and midwife-led antenatal clinics
- Day assessment unit for pregnancy concerns
- Gynaecology outpatients for consultations and minor investigations
- 4-bed in patient gynaecological surgery unit (elective and emergency assessment)
- Day surgery facilities
- A dedicated ambulance vehicle (see section 8)

5.1.4 The MLU accommodation at Withybush was well equipped, light, bright, modern and women-centred. It is permanently staffed by 5.2 WTE midwives with healthcare assistant support. The community midwifery team provide second midwife cover for births as well as centralised antenatal care. Although there are obstetricians on site they do not attend births as this unit is designated a midwifery led unit with clear guidelines, accountability and pathways of care which focus on immediate transfer of mother and or baby to Glangwili if indicated.

5.1.5 The midwifery team were vibrant and enthusiastic, having been supported and encouraged to expand their scope of practice, particularly in promotion of normal childbirth. Although initially the staffing included senior midwives more familiar with consultant led care, the team has over the year embraced midwifery led care and achieved nearly 200 births to July 2015. A recent 'open afternoon' to celebrate the first anniversary of the unit attracted around 150 parents and feedback from those who have used the service is extremely positive.

5.1.6 The transfer rate is within anticipated levels for this type of service and in the first two months most transfers (6/10) were for women requesting epidural pain relief although this has reduced. A total of 31 mothers transferred in the first seven months since the change with an average transfer time of 62 minutes from discharge from the MLU to arriving on the labour ward at Glangwili. The transfer rate appears to be decreasing, which may be due to increasing confidence in the service and practice.

5.1.7 This site has the scope to increase its activity in pregnancy care and births. The review team were told of women being referred by midwives and consultants to Glangwili for investigations which could have been easily accommodated by consultants and suitably trained midwives on the Withybush site. The guidelines for the day assessment unit need to be expanded and updated to reduce the unnecessary transfer of women to Glangwili.

5.1.8 Promotion of this service by the Health Board Communications team appears to have been limited in the months since the changes happened. It was also unclear how GP's or community midwives promote this as a valid choice of place of birth for low risk women. There has been extremely positive feedback from those parents who have used the service and this is perhaps a missed opportunity to assuage the anxiety being generated by those who have been campaigning against the service change.

5.1.9 The new ways of working within the new system should be commended and celebrated, and the team may benefit from visiting other units to gain further ideas and contacts to continue developing the service.

Glangwili

5.1.10 Since August 2014 the provision at Glangwili comprises:

- A 5-room labour ward with one obstetric theatre
- A 15-bed antenatal ward which acts as a spill over area for labour ward
- A 29-bed postnatal ward with limited transitional care
- A Midwife led unit some 4 minutes' walk from the Labour ward at ground level.
- Comprehensive facilities for outpatient obstetric and midwifery care and comprehensive gynaecological care

5.1.11 The current labour ward facilities at Glangwili are inadequate and dated, with too few birth rooms, which are smaller than ideal and room 5 is particularly challenging for adequate care provision. There is insufficient space for women to be offered active birth opportunities although an inflatable birthing pool has recently been acquired. The corridors are cluttered, narrow and dim and staff bases are inadequate. Women are recovered post-operatively yon the ward; the 'phase 2' development will enable recovery on and HDU on labour ward.

5.1.12 If a second emergency theatre is required for obstetrics the procedure has to be done in main theatres. Similarly the other facilities are very disjointed and distant, the ante natal ward, which at peak times of high activity is used for births, has very cluttered corridors which would impede emergency transfer and inductions are not afforded a privacy level suitable for women in early labour.

5.1.13 The changes and poor facilities have put considerable additional pressure on staff and patients in the Glangwili labour ward but despite this they continue to provide a good level of care for the women and are coping with the inadequacies of the facilities. The Review team were told that there is now accommodation for partners at Glangwili but this may not be well publicised

5.1.14 'Phase 2' of the reconfiguration development proposed a total of eight good-sized delivery rooms, including one with a pool, two new theatres, more office space and extension to the SCU which would meet the required standards for a consultant led unit. There is also a clear need for a bereavement suite or quiet space for parents. Completion of these works has slowed and needs urgently to be expedited to accommodate the increased activity, improve the quality of experience for women and their partners and improve the working environment for staff.

Glangwili MLU

5.1.15 This unit is an underutilized resource that if it was fully operational and at peak capacity could relieve some of the pressure on the labour ward.

5.1.16 The unit has been planned around space availability rather than what would work best for women using the service; about 30 women per month use it although at the time of the visit there was insufficient staff (5.2 WTE vacancies) to ensure dedicated staffing of the unit over a 24 hour period. The Review team understand that this unit is now fully staffed and operational. Although the one and only pool was out of action during the visit, there were few natural / active birth aids visible and the rooms have no natural light. Overall the site of the MLU, some distance from the labour ward, and its atmosphere mitigate against its purpose to promote natural childbirth. The operational manager for the service is based at Withybush.

5.1.17 The MLU would benefit from a dedicated band 7 leader and a strong motivated team of midwives who are committed to normalising birth for low risk women. External visits to other such services may help to develop this team and stimulate innovation.

5.1.18 Clear paths to summoning emergency support and routes to transfer from MLU to the labour ward should be planned using drills to ensure all staff are familiar with procedures. Extra birthing pools should be available in each room and women and their partners must have facilities to stay overnight.

5.2 Workforce

Medical staffing

5.2.1 Since the reconfiguration, the eleven permanent consultant obstetrician/ gynaecologists from the two sites provide 40-hour dedicated daytime consultant cover to the labour ward and emergency gynaecology cover at Glangwili, which provides basic compliance with RCOG standards[4]. There are also two locum slots to take the out of hours on-call rota to 1:8. Five obstetricians are based at Withybush General Hospital, sharing the 'safety net' 24 hour on-call rota although this has not been used during its first year of operation. There is one consultant vacancy.

5.2.2 Historically Hywel Dda has not struggled to recruit to obstetric training posts and Withybush enjoyed a strong reputation as a centre to train, despite the low numbers of births. More recently however, RCOG and Deanery requirements that trainee placements should have at least 2500 births and run with 11-post rotas have required consolidation. Recruitment of Medical Training Initiative[5] doctors to fill rota gaps has become challenging but there remain good links with overseas medical teams as a source for additional recruitment, as and when required. The rotas are shared across both units and were originally constituted for 14 staff but are now running with 12 which will be formalised.

[4] Safer Childbirth RCOG 2008?
[5] A government scheme to provide overseas doctors with training posts of up to 24 months

Midwifery staffing

5.2.3 Midwifery staff numbers were calculated by the Health Board using the 'Birthrate Plus' workforce planning tool for maternity services before the reconfiguration took place. Since reconfiguration the Health Board reported that midwifery numbers exceeded the staffing levels recommended by professional bodies[6] due to the complex geography, but the Review team found that there were often shortages on rotas. Vacant posts are apparently relatively easy to fill but there is high midwife turnover and a number of midwives have decided to retire since the changes. Formal midwifery workforce planning has not been undertaken since the service change.

5.3 Outcomes, governance and standards

5.3.1 The maternity outcomes data for the Hywel Dda area are 'better' than for many areas of Wales[7]; perinatal mortality and stillbirth rates for the three counties are the lowest for any health board in Wales. Individual hospital data is similarly favourable but primarily reflects lower levels of social deprivation, and the low numbers of births invoke considerable variation. This must however reflect favourably on the overall quality of the clinical service.

5.3.2 The intervention rate is relatively high with the Caesarean section rate before the change at 30% across the trust in 2013-4, and an instrumental delivery rate of 8.4%. Both were higher in Glangwili than Withybush before the change.

5.3.3 The Review team has seen a summary of the incidents that had occurred in the year since the change, and details of those classified as serious relating to the services under review, in order to determine whether protocols had been followed and the services were operating safely under the new configuration. Overall the rate of reported clinical incidents arising as a result of the change was within expected range and the serious incidents had been fully reviewed with actions and recommendations developed as a result.

5.3.4 The Review team were able to witness first hand through attending the Directorate Quality and Safety Forum that standard administrative processes exist to undertake clinical governance including surveillance of Datix[8] forms, review of serious untoward incidents (SUIs) and patient complaints. The Review team was told that there is a systematic approach to investigating and learning from incidents, which are reviewed by senior midwives and presented at the Labour Ward Forum and perinatal meetings. There had been a significant push since the reconfiguration to encourage staff to complete incident forms and report any concerns about clinical safety,

[6] BirthRate Plus and RCN Safe Staffing standards
[7] All Wales Perinatal Survey 2014
[8] Datix is patient safety and risk management software for healthcare incident and adverse event reporting

although some staff explained that they were not confident in doing so. At the time of the Review visit the Women's and Children's Directorate conducted its own investigations and analysis of incidents reported through the Datix system and was not included in the Health Board's overall processes. The Review team was told that there was an expectation that these processes would be centralised in due course.

Supplementary note 2

Observational studies indicate that for women at low risk of complications, births planned in an FMU [freestanding midwifery-led unit] are not associated with increased likelihood of adverse perinatal infant outcomes and are associated with fewer maternal interventions than those planned in an obstetric unit. Cost-effectiveness analysis combining infant and maternal outcomes is ongoing.

Reference - Evidence note for freestanding MLUs - Healthcare Improvement Scotland 2012

Compliance with Maternity Standards:

5.3.5 In April 2015 the Welsh Risk Pool conducted a detailed review of maternity care across the three Hywel Dda units and reported positively on documentation and compliance with standards but highlighted the following:

- the importance of mandating guidelines to a 'Hywel Dda' model to cement new working relationships
- the capacity of the labour ward
- the absence of staffing cover for low risk births in the MLU at Glangwili
- insufficient communication from senior management to the operational staff
- the risks generated by women presenting late due to the closure of Withybush

This last item was a concern expressed to the Welsh Risk Pool team that Pembrokeshire women may disengage with maternity services if facilities were reduced at Withybush. This was not mentioned by any staff as a concern they had identified, but is an important issue to explore and should be monitored through Datix returns and addressed through active antenatal outreach.

5.3.6 Standard operating procedures have been designed as part of the pathway to ensure all women are offered choice of place of birth; these reflect the All Wales Maternity Pathway. All women are assessed for suitability for midwife-led care throughout their pregnancies but specifically at 36 weeks they are offered birth in the MLU if their pregnancy is considered to be low risk. Women admitted to Glangwili are triaged either on the antenatal ward or in the MLU. The antenatal ward is not a suitable environment for this activity as moving from one environment to another has been proven to inhibit labour.

5.3.7 Women were reported to receive one-to-one care during established labour and birth although anecdotal evidence suggested that the antenatal ward was not staffed to take account of this labour / birth activity. There were 26 births in these medium risk antenatal rooms between 1st April and 20th August 2015, with no adverse incidents reported.

User views (see also chapter 9)

5.3.8 Notwithstanding the formal incident reports, the Review team recognised high levels of anxiety amongst some members of the Pembrokeshire population, including clinical staff, about the safety of the new service, particularly related to the distances and consequential time taken to reach the consultant led unit in an emergency, and this is covered in chapters 8 and 9. A number of moving, and very graphic anecdotes were shared at the public meeting and through a survey established by the Review team, and these were also reflected in a report prepared for the Review by the Community Health Council[9]. Whilst all contributors had been encouraged to contact the Health Board to enable review and learning from the incidents, not all had done so. Where complaints had been raised the Review team found that their handling and management had generally been good, with meetings arranged to go through clinical notes.

5.3.9 Whilst the situations described may not have resulted in long term physical harm to mother or baby, the fear and frustration felt by these parents and their relatives has influenced their confidence in service provision, and was in many cases exacerbated by poor information and staff who may not themselves have been fully confident about procedures and the operational arrangements within the service. It is important that Health Board ensures that staff in direct contact with patients (including GPs, Health Visitors, ambulance staff, receptionists and healthcare support workers) are confident about the service and recognise the impact of their words and behaviours on those they are caring for.

5.3.10 The views of women who have used the maternity service are systematically collected and recorded through the 'Did we Deliver?' survey and a report of 500 responses over the year from 4th August 2014 was shown to the Review team. The report included Bronglais unit and was overwhelmingly positive, which did not correlate with the views of women who responded as part of this review. There was little evidence however of how the views of women were being used more widely in planning and reviewing services. This is a missed opportunity to make small changes to a service that can make a significant impact on a family's experience and long term memories. The Maternity Services Liaison committee was reported to have had logistical problems in convening meetings across the wide geography and was becoming a virtual group. The Review team were uncertain about the merit of this development as this Committee can often be a useful gauge and voice for local

[9] Published September 2015 http://www.wales.nhs.uk/sitesplus/904/document/272858

women; the Board should consult with local women's groups before making this change.

5.3.11 One of the senior midwives (Band 8a) fulfils a operational/clinical lead role for quality assurance and since the Review visit a Band 7 midwife has been appointed with a portfolio including governance, risk management and practice development to support midwives and managers - many units appoint band 7 midwives for this role who impact positively on the quality aspect of care.

5.4 Obstetric anaesthesia

5.4.1 Although the obstetric anaesthetics service moved from Withybush to Glangwili, only two anaesthetic sessions were moved to be delivered by WITHYBUSH anaesthetists. There is no prospective consultant obstetric anaesthetic cover so almost every week there is at least one day when labour ward is covered by a non-specialist consultant anaesthetist. This is compromising the quality and safety of the service for women and must be addressed to provide at least 5-day cover by a consultant or experienced staff grade, which will also secure recognition for training which is currently leading to problems in being allocated trainees by the Deanery. The lack of recognition of the Intensive Therapy Unit (ITU) for training also compromises trainee allocation and the Health Board should consider increasing staffing levels to comply with RCoA guidelines[10].

5.4.2 The anaesthetic team reported that delivery suite is inadequate for the current number of births with poor theatre facilities and they are keen that Phase Two is expedited.

5.5 Interdependency with Gynaecology

5.5.1 Maternity and gynaecology services interlink; in medium sized general hospitals obstetricians and gynaecologists and their teams are one and the same. A pure focus on service efficiency across the two sites would centralise many acute consultant based services at Glangwili, but this fails to recognise the implication for travel and access for Pembrokeshire women, and there is scope to provide a solution that meets RCOG guidance about service configuration[11], providing as many services as possible closer to patients' homes

[10] Guidance on the provision of obstetric anaesthesia services, RCoA 2014
[11] RCOG Guidance15 2013 Reconfiguration of women's services in the UK

Table 3 - Withybush Gynaecology Admissions

	1st Aug 2013 to 31 July 2014	1st Aug 2014 to 31st July 2015
Inpatients	**Total**	**Total**
Elective Emergency	380 460	284 139
Total	**840**	**423**
Day Cases	**Total**	**Total**
Total	**689**	**701**

5.5.2 Reconfiguration of gynaecology must consider the provision of emergency gynaecology through the ED, out of hours. There is a gynaecology registrar on site until 7pm but no new patients are seen after 5pm and the four overnight beds are covered by the hospital at night registrar with a gynaecology consultant on call. Since August 2014, when obstetric beds relocated from Withybush to Glangwili, emergency gynaecology activity has fallen dramatically at Withybush, with only around 10 cases per month since January 2015 compared with an average of 38 per month before the change. Concerns raised by the public, such as ectopic pregnancy presentations, should be picked up by the early pregnancy unit (EPU) and/or largely managed conservatively, medically or using minimal access surgery techniques. The pathway needs to be reviewed with primary care, ambulance services and secondary services to manage suspected gynaecology emergencies and day cases that may require very urgent and potentially life saving care after 6pm.

5.5.3 Some major surgical procedures have been undertaken at Withybush including combined operations with general surgeons .If capacity allows, elective non day-case gynaecology surgery should be relocated to Glangwili to free up the consultant on call rota at Withybush. To balance this, more day case surgical work should be concentrated at Withybush together with facilities for women who present at the Emergency Gynaecology Unit (EGU) and EPU having access to surgical facilities where indicated and appropriate. Although some women will, through the nature of their problem, still require transfer to Glangwili for such care, more facilities should be available locally in Withybush including EGU, EPU, day case theatre, emergency gynaecology theatre, colposcopy, hysteroscopy and imaging.

5.5.4 Failure to resolve this issue will mean that the current consultant out of hours rota at Withybush will have to be retained, minimising any opportunity to strengthen the acute service at Glangwili.

5.6 Improving the maternity (gynaecology) pathway

5.6.1 All obstetric/gynaecology consultants should work across both sites with at least 40 hour labour ward consultant presence being concentrated at Glangwili. Such labour ward cover may need to be reviewed in the light of delivery numbers and

intensity of work to keep pace with standards. In parallel a daily, daytime service at Glangwili comprising Ambulatory Care, EPU, EGU, day case and emergency theatre should be provided at consultant or associate specialist level daily for conventional hours. Outpatients and day case surgery should be increased at Withybush. Consultant presence during the 'clinical' working day will be required at Withybush to ensure that the same quality of care is available for women.

5.6.2 All consultants should provide out of hours on call cover at Glangwili which should be about 1:11 with prospective cover. Consultants domiciled more than 30 mins away will need appropriate accommodation without financial liability for this responsibility. The current delivery numbers are not of a level to suggest resident on call consultant presence. Such a restructuring should also improve the experience for trainees, who should gain experiences across both hospital units.

5.7 Clinical Leadership

Obstetrics

5.7.1 Successful running of the obstetric, gynaecology and maternity services hinges around the quality and visibility of the unit leadership. Historically, the exclusion of clinical leaders from the decision making has created a very alien environment to delivering beneficial change although more recently the clinical lead has chaired the obstetrics/maternity planning group and there was road clinical representation on the programme board and Withybush representation on the planning group. Despite this, the Review team heard from consultants at Withybush about a perceived top down approach to clinical change decision making which they felt had distanced these doctors from a creative interface. The differences in working patterns between the two units created tensions between consultants which reconfigured, and the separate Withybush consultant on-call presence has hampered integration of the consultant body as a single clinical team.

5.7.2 The palpable frustration and anger of some doctors to the perceived ‘down grading’ of Withybush, was not a healthy or appropriate culture for good patient care, despite these individuals claiming to be passionate about improving services for women. New ways of working rely on recruiting different leaders with novel ideas; the consultants must desist from complaining about the process to date and provide support and visible leadership for the non-consultant and midwifery staff, working together with management to identify practical steps to improve services.

5.7.3 There must be a focus on evidence rather than anecdote and the urgent development of workable forward-thinking solutions. The enthusiasm and consistency of some of the staff was obvious but they must be given clear opportunities to develop in the best interests of the service. A new clinical director, who enjoys the support of colleagues working on both sites, is an immediate requirement to deliver the required change programme.

Midwifery

5.7.4 Within the midwifery team the role of the Head of Midwifery (HoM) is key to the development and strategic direction of the staff. This role should work in partnership with the lead obstetrician/clinical director to ensure good multidisciplinary cooperation. The restructure in summer 2014 created five managerial posts reporting to a Head of Midwifery which seems excessive given the size of the maternity remit. Delays in establishing the new midwifery leadership and management arrangements had resulted in the Band 8 midwives developing their (new) roles and teams independently without creating a shared strategic plan.

5.7.5 It is important now, one year in, that the senior midwives support the HoM to develop a clear vision and strategy for the service with one voice and one direction that is positive, demonstrates the value and importance of engaging women and midwives and acknowledges the challenges in getting there.

5.7.6 It was reported that due to the complexities preceding the decision to transfer services, there was an extremely short time frame for staff to be fully engaged with preparing for change and a pragmatic approach to implementing new policies and procedures was adopted to meet the timescale. This forthright approach did little to engage and bring both sets of staff with two very different cultures together. The consequences were still palpable although the Review team was assured by senior midwives and management that morale and relationships between midwives was improving. Staff interviewed by the team indicated however that relationships and confidence remained fragile and whilst this is now being addressed through a programme of organisational development, the scope of this programme must be broad and address cultural change.

5.7.7 Whilst the senior midwives (band 8) indicated they were keen to move the service forward the separation of their duties per area and per site created tension, which was perceived by some midwives as a dismissive attitude to some of the issues raised with them. Strong, visible support to the midwives is essential as they try to settle into new ways of working. It is important that the concerns of midwives are heard with empathy and actioned without judgement.

5.7.8 This relatively new senior team believe they have been as supportive as they could given the challenging pace and magnitude of the change and their own limited preparation for the role. They explained the training opportunities afforded to the teams and the tools in place to monitor practice such as incident reporting. It was however evident to the Review team that this senior group, like the staff teams, share differences in culture that manifest in different working practices. Future success relies on drawing the best from both Withybush and Glangwili and whilst it will take some months, development of the senior midwifery team to fully embrace visible leadership roles is a priority to build a strong midwifery team with shared goals that embrace common beliefs and values and a code of behaviour that reflects respect and dignity.

5.7.9 The Royal College of Midwives offers leadership programmes which should be considered. Human Resource / Organisational Development departments in other Health Boards or English NHS Trusts may also be able to offer some support for this level of staff possibly through action learning sets, conflict management courses and use of Myers Briggs tools

5.7.10 The senior team must be visible throughout the extended day. They should adopt a zero tolerance for any subliminal subversive behaviour and language, and should resist any desire to develop further 9 to 5 / Monday to Friday roles.

5.8 Training

5.8.1 Team working is vital to the safe delivery of care and more emphasis must be placed on genuine multi professional team working and training. Multidisciplinary Skills and Drills training was reinstated in January 2015 following the reconfiguration and midwives are permitted three study days per year which is considered good practice.

5.8.2 Midwives described additional good quality training such as a two day multi-disciplinary training programme following the reconfiguration, a pump infusion training day and access to hypno-birthing training. Midwifery staff training records are not consolidated into one central database and some midwives indicated that they were keen to undergo more training but did not have the opportunity to undertake it. The use of a short questionnaire to all midwives may be helpful as a baseline assessment of need.

5.8.3 The consolidation of labour ward and high risk pregnancy care on one site has improved the training opportunities for all grades of maternity staff. The redesign of outpatient based gynaecology services at Withybush (see para 5.5.2) will give new and valuable training opportunities for all medical staff under consultant supervision, and the obstetric rotas are now compliant with Deanery requirements in terms of meeting the 2500 birth threshold.

5.8.4 The recent GMC obstetric trainees survey (August 2015) indicated that the Hywel Dda Health Board was one of the lowest-scoring services for trainee satisfaction, ranking 133rd out of 148 for overall satisfaction, 139th for educational supervision, 101st for workload and 97th for clinical supervision. Albeit the small number of trainee responses results in each one's opinion having high weighting, consolidation of the consultant body and strong clinical leadership must be established swiftly to provide better focus on and support for trainee doctors

5.9 Recommendations for Obstetric, Maternity and Gynaecology Services

Strategy and Patient safety

- Expedite the 'Phase Two' business case and commence development to provide a high quality environment for consultant-led maternity care and compliant facilities for neonates

- Develop a clear sustainable strategy for obstetric, midwifery and gynaecology services, prioritising patient safety, patient access and quality of care, building on and completing the changes of services introduced in August 2014. New ideas, perhaps from a 'task and finish' innovation group can refresh the team, harnessing external support to examine new ways of working with the support of the local clinicians and women

- Identify clinical line management for the Directorate to provide visible and robust professional support, mentoring and development to the clinical leads for obstetrics and paediatrics and the Head of Midwifery. An independent member at Board level should have a remit of responsibility for women's and children's issues

- Expand community based consultant and midwifery based services at Withybush, developing more comprehensive EPU, EGU, day theatre, and clinical community based services there in line with RCOG standards[12]

- Retain provision of dedicated transport facilities (see Chapter 8)

- Rationalise major in patient gynaecological surgery onto one site, if accommodation allows

- Phase out the obstetric and gynaecology out of hours consultant rota at Withybush with a target date of April 2016, integrating and strengthening the obstetric and gynaecological consultant team at Glangwili

- Review of the uptake of midwife led care, and plan to expansion of use by women who have been appropriately risk assessed. Unified patient pathways, guidelines and clinical governance structures must be incorporated into all units within 6 months

- Assurance to public of the safety of birthing in MLU's in line with the All Wales Pathway for Maternity Care; community midwives should take a stronger lead in this. A band 7 midwife should be appointed to champion a team to develop each of the MLUs in terms of increased usage, active birth supporters and midwives competence and confidence in supporting active, non-pharmacological birth

[12] 2013 Good Practice 15 Reconfiguration of women's services in the UK RCOG

Staff Team and Leadership Development

- Conduct medical staff job planning to provide a unified safe service which delivers professional satisfaction to staff across both sites

- Develop a programme of opportunities for midwifery development that reflects the aspirations of service developments – these should be achieved within a 12 month period

- In order to meet RCoA standards and secure future allocation of anaesthetic trainees further additional sessions are needed on the labour ward

- The multi-disciplinary training opportunities for doctors, nurses and midwives are considerable and need further development. A training lead should be identified to ensure training is carried out across all groups including simulation and skills/drills.

- A programme of organisational development should be instigated to build team working and a sense of '*one service'*; across all staff groups from all three sites including community. This could be informed by the Fundamentals of Care audit, and include encouragement and time to nurture potential future medical leaders

Governance and Accountability

- The new Band 7 maternity risk manager should administer the clinical governance programme including three-monthly reports with action plans to the Trust Board and clinical directorate meetings.

- The maternity dashboard should be reviewed by the directorate Quality and Safety Committee quarterly for review and appropriate action. Review of compliance with the RCOG Maternity Standards should be undertaken immediately and upon publication of the new standards expected during 2016

- Review of the midwifery workforce establishment using Birthrate Plus acuity tool should be completed immediately and at least every 2 years

- Quality Improvement projects such as the Productive Ward, Releasing Time to Care should be used to involved all groups of staff in the quality improvement programme

Public Engagement

- The Maternity Service Liaison Committee should be re-instated with membership drawn from local recent service users. Additionally the service should seek out ways to engage with the local families living in the three counties

- A social media campaign should promote positive birth experiences / normal birth in various media and establish a user group to provide feedback and advice on improving take-up of the MLU

- Ensure all staff in contact with expectant parents are fluent in the service arrangements, choices available for women, thresholds for transfer and outcomes

- Facilities for birth partners, whose partner may not be in established labour, to rest and obtain a hot drink should be available 24 /7 at Glangwili

6 Neonatal care

6.1 Background

6.1.1 About ten per cent of infants require some form of specialist postnatal care and professional standards for neonatal care developed by the British Association of Perinatal Medicine (BAPM)[13] set out the staffing and procedures appropriate for three levels of neonatal provision. These standards are mirrored in the All Wales Standards for Neonatal care.

Figure 2 – BAPM (2011) levels of neonatal provision

	Care synopsis	Staff synopsis
Level 1 Special Care Unit (SCU)	Infants over 32 weeks[14] HD/IC only to stabilise and transfer	Shared rotas with paediatrics. Lead consultant with neonatal interest. 1:4 nursing
Level 2 Local Neonatal Unit (LNU)	Infants over 28 weeks Offer transfers in HD/IC for observation	Separate Tier 1 rota, sometimes separate T2 daytime All consultants have neonatal skills, 1 with neonatal interest 1:2 nursing
Level 3 Neonatal Intensive Care Unit (NICU)	All infants	Separate rotas at all tiers 7 consultants with lead interest / CCT 1:1 nursing

6.1.2 Categories of care are defined by BAPM[15] as follows:

Intensive care (IC) includes – mechanical ventilation, presence of lines, drains, transfusion, hypothermia, catheter, day of surgery, day of death, PN together with non-invasive ventilation

High Dependency (HD) includes – Non-invasive respiratory support, parenteral nutrition (PN), presence of invasive support, close observation or barrier nursing

Special Care – (SC) includes nasal or iv cannula, feeding by tube or gastrostomy, continuous physiological monitoring, stoma care, receipt of phototherapy.

Transitional Care (TC) includes infants requiring additional care which is provided by their mothers under supervision, this may be on a postnatal ward or a special transitional care ward

6.1.3 Units are designated by the Wales Neonatal Network and are expected to liaise closely with neighbouring units and specialist transport services to ensure that a) as far as possible infants are transferred 'in utero' when early labour is anticipated

[13] BAPM 2010 Service standards for hospitals providing neonatal care and BAPM 2011 Categories of Care
[14] The usually-agreed threshold for SCU transfer but exact gestation is agreed by a network
[15] Categories of care BAPM 2011

b) infants are cared for as close to home as their need permits.

6.1.4 The reconfiguration proposals, supported by the Scrutiny Panel, consolidated the SCUs at Withybush and Glangwili with the phased development of a Local Neonatal Unit at the Glangwili site. In approving the proposals, the Minister required a detailed plan for the delivery of the new LNU and a review of the neonatal service after one year's operation.

6.1.5 During the summer of 2014 the Glangwili unit was remodelled, opening four high dependency cots, 8 special care cots a new nursery and an expressing room, and in August 2014, following a period of organisational development and training, the neonatal staff transferred from Withybush to work alongside the Glangwili team.

6.1.6 The current environment however remains temporary pending the 'Phase 2' development which will include a further extension to the clinical space, improve facilities for parents to stay and improve the working environment for staff. At the present time there are poor facilities for families and the unit does not meet BLISS guidance[16] for accommodation and support for breast feeding. In January 2014 the BLISS audit findings indicated the Glangwili unit was the least compliant in Wales.

6.1.7 As part of the service change, a rudimentary transitional care service has been developed together with a neonatal outreach nurse team (now 3.8 WTE) which offers on-going support (up to a year) in their own homes for vulnerable infants discharged from the unit. The team reported that this service has supported shorter length of stays for some babies and frees up capacity amongst the community children's nurses who would otherwise be responsible for the visits. The team cover the whole Hywel Dda area although given the geography this can be quite a challenge for this small group. This service is commendable and is already proving to be a highly valued addition to the overall service.

Table 4 – Neonatal outreach activity 2015

Number of babies on caseload per county						
County	Month					
	January	February	March	April	May	June
Carmarthenshire	6	10	12	13	21	25
Pembrokeshire	1	5	6	7	10	14
Ceredigion	1	0	1	3	3	4
Out of Area	1	1	2	0	0	0

[16] see http://www.bliss.org.uk/baby-charter-audit-tool

6.2 Workforce

6.2.1 Nurse staffing for neonatal units is clearly defined in the BAPM / All Wales standards and should comprise 1:1 for Intensive care, 1:2 for High Dependency and 1:4 for special care. Staffing levels and activity are monitored through standardised data collection on the 'Badgernet' system.

6.2.2 There has been a significant nursing staff workforce expansion, from a total of 33 on the two units before reconfiguration to the current 43 and 6 transitional care staff. This is more than needed to satisfy BAPM requirements and sends a positive note of intent to develop neonatal services. Although there are some nurse vacancies the service is able to attract staff, and all the nurses were reported to be qualified in specialty (QIS). Nurses were keen to develop their roles further; a number of nurses take on lead roles for areas such as safeguarding, developmental care, guidelines etc., but there are no Advanced Neonatal Nurse Practitioners (ANNPs). Given national and local pressure on medical recruitment and the aspirations of the service towards a LNU, a strategy to develop the ANNP role should be embraced and expedited.

6.2.3 Medical staffing is compliant for operation as a SCU, with shared paediatric/ neonatal rotas at all three tiers. Two consultants share a lead role in neonatology with one session each. A third who does not participate in the rota is also a trained neonatologist.

6.2.4 To move the service to a compliant LNU would need a dedicated Tier 1 rota, a part-separate Tier 2 rota (depending upon how busy the unit is), at least one consultant with a designated neonatal qualification (CCST or equivalent) on the Tier 3 rota and all consultants covering the service demonstrating expertise in neonatal care. Given the Deanery's plans to reduce trainee numbers in Wales, and focus neonatal training within NICUs, conventional compliance seems unlikely and a plan for development of enhanced and advanced neonatal nursing roles is urgently required. The absence of a training programme in Wales for nurse practitioners and other competency based workforce roles makes this more challenging given the scarcity of trained practitioners and the time required for training and achievement of competencies.

6.2.5 The Review team was advised that the requirements for the wider multi-disciplinary team for dedicated pharmacy, Speech and Language Therapy, Dietetics and developmental care are met.

6.3 Activity

6.3.1 Comparison of activity since the reconfiguration is difficult without a full year's data. In terms of overall activity in the unit the Neonatal Network / Badger net shows the following:

Table 5 - Activity 2013 (from Wales Neonatal Network report) BAPM 2011 categories

	Intensive Care	High Dependency	Special Care	Normal care	Unknown
Withybush	24	28	67	2	16
Glangwili	17	37	100	2	0
Singleton	182	84	91	0	0

Table 6 - Activity 2015 (Jan - June) from Wales Neonatal Network BAPM 2011 categories

	Intensive Care	High Dependency	Special Care	Normal care	Unknown
Withybush	Not applicable				
Glangwili	2	35	145	34	9
Singleton	Not available			0	0

6.4 Transfers and Network working

Transfers

6.4.1In the first six months of 2015 there were twelve infants born at Glangwili between 26-30 weeks gestation, and a total of twenty-one infants were transferred out of the unit; the Review team was told these were for clinical reasons, not capacity related. The Review team was told that this represents a significant change from the pre re-configuration period when transfer out due to capacity pressures on the former Glangwili SCU were a common occurrence

Table 7 – Transfers out from Glangwili (January – June 2015)

Destination	Jan-June 2015	Extrapolated - 12m	2013[17] (Glangwili + Withybush)
Singleton	11	22	7 +17
UHW	9	18	9 + 4
Other	1	2	5+2

Table 8 – Transfers 'in' to Glangwili (January – June 2015)

Transferring Unit	Jan-Jun 2015	Extrapolated 12m	Total 2013 (Glangwili + Withybush)
Singleton	20	40	8 +10
UHW	4	8	5+2
Bronglais	1	2	2+1
Other	4	8	7+4
Withybush	1	2	4

6.4.2 These data and information from the Network indicate that the expansion of the Glangwili unit has increased in the number of preterm infants cared for close to

[17] Source – All Wales Annual report 2013

home, reduced the need for transfer out of the area and enabled swifter repatriation from regional neonatal intensive care for local step down care. This is very important to families who reported travelling great distances and spending large amounts on accommodation when their baby was being cared for in Singleton or beyond.

Neonatal Transport (see also Chapter 8)

6.4.3 South Wales is served by a specialist neonatal transport service (CHANTS) that operates 12 hours per day 7days per week, and this has recently been integrated with phase 1 of the EMRTS service (see chapter 9). The team includes specialist neonatologists and nurses who stabilise and retrieve infants from SCUs and LNUs to the nearest available NICU, usually Singleton hospital in Swansea for infants born in the Hywel Dda catchment. There is some frustration that retrieval is not yet a 24/7 service, although neonatal units should be suitably equipped and staffed to be able to stabilise and retain infants until the service is available.

6.4.4 The Review team was told by Singleton clinicians that they are not infrequently called out outside the CHANTS operating times to retrieve a compromised infant from Glangwili. This requires some upheaval and goodwill on the part of the Singleton team, and there is some tension between the units over the thresholds for seeking tertiary level assistance.

Network Arrangements

6.4.5 The Neonatal Network for Wales supported the proposal for the LNU during the consultation stage of the reconfiguration.

6.4.6 The Neonatal unit at Glangwili is currently designated by the network as a special care unit which, according to BAPM standards and locally agreed neonatal network guidelines, should transfer out all infants with gestation under 32 weeks (34 weeks for twins) or needing sustained high dependency or intensive care. The unit is moving incrementally towards designation as a LNU, with plans to implement peripheral parenteral nutrition (PPN), later in 2015 following staff training, and retaining infants from 30 weeks. Recent meetings with the Network representatives have strengthened relationships and it is important that the developments are supported and encouraged by the Network.

6.4.7 The Review team was told that infants below 30 weeks gestation are usually transferred in utero but there have been some problems with capacity and infection at the Singleton unit recently which have sometimes meant transfers have been further afield, including Bristol and other English units[18]. Since the expansion of the unit at Glangwili there is increased capacity to accept repatriated infants with the agreement of the Network and reduce pressure on services at Singleton. Indeed the numbers of infants repatriated has increased since the new unit was established and refusal to

[18] University Hospital of Wales (UHW) Cardiff had an IC occupancy rate of 84%, Singleton Hospital Swansea a HD occupancy rate of 126% and Royal Gwent Hospital, Newport a SC occupancy rate of 158%.(from network 2013 report)

repatriate infants due to capacity pressures is rare. Infants between 30-32 weeks are routinely accepted for repatriation subject to assessment of other clinical indicators.

6.4.8 The Singleton NICU protocols and policies were available through 'SharePoint' to the team at Glangwili but IT difficulties meant that only a few staff had online access with others relying on hard copies, not easily interrogated when needed.

6.4.9 Neonatal expertise is continuing to grow in Glangwili and the team at the Singleton encourages early interaction and expressed a desire to support the service with expert advice and guidance. At the time of the review there were regular, although un-minuted, meetings with the lead consultant and lead nurse, but attempts to provide cross-site peer-support sessions had not been taken up. Subsequent to the Review visit there has been thorough senior level engagement with the Singleton team and All Wales network representatives around a number of obstetric/neonatal cases. A set of positive learning points have been generated as a result of this engagement and an action plan Is in place to increase the neonatal capability and skills of the reconfigured Hywel Dda paediatric team.

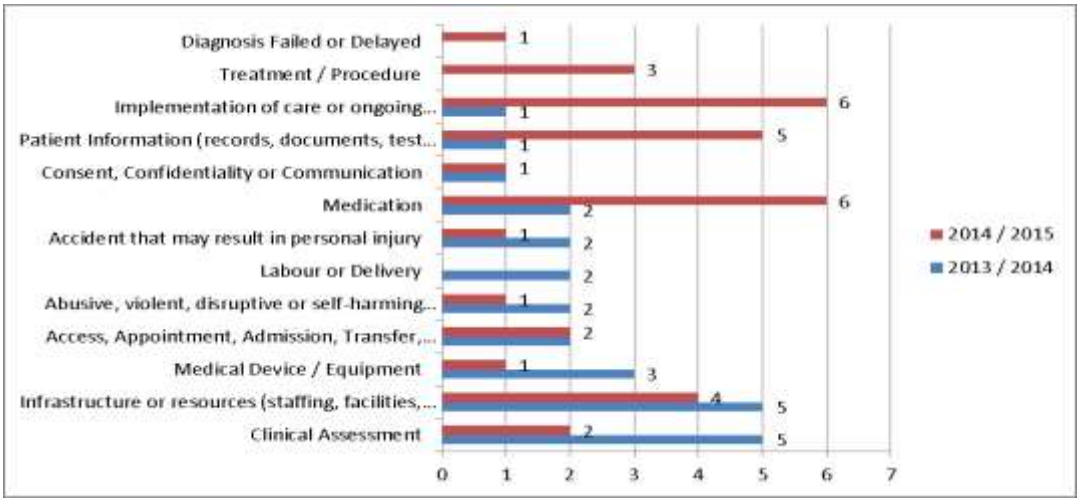
6.5 Governance, Safety and outcomes

6.5.1 Neonatal outcomes and safety are difficult to measure objectively; relatively few infants die and longer term morbidity or reduced function is difficult to measure[19], hence the importance of using evidence-based standards as a proxy for high quality care. The Review team was told that each death (and significant incident/impairment) is investigated using a comprehensive proforma based on NPSA process, and the contributing factors are examined at mortality/ morbidity meetings to prevent recurrence of any avoidable factors. There is also a reporting requirement to the Welsh Government. During the period of the review detailed work took place between the Network and Health Board resulting in the conclusion from the Director of quality and Nursing at the WHSCC that there was no evidence presented to suggest that there was a concern regarding the overall safety of the neonatal unit in Glangwili Hospital.

6.5.2 Since the transfer there has been a change in the pattern of reported incidents but the numbers are relatively low, numbering 33 in 2013-4 vs 36 in 2014-5. Reporting could be affected by increased awareness and trust in the reporting system rather than increased hazards per se. The main increase has been no-harm incidents affecting patients which could indicate good reporting and awareness. Given the developing nature of the new service arrangement it is suggested that a further, focussed external assessment of the clinical management of the neonatal unit be conducted within 6-9 months.

[19] The National Neonatal Audit indicator of 2-year follow up of infants has to date shown the difficulty in gathering longer term evidence. www.rcpch.ac.uk/NNAP

Figure 3 - Neonatal incidents, August – April before and after change



6.5.3 The MLUs were designed to be compliant with BAPM standards for stand-alone units[20]. These standards detail the protocols, communications, relationships and equipment that need to be in place for optimum outcomes for infants. The Review team found that whilst generally these standards were met, it would be helpful for the units to self-audit and document compliance as part of their ongoing development. In terms of emergency support, the introduction of the helicopter-supported EMRTS team, which can provide rapid expert assistance and transfer, provides additional reassurance and procedures should reflect this.

6.6 Culture and leadership

Nursing leadership

6.6.1 Although the transition of staff to the one site was handled carefully with a clear organisational development process, including one-to-one interviews and skills needs assessment, transfer of the Withybush nurses to work at Glangwili initially provoked a difficult working environment. The nurses themselves acknowledge that the units had "different ways of working" with some inconsistencies which staff reported parents also picked up. An example of differences cited by individuals was the strong commitment to quiet time for babies, which appears to be more of a priority for one group of staff than another and does not appear to be supported by the medical team.

6.6.2 The Review team was impressed by the commitment demonstrated by the neonatal nurse leaders who have invested a great deal of personal time and effort into facilitating the change and merging both groups of staff. Inevitably this has not been easy for some and differences and tensions among staff were palpable during the Review. It is unacceptable that parents are drawn into staff differences. Efforts to bring staff together need to continue, using tried and tested organisational development strategies to facilitate unity and a shared vision. The Unit Nurse leader

[20] 'Neonatal Support for Stand Alone Midwife Led Units: a framework for practice' BAPM 2011

attends the Network Board meetings and nurses have opportunities to take part in Network nurse training days.

Medical leadership

6.6.3 There is a strategic neonatal clinical lead for the unit who also attends the Network Board and ensure policies are embedded, and an operational lead who provides medical back up and advice. Each has a single programme activity (PA) for neonatal work which juniors feel is insufficient in terms of their supervision and training. Junior doctors also reported that procedures usually carried out by medical staff are undertaken by nurses, which means their exposure to more complex care is limited.

6.6.4 It was evident that there is significant enthusiasm for the service to achieve LNU status and the Review team heard of a number of practice developments and staff training programmes underway to secure this.

6.6.5 However the enthusiasm to care for infants as locally as possible and aspire to provide LNU care must be balanced against compliance with the All Wales Standards for Neonatal Care and the Neonatal Network support. The unit is designated as a level one service and needs to draw back from other levels of care, unless for stabilisation, until they have implemented the steps to gain compliance with Standards and a formal re-designation of the unit by the Network. A detailed review by the Network and health board managers and clinicians identified a number of learning points and actions for the Glangwili team, including simulation training and clear communications protocols for when concerns or emergencies arise. To achieve these actions and also extend to provide LNU cover will require significant investment and Board level commitment alongside sustained improvement in dialogue, partnership working and accountability with the Singleton unit.

6.7 Neonatal Recommendations

Strategic Planning and patient safety:

- Implement the ‘Phase 2’ developments to provide adequate accommodation for neonates and families

- Gain commitment and support from the Health Board and The Wales Neonatal Network for a strategic plan for neonatal care towards designation of the unit as an LNU

- Conduct a training needs analysis amongst medical staff for competencies pertinent to operation as an LNU and a plan to meet those needs

- With facilitated OD continue to develop team cohesion and a sense of ‘one service’

- Include EMRTS procedures into MLU protocols at WITHYBUSH

- Strengthen and formalise clinical meetings with Singleton, reviewing all cases weekly and documenting discussions and actions

- Ensure the Wales Neonatal network guidelines are available to all staff working on the unit

- Review protocols and skills for emergency out of hours stabilisation given that CHANTS is not a 24-hour service.

- Initiate and support opportunities for the neonatal leads to join sessions at the Singleton to help sustain and further develop their neonatal expertise

- Ensure that all consultants providing out of hours cover have some daytime involvement on the neonatal unit which could be attendance at the weekly grand round as a minimum

- Revisit the BLISS audit with service users and develop an action plan ‘you said-we did’

- Improve accommodation arrangements for parents and communicate them clearly, perhaps utilising the CHC to audit awareness

7 Paediatric services (including emergency care)

7.1 Withybush

7.1.1 Facilities for children at the site comprise

- Emergency Care
- Day case surgery
- Outpatient services
- Out of hours primary care, co-located on site
- 8-bed Paediatric Ambulatory Care Unit (PACU) open 10am to 10pm daily
- 4-bed Paediatric diagnostic unit open weekdays 9am to 5pm
- Out of hours on-call paediatrician and ambulance vehicle
- Day case and general orthopaedic surgery

7.1.2 The Emergency Department at Withybush is a modern purpose built environment with plenty of space in all areas, minors, cubicles and a four bay Resuscitation area. There is a separate paediatric area and one bay in the resuscitation area equipped for children although the Review team was unable to view this due to a patient being treated in the bay. There is an area adjacent to the Emergency Department into which the PACU will be relocated which was large and airy and seemed to have the potential to provide a good environment although this would obviously require some building works to achieve.

7.1.3 There are three consultant emergency physician posts although only a part time (0.5) consultant is permanently in post, the remaining posts being filled by locums, supported by middle grade doctors. These posts are extremely hard to fill and impossible if there is an enhanced requirement for paediatric skills.

7.1.4 The ED has no children-trained nurses, and support is provided by Registered Children's Nurses from the PACU team when they are on site. The ED is still not complaint with nurse staffing Standards for Children in EDs[21] which requires (chapter 9) that "In DGH mixed emergency departments, a minimum of one registered children's nurse with trauma experience and valid EPLS/APLS training must be available at all times. All other registered nurses caring for children must attain and maintain the minimum knowledge, skills and competence outlined in RCN and RCPCH guidance".

Paediatric Ambulatory Care Unit (PACU)

7.1.5 Following the transfer of inpatient services to Glangwili in October 2014, urgent and emergency care is provided in the PACU which remains on the former inpatient pending relocation adjacent to ED.Children are referred to the PACU by their GP,

[21] Defining staffing levels for children and young people's services (RCN 2013)

from the ED or increasingly from the children's community nursing team. The PACU operates 10am to 10pm Monday to Friday, and in addition to assessing emergency referrals the PACU supports planned medical investigations and some day case procedures.

7.1.6 The PACU is staffed by Tier 1 and Tier 2 doctors and children's nurses, with consultant oversight from outpatient clinics which also run on the site. Activity in the PACU is lower than anticipated, averaging 286 attendances per month or approximately 9.5 daily between November 2014 and April 2015. Attendances have usually shown an increase during the summer, particularly August, as a result of holidaymakers.

7.1.7 Patients and families who attend PACU during the daytime report very positive experiences, but this is less good for those who arrive during the busiest part of the day, between 6-8pm.

7.1.8 Despite the Health Board running an active communications campaign, some primary care staff considered that the change in service configuration had lacked planning detail and was not well communicated in terms of engaging with GPs and other primary care staff. Uncertainty about the availability of local paediatric expertise may, we were told, be resulting in children being sent directly to Glangwili ED by their GP only to be assessed, treated and discharged home. It would be helpful to audit whether this is in fact the case and engage directly with those practices to improve their skills in identifying and managing sick children so patients can receive the right care as close to home as possible. The RCPCH launched in April 2015 standards for care of children outside hospital[22] including provision of 'hotline' paediatric advice for primary care practitioners to reduce unnecessary referrals and consequent upheaval and anxiety for families.

7.1.9 Staff in the PACU however reported that the changes have resulted in significant improvements in the care offered to children. Liaison between teams seeing children in Withybush have improved, inpatient admissions have decreased with a culture change from 'admit and sort out the problem' to 'sort out the problem and discharge home' with the appropriate 'safety netting' in place. Nurses reported that they have had opportunities to expand their skills and experience. The Review team were told that nursing staff are up to date with PILS training, and are working towards full compliance with PICS standards (at least one nurse with APLS per shift) and the PACU's nurse staffing levels meet RCN guidance[23].

7.1.10 Comparative activity / outcome data is collected across the three sites but the current arrangement of separate teams makes organisational clinical audit challenging and time consuming. Before the reconfiguration, Withybush had a

[22] Facing the Future together for child health (RCPCH 2015)
[23] Defining staffing levels for children and young people's services (RCN 2013)

relatively high percentage of attenders admitted for more than 12 hours (54%) compared with, for example, similar units in Glasgow and Paisley at around 33%. With the loss of the inpatient service, better decision making is resulting in more Pembrokeshire children being discharged home rather than transferred for admission at Glangwili, and the return rate is lower than anticipated.

7.1.11 Overall, although nurses reported the changes to the Withybush service had been challenging personally and professionally it was apparent they also had good insight and a balanced view of what is working well and what could be better. They reported that although managers are often seen as 'fire-fighters' they are receptive to ideas and innovation and were visible and engaged.

Out of hours cover

7.1.12 The PACU will receive patients and provide advice up until 8pm when the Tier 1 doctor leaves; at this point the Tier 2 doctor remains to discharge or transfer any remaining patients and the unit closes at 10pm. The DAV crew changes shift at 8pm, so where a transfer to Glangwili may be needed, they will endeavour to start around 6pm to enable the crew to return to base by 8pm, but there is always emergency cover from the 999 service if the DAV is on a transfer. The rate of transfers of children from WITHYBUSH to Glangwili has not reached the planned levels, although this may be a reflection of the overall throughput in the PACU being lower than anticipated (see chapter 9).

7.1.13 A GP-led out of hours service is co-located at Withybush from 6.30pm to allow appropriate triage of patients to primary or secondary care after local GP surgeries close. The service comprises four salaried GPs who work overnight and two who cover other shifts (as of June 2014). The rota bases one GP in the Ambulatory Care unit with administrative support and one GP who is mobile to conduct home visits. These GPs do not all have high levels of paediatric experience and may have a low threshold for seeking paediatric advice or referring patients to secondary care.

7.1.14 The GP-service receives a high volume of contacts in the early evening, including children, and reported that a number of residents and visitors to the area (e.g. caravan sites) are not registered with a GP and attend the OOH or ED service instead. Several sources identified tension between ED and the GP out of hours (OOH) service which can hamper effective communication consequently increasing the risk of inferior overall care. The Review team detected some confusion generally as to the pathways of care in the early evening if paediatric advice is required, and although there is currently a rostered on-call paediatric consultant at Withybush, the GP OOH service explained that they will use the DAV or parents to transfer a child to Glangwili rather than call the paediatrician.

7.2 Paediatric anaesthetics and emergency care

7.2.1 There is a clinical lead for the anaesthetic service based at Withybush but the teams operate separately by site. The level of anaesthetic support at each site includes juniors, middle grades and consultants, with a Consultant always on call at each site. The Deanery is removing the CT1 anaesthetists from Withybush from February 2016 which might make recruitment to the middle grade problematical. Recent appointments have, however brought the total number of consultant anaesthetists to ten at Withybush with another starting soon so there is an opportunity to review the skills and rota arrangements to support emergency provision.

7.2.2 An important concern at Withybush relates to paediatric medical support out of hours, with the anaesthetic consultants feeling that their paediatric airway skills would diminish with the loss of regular activity and absence of on-site paediatricians. They would expect to intubate children prior to emergency transfer and there were instances (now being resolved) when differing criteria for the emergency transfer of sick children from Withybush to Glangwili had delayed treatment. It is important that there are shared protocols and increased collaborative working between the teams at the two sites.

7.2.3 The Review team considered the current arrangements against two key documents. Firstly, the 'Tanner' report, published by the Department for Health in England in 2006[24] examined the pathway for critically sick children from any point of presentation and stated:

Supplementary note 3

1. In planning for the care of the critically sick child, the emphasis should be on:

- competencies rather than professional labels;
- team working;
- networks of care; and
- the whole pathway, from presentation to paediatric intensive care (PIC).

Skills, training, and maintaining competence

2. Six generic skills are expected of all personnel involved with the care of the critically sick child:

- to recognise the critically sick or injured child;
- to initiate appropriate immediate treatment;
- to work as part of a team;
- to maintain and enhance skills;
- to be aware of issues around safeguarding children; and
- to communicate effectively with children and carers

[24] The acutely or critically sick or injured child in the district general hospital – a team response (DH and intercollegiate 2006 – " Tanner report")

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25. Where a hospital with no on-site inpatient paediatric facilities offers children unrestricted access via the A&E department, very careful consideration should be given to how a critically sick child should be managed, and also to provision of 24-hour cover.

Reference – 2006 Tanner report (see above)

7.2.4 More recently, pages 5, 21 & 26 of the 2012 intercollegiate guidance[25] states: "Urgent help [should be] available for advanced airway management and intubation and ventilation is only carried out by competent staff" and "if paediatric on site support is unavailable, the paediatric skills of the emergency department staff are enhanced, or additional paediatric-trained staff employed'. "Emergency paediatric resuscitation skills should be within the remit of all anaesthetists attending emergency departments and hospitals with a low throughput of children should ensure that these skills are maintained. This can be achieved by staff secondments or rotations to other centres".

7.2.5 The paediatric consultant is currently on call from home and the ED staff do not feel that they are sufficiently trained in paediatric resuscitation. As so few paediatric cases are being done at Withybush arrangements should be agreed for how the consultant anaesthetists maintain their skills in paediatric life support in the event of an unexpected severely compromised child being brought in out of hours. Given that there are now ten anaesthetists at WITHYBUSH, a smaller 'sub rota' of consultants with paediatric experience and ideally some daytime paediatric elective surgery should be established who could be released to spend time in regional PICU/doing anaesthetic lists with a paediatric anaesthetist would better ensure maintenance of skills and enhance safety.

7.2.6 Additional training is therefore required particularly for airway respiratory emergencies out of hours at Withybush but also to ensure that all staff who may be in contact with sick children can recognise acuity and refer/transfer appropriately. As far as possible paediatric emergencies should be stabilised and transferred to Glangwili by means of the Dedicated Ambulance Vehicle.

7.2.7 At Glangwili the out of hours anaesthetic consultant rota should be 1 in11 but currently they have three long term absences and three of the consultants on call do all their daytime work at the Prince Philip hospital in Llanelli which provides no paediatric or obstetric experience. They are now covering what has become a much busier paediatric and obstetric service out of hours after the service reconfiguration.

[25] RCPCH Standards for the care of CYP in urgent and emergency settings 2012

Some of these consultants have not done paediatric or obstetric anaesthesia for many years and are concerned about their lack of skills and experience.

7.2.8 The middle grade anaesthetists are currently covering for many absences on their own tier due to recruitment problems and also for absences on the first on call tier; they are working very long hours. These hours were felt to be unsustainable by the consultants who also felt that the middle grades were not getting adequate rest breaks between shifts.

7.2.9 The Health Board has expressed a keen desire to maintain Withybush as an acute site and it is supporting and developing the ED service. There is a misconception that all issues related to paediatric care are the remit of the paediatric team but this is not the case and it is paramount that all parties - paediatricians, anaesthetists, ED staff, OOH GPs and DAV staff - work together to identify what skills are needed, how they are to be sustained and how the rare unexpected emergency will be managed.

7.2.10 Many ED services are able to deal with paediatric emergencies without on site paediatricians, compliant with standards[26] but in such situations the paediatric skills of the emergency department staff need to be enhanced. There should be at least one RCN per shift APLS trained to support the medical staff. Higher specialist trainees in Emergency Medicine should ideally spend six months of the third year of their core training focussing on paediatric emergency competencies although this will require Deanery consideration. Senior ED medical staff must maintain paediatric competencies and demonstrate ongoing CPD relevant to paediatrics and there must be a clear pathway for ED staff to access advice from a senior paediatrician. The Consultant paediatricians should take a lead in clarifying policies and protocols and providing training such as scenario teaching.

Supplementary note 4

The Scottish Centre for Telehealth and Telecare has completed a pilot project using video-consultation from remote and rural DGHs with no in patient paediatric facility to an experienced consultant paediatrician. This reduced the number of transfers and supported decision making about mode of transport where required.

Reference: http://sctt.org.uk/programmes/health/paedriatrics

7.2.11 In the longer term there is scope for the service to evolve and develop to strengthen skills and reduce the requirement for DAV support. Such developments could include:

[26] Standards for Children and Young People in Emergency Care Settings" (RCPCH 2012)

- Deploying paediatric Emergency Nurse Practitioners (ENPs). Some staff expressed an interest in pursuing the appropriate training.
- 24-hour coverage of EMRTS (see chapter 9)
- Development of GPs with special paediatric interest
- Increasing use of telemedicine
- Low acuity overnight beds staffed by Advances Nurse Practitioners (ANPs) which the RCPCH are just beginning to consider in other sites.

7.3 Glangwili

7.3.1 Facilities for children at the site comprises

- Emergency Care
- Surgery
- Outpatients
- 8-Bedded Paediatric Ambulatory Care Unit (PACU)
- 3-bedded High Dependency Unit (HDU)
- 30-bedded Inpatient ward (Cilgerran)

7.3.2 Inpatient paediatrics moved from Withybush to Glangwili in October 2014, and before the transfer Cilgerran ward was refurbished with seven additional beds to accommodate the additional activity and has received very positive feedback. The full team were involved with the planning of the unit, including the HDU which was well equipped and bright, but tight if all three beds were in use. There were 1072 admissions to Cilgerran Ward over the first six months of operation, including the 194 transferred from WITHYBUSH and possibly some elective admissions as well.

Paediatric Ambulatory Care Unit (PACU)

7.3.3 The PACU operates 24/ 7 with a maximum stay of six hours and referrals are direct or through ED, with a good flow of information across the hospital site. There are an average of 10.7 attendances between 10am and 10pm each day and 4.2 per day overnight[27]. The PACU is quite a distance from the ED but staff reported they work closely with this and other departments where children attend.

7.3.4 Staff reported that the PACU is significantly understaffed and not compliant with the RCN staffing recommendations[28] which impedes the number of children it is able to manage at any one time. Overall recruitment was reported to be challenging for registered children nurses although the Review team were informed that pre-registration places for RCN's has been increased and the HDU has recruited two new band 6 nurses and is advertising for a band 7.

7.3.5 Activity levels in PACU include a significant number of children seen there inappropriately i.e. they did not need assessment. Conditions such as constipation

[27] Hywel Dda evaluation and monitoring report 3rd Quarter
[28] Defining staffing levels for children and young people's services (RCN 2013)

and eczema were cited as examples of inappropriate use of the PACU usually by primary care, and these could be avoided with greater development of community and specialist nursing. Medical staff are not rostered to the PACU so there are often long delays for children to be seen prior to discharge. Nurses expressed frustration with this model of care and feel strongly that they have the skills and competence to assess children at key points within an agreed protocol to enable children and their families to return home or otherwise. This could be an opportunity to develop Advanced Paediatric Nurse Practitioners (APNPs).

High Dependency Care

7.3.6 As part of the service change a three-bedded High Dependency area is provided on Cilgerran Ward at Glangwili. It is clearly early days for provision of this service as borne out by the relatively low throughput in the typically busier winter months with 67 admissions between November 2014 and April 2015 (Evaluation and Monitoring Report Quarter 3). However the numbers of children being transferred to the Cardiff PICU has dropped from 13 (9 Glangwili and 4 Withybush) from November 2013 to October 2014 to a total of 5 between October 2014 and August 2015. Calls to the PICU team for advice have increased but physical transfers have not.

7.3.7 The rationale for reconfiguration made clear the intention of developing HDU and reducing transfers out of area. Clearly this should only be done if a safe service is available locally and should be benchmarked against national standards[29] . The 2010 Standards provided generic standards such as 'all staff treating children should have appropriate safeguarding training' but also some specific standards for High Dependency Care:

- If HDU is to be provided for more than 48 hours then there should be facilities for parents and carers to stay. The Review team would suggest that this should always be available for families travelling from afar such as Pembrokeshire.
- There should always be 24 hour resident paediatric cover of at least RCPCH Level 2 competence
- There should be a nominated lead consultant who should have time allotted to coordinate policies and procedures and appropriate medical staff training
- There should be ready access to other medical specialities such as anaesthesia or ENT when needed
- There should be a senior children's nurse lead who should have experience of working in HDU
- There should be 24 hour on site access to a senior nurse with intensive care skills and training
- Children should be looked after in HDU by children's' nurses with paediatric resuscitation training and competence
- There should be a ratio of nurse staffing of 0.5:1 patient or 1:1 if in a cubicle

[29] Standards for the Care of Critically Ill Children, PICS 4th Edition June 2010.

- The HDU should be appropriately designed and equipped and with ready access to any drugs that will be needed
- There should be clear guidelines to cover the types of children and conditions that will benefit from HDU care
- There should be facilities for data collection and for audit.

7.3.8 In October 2014 the RCPCH in conjunction with nine other organisations, published a new approach to defining and delivering High Dependency care[30]. This proposes that units are designated by the paediatric intensive care networks as Level 1 Critical Care (CC) (proposed in most District General Hospital paediatric departments) and Level 2CC (a smaller number providing more complex care) with Level 3CC being existing PICUs. The HDU service at Glangwili is in its infancy and is likely to develop step by step as has been the case for neonatal care. It was perhaps too early for the Review team to get a clear view on progress and we would suggest liaison and networking with the regional intensive care service towards acquiring designation first as a Level 1CC for which the criteria are largely met, and aspiring if appropriate to be Level 2 given the catchment area and size of the paediatric team. The standards are developmental, requiring a strengthened network of support but they provide a framework for training options, peer review and some commonly agreed protocols. The lead consultant and nurse for HDU should have the opportunity for liaison with the referral centre.

7.4 Workforce and sustainability

Medical staffing

7.4.1 There are fifteen consultants across the two sites, seven at Glangwili who cover the out of hours rota across inpatients and SCU and five based at Withybush, of whom three cover the 1:5 'safety net' out of hours rota using internal and external locums. There are also three consultants based at Bronglais. The Job plans are still being finalised but are aiming for 10 session including 3 SPA and 1 in lieu of on-call. There is a 1:10 consultant of the week system at Glangwili which is covered by consultants from both sites.

7.4.2 The Tier 2 rota works across both sites as a 14 person system. These doctors initially wanted to do on-calls in Glangwili overnight which had resulted in some being awake for 24 hours. The Deanery and consultants had expressed concerns around safety, workload and tiredness and two posts had remained unfilled, so they will move to a 12-person full shift system. This will mean more stability for the service and them and reduce cancellation of clinics. The Tier 2 doctors at Glangwili cover the SCU, ED, PACU and calls to the labour ward out of hours as well as in patient paediatrics.

7.4.3 There were some concerns that new specialty doctors do not receive a full induction and their consequent lack of detailed knowledge can result in some feeling

[30] Time to move on RCPCH 2014 www.rcpch.ac.uk/high-dependency-care

undermined. They do not yet have formal agreement of new job plans, subject to confirmation of the 12-person full shift system but the Review team was told that they are supported well by their consultants at busy times.

7.4.4 At the time of the Review team's visit there were reported to be thirteen Tier 1 doctors on the rota across both sites. The GMC and Deanery paediatric trainee survey findings for the first half of 2014-5 were concerning, particularly around Tier 1 and Tier 2 assignments at Withybush. A new clinical tutor has been appointed and the situation is being monitored, recognising that the survey timing coincided with considerable staff turbulence as the reconfiguration changes were in progress. In October 2015 the Deanery undertook a targeted quality visit to follow up on identified issues around clinical leadership and engagement and reported positively, with relatively few recommendations.

7.4.5 There are significant advantages to integrating the consultants into a single service providing care in different formats onto two sites. The larger number lends itself more readily to the Consultant of the Week with one consultant relieved of other duties and dedicated to assessing and managing acute admissions or urgent GP referrals (Standard 7 of the RCPCH Facing the Future 2015[31]). It allows greater flexibility in on call arrangements and to be available in the hospital during times of peak activity (RCPCH Standard 1), for twice daily handovers (RCPCH Standard 4) and to support the Ambulatory Care unit (Standard 6). In addition the expanded number of consultants would have access to a greater cohort of patients which lends itself to consultants developing subspecialty expertise e.g. cystic fibrosis, diabetes, epilepsy, HDU care. This may be as part of a network with tertiary services and means that more patients can be seen and treated locally. The specific breakdown of consultants' duties would need careful job planning which we understand is ongoing but would need regular review as services evolve. We were informed that there are two consultant vacancies at Withybush and that other consultants were likely to retire in the near future providing the opportunity to appoint to specific roles within the evolving service.

7.5 Community paediatrics and community children's nursing provision

7.5.1 The community children's health service has benefitted in recent years from the joining of the health boards, enabling better integration, and the community team is enthusiastic and keen to improve the care they can offer to families. The paediatric team, which covers all three counties, is however limited and whilst the reconfiguration did not directly affect this service, it is supported by the same team of consultants and the requirement for 'safety net' cover at Withybush mean that resources have been diverted away from community medical provision. There is currently consultant presence in each County covering community paediatrics, each with a middle grade training post. There is one vacant consultant post in

[31] see www.rcpch.ac.uk/facingthefuture

Carmarthenshire and the training post in Carmarthen has been left vacant for the coming year despite sufficient applicants due to concerns about the quality of training. The Review team heard that this is being addressed.

7.5.2 Children with suspected ASD and ADHD are currently not being diagnosed promptly which can have a huge impact on families and the children's development. The Review team was told however that the education service recognises and provides some support for these children until a clear diagnosis is available. Both of the consultants in Withybush whom the Review team spoke to stressed that the community service is significantly under-resourced and seen as a lesser priority. One reported a wait for a new patient appointment of thirteen months and some parents reported waits of 4-6 years for an ASD assessment. It is imperative that this is reviewed urgently and necessary recruitment and changes introduced to improve the service in all areas both clinically and geographically.

7.5.3 There are 15 WTE Community Children's nurses (CCNs) covering the three Health Board counties including the CNS for Palliative care, a Paediatric Outreach Oncology Nurse Specialist and a WellChild Transitional Care Nurse working 5 days a week, 9-5 pm. The RCN guidance[32] for the population expects 29.2 WTE. There is no respiratory or epilepsy specialist nurses (ESNs) provision as these conditions are expected to be managed by GP Practice nurses.

Supplementary note 5

3 Epilepsy specialist nurses (ESNs) should be an integral part of the network of care of children, young people and adults with epilepsy. The key roles of the ESNs are to support both epilepsy specialists and generalists, to ensure access to community and multi-agency services and to provide information, training and support to the child, young person or adult, families, carers and, in the case of children, others involved in the child's education, welfare and well-being.

Reference - NICE 2004

7.5.4 There was good feedback about the palliative care pathway for children (0-25) with life limiting conditions and end of life care which is supported by a clinical specialist based in Cardiff, with a local paediatrician being allocated one session per week. Complex care packages at home are commissioned from a specialist provider, and arrangements are in place for them to be seen swiftly in ED/PACU but there are concerns that families will be unable to travel for local services and attempt procedures such as re-intubation themselves without training . The reduction in medical support is adding unhelpful pressure and risks to the service. For example, parents explain that it is harder to get outpatient appointments, and they have to

[32] RCN 2014 The future of community children's nursing, challenges and opportunities

travel further and attend acute services which are less familiar with their child's condition.

7.5.5 The Review team heard how some families are having to travel to Glangwili simply to have blood samples taken. Unless these are for very specialist tests needing expertise in determining which specialist laboratory will process the test then the vast majority of venepuncture should be available at Withybush and the clinical lead confirmed this is the case. The RCPCH guidance for Small and Remote units[33] refers to the role of audit and it may be helpful to monitor the reasons for families being transferred to Glangwili for outpatient care and if there are further services which could be provided locally.

7.5.6 The transition of families from receiving neonatal outreach to care from the CCN team (usually after 12 months) needs to be streamlined although the CCN team reported the pressure on their workload has improved as a direct result of the NN Outreach team. There are good relationships with health visitors, but there were some concerns that the CCN team is not known by GPs. There is no strategy for community nurse based prescribing although ANPs had been (expensively) trained and there is increasing integration with the PACUs to reduce attendance and improve outreach. The 'Facing the Future - together for child health' standards should support this.

7.5.7 A clear business case has been prepared seeking £784k additional annual investment to staff a comprehensive community children's nursing service that meets the RCN and RCPCH[34] guidance for out of hospital care, palliative care, and support for children and families with complex disabilities and needs. There is a separate proposal for a specialist epilepsy nurse, working out of the acute hub but linking closely with the community nursing team. The Review team supports these developments and encourages the establishment of a seven-day service, perhaps with rotations through the PACU units to identify and support 'frequent flyers', reduce potential hospital attendance /admission and facilitate early discharge.

7.5.8 The Review team noted some additional short term issues which could improve the efficiency and impact of the current team such as investment in IT facilities for mobile working and appropriate office accommodation at the base.

7.6 Safeguarding

7.6.1 There are named nurses for safeguarding through all the services, plus six sessions for a Named Doctor, but concerns were raised out of hours in Withybush when ED detects safeguarding concerns. Pembrokeshire cchildren requiring place of safety or observation are transferred to Glangwili which is in a different social services area and whilst the reconfiguration highlighted misunderstandings around discharge

[33] www.rcpch.ac.uk/facingthe future
[34] Facing the Future Together for Child Health RCPCH 2015.

arrangements and second opinions on skeletal surveys, the Review team was told that these have now been resolved and strategy meetings are arranged within 48 hours.

7.6.2 The Review team was advised that all staff undertake safeguarding training to level 1 or 2 as appropriate and this is provided by the Learning and Development team. It was not ascertained what level of safeguarding training the ED doctors had undertaken, particularly given the challenge in appointing permanent staff. It is important that the wider safeguarding team is vigilant to ensure that senior ED staff and all those with paediatric involvement, including locums, are trained to level 3 as soon as possible. The Named Doctor was appointed to this new role after retiring in 2012 from his post as consultant community paediatrician.

7.6.3 Current pressures on community paediatric capacity are leading to subsequent delays in the assessment of children (including LAC children) for non-urgent conditions but these pressures have not delayed LAC health assessments which are undertaken by health visitors and school nurses. Standards require Initial Health Assessments (IHA) to be conducted by a doctor, and this should be reinstated once the community paediatric team is restored to full capacity.

7.6.4 The Review team heard accounts of inappropriate advice being given to families by health professionals, for example suggesting transferring a child by car when treatment would have been accessed more quickly with subsequent safe transfer by calling for an ambulance but these were anecdotal and where such occurrences are brought to the attention of the Health Board action was taken to inform staff or revise procedures.

7.7 Leadership / vision

7.7.1 Although all consultants agreed with the clinical lead that there should be a unified service there has been some resistance to change subsequently and his relationship with the Withybush consultants has been strained. Meanwhile the Glangwili Consultants perceive an inequity in workload and the result has been some tension between the two teams and a failure to progress to a seamless service. The Clinical Lead would benefit from senior clinical management support, perhaps an Associate Medical Director, to drive through changes to the service as the role can be isolated, particularly when job planning and implementing potentially unpopular changes.

7.7.2 The nursing leadership was committed and positive and had delivered a programme of organisational development to help the team through change. All staff had been interviewed individually and moved or not according to their home location or preference, and several staff conferences had been held with great awareness of the importance of human factors in combining and developing teams. As a result,

morale seemed to be reasonably good and the teams appeared to have merged successfully with effective multi-site working.

7.7.3 The RCPCH has been developing intercollegiate standards specifically relating to the types of pressure being faced by hospitals in remote settings such as Pembrokeshire, Cumbria and Scotland. In April 2015 a suite of standards under the 'Facing the Future' series was published focussing on better partnership working by primary care, community nursing and acute paediatricians to reduce the number of unnecessary attendances at hospital and increasing local expertise . Implementation should reduce emergency and urgent attendance and admissions and keep care as close to home as possible, and given the single Health Board rather than the structural complexities of the English NHS, adoption of a whole system approach, led by the paediatric team and supported by managers should demonstrate relatively swift benefits in terms of quality of care and reduction of hospital activity. Bronglais hospital was visited as part of development of these standards. The RCPCH is keen to continue to work with the team towards implementing the standards and the Welsh model of an integrated Health Board with oversight across primary and community services provides an excellent opportunity to push ahead swiftly with these.

7.8 Paediatric conclusions and recommendations

7.8.1 Providing a single inpatient service with an integrated consultant team and twelve middle grade posts should prove attractive and aid recruitment which has been a long term problem with the dual site inpatient model. In the event of full recruitment then it seems likely that all of the ten Facing the Future Standards (RCPCH 2010 Revised 2015) are achievable.

7.8.2 There would be capacity for a Consultant on site during times of peak activity for seven days each week (Standard 1). This would facilitate other standards requiring Consultant input (3,4,6 and 7). The middle grade tier would satisfy the rota requirement (Standard 8) and those with clinical expectation (2 and 5). Standard 9, access to tertiary telephone advice for all specialities, depends on the appropriate network arrangements being instituted. The greater potential for consultants to develop subspecialty interests would aid the establishment of such networking. Standard 10 would depend on very carefully constructed referral pathways for all agencies and from different geographical sites and with different modalities of abuse noting the variance in referral for suspected physical and sexual abuse. In addition social care in Pembrokeshire would need to know exactly whom they should contact out of hours on the rare occasion that this is needed. It also depends on all staff being appropriately trained and appropriate pathways to ensure that all cases are at least discussed with the Consultant. Robust safeguarding arrangements are a cornerstone of a good paediatric service and it is essential that clear pathways are in situ to ensure that this standard is achieved.

7.8.3 A full and regular paediatric outpatient service should be provided at Withybush including the opportunity to develop subspecialist clinics with a lesser need to travel to Carmarthen or Swansea. In addition community services – medical, nursing and neonatal outreach – should be further enhanced for all areas. This again will reduce the need to travel for local families. As much investigation as possible should be done locally such as venepuncture.

7.9 Recommendations

Emergency Pathway

- Clarify the governance, decision making and pathway arrangements for paediatric attenders at both sites between ED, OOH and the paediatric team

- Audit Welsh Ambulance Service NHS Trust (WAST) out of hours paediatric decisions around 999 destination, with a group including anaesthetists, WAST, paediatric and ED staff and revisit criteria/refresh training as necessary

- Provide a further 12 month extension to the DAV to March 2017 reviewing again once other changes have been made

- Ensure there are adequately qualified staff with paediatric resuscitation skills available at all times at WITHYBUSH, perhaps through a programme of training and skills
  development for the anaesthetic team with rotation to other units to maintain skills. The paediatric team should play a leading role in overseeing arrangements.

- Strengthen nurse staffing in ED through urgent appointment of Registered Children's Nurses and longer term consider development of Emergency Nurse Practitioner (ENP) roles, including nurse prescribers, and a 5-year plan for training and retention

- Ensure that all staff who advise members of the public are aware of the correct clinical pathway to access early treatment and safe transfer.

Paediatric Care

- Formally merge the paediatric consultant team and remove the out of hours cover for Withybush once alternative emergency arrangements are in place.

- Redesign job plans for consultants and speciality doctors to deliver Facing the Future standards including consultant cover at peak times.

- Ensure there is sufficient outpatient capacity for all local children to be seen in clinics at Withybush. This would be for general paediatric problems and also subspecialty clinics.

- Ensure that most investigations – uncomplicated radiology and ultrasonography, venepuncture and ECG – can be undertaken at Withybush.

- Develop a vision for PACUs as a single service for the Health Board.

- Review, with primary care colleagues, compliance with the Facing the Future Together for Child Health standards and establish a plan for implementation and audit.

- Continue development of the High Dependency service as part of the network with Cardiff as the local PICU provide and conforming to national standards[35].

- Support investment in the Community Children's Health service towards compliance with the RCN[36] and RCPCH[37] guidance for community child nursing. There is an urgent need for recruitment of Consultant Community Paediatricians.

- Develop the roles of specialist nurses, for example in epilepsy, asthma/ respiratory.

- Review the scope of on-call activity and maximise the role of nurses to help reduce pressure on doctors, including development of a criteria led nurse discharge programme.

[35] RCPCH/PICS Time to Move On 2015
[36] NHS At Home – developing Community Children's Nursing DH England 2011
[37] Facing the Future Together for Child health – RCOCH 2015

8 Transport and the Safety Net

8.1 Dedicated Ambulance Vehicle – DAV

8.1.1 For Pembrokeshire people, the time taken to reach Glangwili, particularly from the Western coast, is a major concern. They are anxious that delays in reaching urgent and emergency care may result in deterioration of condition or outcome, and that routine appointments may be inaccessible. The area has lower than average car ownership and public transport is limited – there is no bus on Sundays between the sites and railway stations are not ideally situated. The Review team saw nine months of data which demonstrates no measurable deterioration in clinical outcomes, and it is important that staff and the public are reassured with statistics to mitigate their concerns.

8.1.2 For urgent maternal neonatal and paediatric transfers from Withybush to Glangwili, the Dedicated Ambulance Vehicle (DAV) is commissioned by the Health Board from WAST. It is staffed by a 10-strong team of paramedics and emergency technicians who provide 24/7 cover. This resource costs the Health Board approx £600,000 and was established as s short–term project, with seconded / directly recruited staff on six-month contracts. The contract was recently extended to March 2016, and the staff are keen for the arrangement to be made permanent. There have been neither complaints nor criticism of the team and its approach since launch in August 2014.

8.1.3 The service was modelled and designed to handle around nine transfers daily, but in practice has made 636 journeys in eleven months, averaging around 2 per day, including provision of some transfers of women or children from home when the 999 service was unavailable. Given the team is underutilised in in terms of transfers, the staff provide additional support to WITHYBUSH through providing emergency training to staff, support for activity in ED and on the wards, and occasional assistance in the MLU. There is a Service Level Agreement with the Health Board to support this activity and indemnify the staff enabling them to work to the full scope of their practice when inside the hospital and there is potential for greater integration particularly where there are skills gaps in ED out of hours.

Table 9 - Car Travel Times to Glangwili Hospital:

Time (mins)	% of population of Hywel Dda
0-30	24.3
30-59	53.8
60-89	21.4
90+	0.5

Reference: Public Health Wales Observatory, 2011

Table 10 - DAV users - 4th August 2014 to 19th July 2015

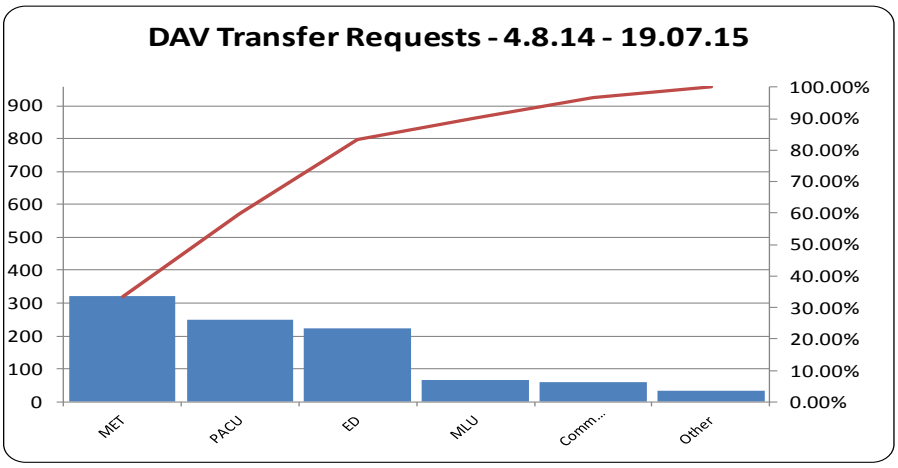
	Count	Percentage
Children	404	64%
Women	228	36%
Other	4	1%

Table 11 - DAV transfers by time (4th August 2014 to 19th January 2015)

Arrival time	Count	Percentage
After - 20:00	125	48%
16:00 - 20:00	74	28%
12:00 - 16:00	34	13%
08:00 - 12:00	17	7%
Not Recorded	11	4%

8.1.4 All transfers are reviewed and the data collection for the project is very comprehensive. As of 17th July 2015 there had been 66 transfers from the MLU, and 225 other transfers of which 64% were children who had presented at ED, with the rest being gynaecological (ectopics, bleeds, miscarriages). One baby had been born during transfer but this was an anticipated, safe, occurrence with appropriate staff and procedures and not recorded as an incident.

Figure 4 - Source of DAV transfer request (4th August 2014 - 19th July 2015)



*MET= Medical emergency team – within the hospital

8.1.5 The DAV staff follow very clear operating procedures and maintain their skills through working occasional overtime shifts on the regular WAST vehicles. There are significant benefits of the WAST link, compared with contracting a private provider, not least the integrated communications, consistency of approach, opportunities for staff development and practical availability of spare vehicles.

8.1.6 If the DAV was not available the ambulance service would require urgent additional capacity. There is no doubt that this service is excellent with no generated Datix reports but it is very labour intensive and the staff are active in other areas of the hospital to update their skills and share their considerable expertise.

8.1.7 The uncertainty of the long term of the DAV project is undermining for a group of enthusiastic staff and a decision needs to be made on the way forward. For the community it is perceived to be a central component of safety for women and children. With the growing demand on the conventional service through the

increasing age of the population using the other ambulance service vehicles, it may be wise to maintain it, ensuring the expertise and skills of the paramedic and technical team are fully utilised to support other areas of the hospital when transfer is not required, and in the meantime developing the paediatric skills and competencies of the emergency department staff and strengthening the anaesthetic cover as discussed in section 7.2. If it were feasible to increase the overall ambulance provision, perhaps by making the hospital a priority location, withdrawal of the dedicated service may be appropriate in the longer term. A detailed review of the cost/benefit of the provision should be conducted after a further 12 months once the other recommendations in this report (removal of paediatric and obstetric safety net, better public communications, increasing attendance at the MLU) have bedded in.

Non-Urgent transport and Returns from Glangwili

8.1.8 Patients and relatives who have been transferred to Glangwili by the DAV reported finding it difficult to return home, particularly if they have no private transport and/or it is during the night. Although the Review team heard many reports of 'stranded' parents and expectant fathers, the prevalence was not quantified. There were examples where the Health Board has covered the costs of taxis for those who have become distressed but it was disappointing that improved non-clinical transport for staff as well as patients was not arranged alongside the reconfiguration.

8.1.9 To address these concerns, the Health Board has established an Integrated Transport group which has published plans to provide from 1st September 2015 an integrated daytime family transport service between the sites, including bus, taxi and volunteer driver services. This will cover both way transport for repatriation and attendance at clinics and can be booked through hospital managers and GP practices. An information pack Collated by Pembrokeshire Association of Community Transport Organisations (PACTO) is available in all GP practices and other acute units seeing children. This is an excellent development which demonstrates that the public concern about transport availability and cost has been acknowledged.

8.2 Welsh Ambulance Service (WAST)

8.2.1 Whilst the operation of the Welsh Ambulance Service was outside the scope of this review, the availability of regular 999 ambulances is a concern of the Pembrokeshire public given the perceived loss of paediatric and gynaecological expertise at Withybush. There are difficulties with releasing ambulances which had transported patients eastwards, although there are two priority locations in Pembrokeshire that are covered by an ambulance at all time based on use and . These do not include Withybush as there is the DAV in place.

8.2.2 The Review team was told that ambulance crews are trained to transport to the nearest emergency centre and were anxious about bypassing Withybush for children out of hours. Attempts to secure resolution of the concerns and agreed protocols with the Health Board emergency and paediatric teams should be renewed.

8.2.3 For infants and children, urgent and emergency ambulance transport provides stabilisation, treatment in some cases and engagement with the receiving services who can prepare for the child's arrival. Many parents however cannot wait and transport their sick children themselves, during which time the child may deteriorate. It is important to provide clear information for parents to enable them to make safe choices for their children

8.3 Paediatric intensive care and emergency transport team (EMRTS)

8.3.1 The introduction in June 2015 of a vehicle and helicopter-based emergency support, stabilisation and retrieval service (EMRTS) working out of Singleton Hospital is an important and positive development. The service, funded initially for a year, will include the capability to stabilise and retrieve infants from MLUs such as Withybush should this be clinically indicated. There are examples of similar systems working in Scotland[38] which use a range of transport types depending upon clinical need and distance. Although EMRTS is initially a 12 hour/day service designed to reach emergencies in remote and rural areas it provides additional reassurance to families in the more remote areas of Pembrokeshire. It is important that the existence and effectiveness of this service is communicated widely.

8.3.2 The road-based paediatric intensive care retrieval team relocated from Cardiff to Bristol from 1st September, and although not widely consulted upon, the clinical view is that from a practical viewpoint the experience of families who need the service is unlikely to be much different and may be improved. The children that need PICU will still be taken to Cardiff, whilst having a dedicated transport service (as in the rest of the UK) will hopefully lead to fewer refusals for transfer or delayed transfers as currently the Cardiff PICU consultants cover the unit and do retrievals - which sometimes leads to a delay dependent on the acuity of PICU inpatients at the time. A team travelling from Bristol might add 30mins onto a 2-3 hours journey, which should not adversely affect the outcome for the child - they will already be waiting and intubated for retrieval, and advice will be available in real-time via telephone. With the additional backup of EMRTS the provision overall is enhanced.

8.4 Conclusions

8.4.1 The DAV is an expensive resource but is providing the public and staff with additional assurance whilst the changes to services bed in. Although used much less for transport duties than initially anticipated, the staff are deployed as efficiently as possible to add value and skills to the Withybush team. Whilst the Review team currently recommends continuation of the service in the short term, a more sustainable solution, involving 'upskilling' of staff working within Withybush to confidently provide paediatric emergency care and anticipate early a need for maternal transfer should be explored, including involvement of WAST and EMERTS.

[38] SCOTStar Paediatric retrieval service http://www.snprs.scot.nhs.uk/

9 Involvement and support for families

Feedback and involvement opportunities did not appear to be well developed within the maternity and children's service. A Health Board-wide patient feedback group is being launched during summer 2015, and the Community Health Council is very active in engaging with the public and providing a liaison role between the Health Board and those who use the services.

9.1 Maternity care

9.1.1 Whilst the 'Did we deliver?' questionnaire is offered to all women and championed as the method of collecting feedback for the maternity services, the results are collated by a healthcare assistant and are not routinely fed back to staff. This has dual consequences, as problem areas may not be acted upon, but also people whose experiences were uneventful and on the whole positive are not necessarily reported or highlighted. The Review team was told that women can also write comments at the back of their maternity notes which are read by the midwife and adverse comments followed up but this did not appear to be systematic or recorded formally. Plans are in place to seek out feedback from postnatal and breastfeeding groups

9.1.2 Evaluation of patient and family experience should ideally be carried out methodically in all settings, from antenatal clinic to the neonatal unit, and it may be possible to engage a user group or the CHC to assist with this process as identifying staff resources can be difficult. Extending data collection to the community, through community teams (postnatal checks), outreach teams (neonatal care following discharge) and other settings such as postnatal groups and breastfeeding groups would help to ensure that feedback is balanced and relevant and the newly-established engagement group is a very positive development towards a systematic culture of listening to and engaging user experiences.

9.1.3 Results of patient and family experience surveys (or other methods of data capture) should be published and acted upon. This is simple to do at a ward level, but a wider reach would be expected. It is essential that this information reaches those making decisions and the wider public

9.1.4 Working with women and hearing their hopes for labour and delivery afford professionals time to reflect on their services and seek to improve care. Efforts should be made to offer opportunities for women to meet team members and discuss their experience, and volunteers from the CHC or maternity user groups could be invited to audit/survey dads about current arrangements and their experience of care.

9.2 Communication with wider public (see appendix 5)

9.2.1 As part of the engagement process the Review team received over 830 responses to a survey, and hosted a lively 2-hour public meeting near the Withybush site at which members of the public and locally based staff shared their concerns about the reconfiguration. They were extremely passionate about their local services and wished the team to hear their stories.

These are details in Appendix 5 but can be summarised as:

1. Transport / travel times / cost of travel / access to transport / parking at both sites / confidence in ambulance response times
2. Safety – fear of unknown / not confident in new services / unclear about pathway and out of hours care / tertiary services
3. Accommodation and facilities for parents / partners / mothers / families
4. Communications / mis-information / staff attitudes/ complaints process
5. Impact on residual services

9.2.2 The Community Health Council (CHC) maintains a presence as the 'patients' watchdog' for the Health Board. They work well with the new senior management and the new Chief Officer brings a positive and constructive approach to engagement with the Health Board providing encouragement and balance on behalf of all patients. The CHC prepared during the RCPCH review a dossier of anecdotes and reports about the services from those who had used them and their representatives and we are indebted to them for this information which has provided helpful pointers on key areas for investigation.

9.2.3 The reconfiguration took place after an extremely turbulent process of planning and consultation by the Health Board, which, with hindsight had failed to engage effectively either with Health Board staff or with the people of Pembrokeshire. Prior to the change there ensued a vigorous and well-organised campaign to 'Save Withybush Hospital', which delayed implementation and provoked in the public extremely strong feelings of uncertainty and fear about the impact of change on the safety and sustainability of maternity and paediatric care.

9.2.4 The Review team heard extensively of anxieties about the gradual loss of healthcare facilities in Pembrokeshire and worries from the public about the future shape of services and availability of emergency care when needed. Some patients and members of the public do not feel that they are being well informed, despite the Health Board's positive use of social media and press releases and the Review team did not see evidence of attempted interaction with groups such as young mums, ethnic minorities or the travelling community.

9.2.5 Patients and the public should be involved in decision making and planning from the earliest possible stages. This has been patchy to date although there is a Maternity Services Liaison Committee (MSLC) representative on the design and

programme board for service changes. It is important that the experiences of families and individuals inform the plans for phase 2 and for the future design of services. This could be on a task and finish basis, to reduce the risk of one individual becoming overwhelmed or leaving the project and leaving a gap. If input was sought regularly and at every level, this would be useful.

9.2.6 There should be a transparent and robust framework for reporting patient experience, whether positive or negative, throughout every level of the organisation, across all sites. Therefore experiences for patients and families could be compared across sites and services, and for service improvement a baseline for patient experience should be gained prior to the commencement in order that any improvement can be measured. This could be incorporated into standard data collection.

9.3 Recommendations

- Develop ongoing communications and engagement plan through the new committee to include
    - Pushing positive birth stories to the media and staff
    - Proactive analysis of the 'did we deliver' materials
    - Engagement of GPs with clear information about referral criteria

- Suggest CHC or user group be invited to audit/survey fathers about current arrangements and their experience of care.

- Re-establishment of the user group and MSLC

10 Sustainability

10.1 Leadership

10.1.1 The Chief Executive, Chair, Medical Director and Director of Operations are relatively newly appointed and are keen to improve their visibility throughout the organisation. The CHC acknowledged the new leadership in the organisation is "a breath of fresh air" and also that systems appeared to be functioning but need to mature further. The Health Board leadership structure appears to be evolving to a more streamlined service to cover the community and hospital health care sectors. The Review team was told that the planned structure will restore the triumvirate of a senior manager, Medical lead and Head Nurse to effectively run each site.

10.1.2 There is a need to build up media relations and review how to take space to plan the service rather than firefight. It is important that senior staff meet with department leaders and ensure they are developed to be fit for their role, particularly providing strong support for the maternity and paediatric clinical leads as they endeavour to bring their teams together.

10.1.3 The enormous challenges faced by any Health Board in Wales within their administrative structure are considerable and in these three counties this is compounded by the rural and distance dynamic for patients. Access to care for childbirth is a perceived requirement for all and the development of MLUs was demonstrated by the NPEU Birthplace study[39] to be safe and appropriate if procedures are followed, with clear arrangements for transfer should unforeseen events occur. The uptake of MLU births should be promoted as a safe, local service and the positive experiences of those women who have used the service should be more actively promoted to increase usage and build confidence amongst women and staff in the service.

10.2 Reconfiguration and calls for 'restoration' of services at Withybush

10.2.1 Although there is majority consensus that services in Hywel Dda should combine into a single provision on two sites the Review Team perceived a strong support amongst some of the public and health professionals for this being at Withybush as opposed to Glangwili. There had been extensive consultation and options appraisal as documented in "Your Health, Your Future" which concluded that Glangwili be the favoured site of developing the major role in a network arrangement. The Scrutiny Panel (September 2013 with subsidiary report January 2014) independently supported Glangwili as the potential site for the development of a Local Neonatal Unit in Hywel Dda and ipso facto for paediatric and obstetric services as well bearing in mind the close interdependencies of these specialities. The RCOG

[39] https://www.npeu.ox.ac.uk/birthplace

standards[40] state that consultant led obstetric services need a significant additional infrastructure with specialist anaesthetic support, access to adult HDU and intensive care amongst others. The Review team heard how bed numbers had declined at Withybush over the years and the necessary support is more robustly developed at Glangwili. The Review team therefore felt that they could only advise a reverse of the reconfiguration if there were clear evidence of clinical risk and adverse effects on patient safety. This was not found to be the case, although there were many reported anecdotes of poor experiences, partly due to the speed of reconfiguration and staffing issues, which are being addressed. In addition direct questioning to various health professionals suggested that they did not feel patient safety was jeopardised. The Review team concluded therefore that there was no clinical sense in reversing the process to date.

The challenge is to provide safe emergency care for the children of Pembrokeshire, clear processes of ambulatory care and transfer and enhanced outpatient and community provision to allow as much care as possible in the local vicinity.

10.3 Specific response to terms of reference

The following specific improvements were suggested to be resultant from the reconfiguration and included in the terms of reference (Chapter2). Where there is evidence to respond this is given in the sections above, but some indicators are not yet proven as a longer period is required in 'steady state working' to gather and analyse the data meaningfully. To summarise, therefore:

- Provision of more care for children in their own homes or as close to home as possible;

  The PAU at Withybush is reducing the numbers of children being admitted overnight or for extended periods of observation using safe protocols to discharge sooner with safety-netting. The neonatal outreach team enables earlier discharge of premature or sick infants. More still needs to be done to develop community services in line with Facing the Future Together for Child Health and extend the range of outpatient services at Withybush.

- A reduction in the number of pregnant women over 30 weeks gestation who are transferred outside of the Health Board area for possible or actual delivery;
- Swifter repatriation of babies requiring neonatal care back into HDUHB hospitals;

  Neonatal care is presently not designated as a LNU, so according to professional standards should not care routinely for infants under around 32 weeks at present. There is however greater capacity in the unit for premature and sick infants. This objective cannot be achieved until completion of Phase 2 and the recommendations for neonatal services

[40] Standards for Maternity Care - A Report of a Working Party" (2008)

above are addressed. The birth-rate across the Hywel Dda catchment does not justify developing a tertiary neonatal facility and therefore some high risk mothers and babies will continue to be transferred out to maximise quality care.

- Improved compliance with Royal College of Obstetricians and Gynaecologists Guidance regarding consultant cover on wards and minimum birth levels;
- Improved support for middle grade doctor training and sustainable rotas by consolidating obstetric care in locations that exceed 2,500 births per annum;

  These have been achieved, and will be further improved if the recommendations above are implemented. The availability and sustainability of other specialists such as midwifery, neonatology, anaesthesia, surgery and imaging to deliver a contemporary consultant based maternity service must be appropriately evaluated when determining safety and location of services, and consolidation of care on one site has a range of benefits for women and families, although their wider need such as accessibility and transport must be considered

- Improved compliance with British Association of Perinatal Medicine standards where neonatal care is provided;

  See Chapter 6. Compliant with SCU requirements but some way to go to meet BAPM LNU designation.

- Improved compliance with Royal College of Paediatrics and Child health Guidelines for Acute Paediatric Inpatient Units (Facing the Future) and subsequent revisions

  See section 7.8

- Improved arrangements for High Dependency Care for children in the Hywel Dda catchment area to minimise their transfer outside of the Health Board and meet standards developed by the Paediatric Intensive Care Society.

  See section 7.3.6- 7.3.8 with fewer patients being transferred.

- Review the impact and outcomes of the neonatal service change as required as part of the Ministerial decision

  See chapter 6. The integration is essential if a Local Neonatal (Level 2) Unit is to be provided in Hywel Dda which the Review team support as a viable and welcome development. This would certainly allow for the delivery of babies of lower gestation without transfer but must demonstrate fulfilment of all the All Wales Neonatal Standards / BAPM criteria, before it can function in this way. Certainly there is no reason why babies of 30 weeks gestation (as in TOR) and above could not be safely delivered once all criteria are satisfied. In addition this would allow for earlier repatriation from the tertiary services. It is crucial that the Glangwili team and its counterpart in Swansea work cooperatively and the current tensions must not be allowed to impair progress nor to impact on patient care and safety.

- Determine how the current services meet recognised Royal College and other professional standards not included above.

  The narrative sections above explain the position and implementation of the recommendations above will further strengthen compliance

  - **Section 5 covers obstetric and midwifery standards**
  - **Section 7.7.3 details “Facing the Future - together for child health”**
  - **Section 7.3.8 considers “Time to Move On” HDU guidance**
  - **Section 7 overall considers the Intercollegiate Emergency Care standards**

11 Recommendations

1 Obstetric, Maternity and Gynaecology Services

Strategy and Patient safety

- Expedite the 'Phase Two' business case and commence development to provide a high quality environment for consultant-led maternity care and compliant facilities for neonates.

- Develop a clear sustainable strategy for obstetric, midwifery and gynaecology services, prioritising patient safety, patient access and quality of care, building on and completing the changes of services introduced in August 2014. New ideas, perhaps from a 'task and finish' innovation group can refresh the team, harnessing external support to examine new ways of working with the support of the local clinicians and women.

- Identify clinical line management for the Directorate to provide visible and robust professional support, mentoring and development to the clinical leads for obstetrics and paediatrics and the Head of Midwifery. An independent member at Board level should have a remit of responsibility for women's and children's issues.

- Expand community based consultant and midwifery based services at Withybush, developing more comprehensive EPU, EGU, day theatre, and clinical community based services there in line with RCOG standards[41].

- Retain provision of dedicated transport facilities (see Chapter 8).

- Rationalise major in patient gynaecological surgery onto one site, if accommodation allows.

- Phase out the obstetric and gynaecology out of hours consultant rota at Withybush with a target date of April 2016, integrating and strengthening the obstetric and gynaecological consultant team at Glangwili.

- Review of the uptake of midwife led care, and plan to expansion of use by women who have been appropriately risk assessed. Unified patient pathways, guidelines and clinical governance structures must be incorporated into all units within 6 months.

- Assurance to public of the safety of birthing in MLU's in line with the All Wales Pathway for Maternity Care; community midwives should take a stronger lead in

[41] 2013 Good Practice 15 Reconfiguration of women's services in the UK RCOG

this. A band 7 midwife should be appointed to champion a team to develop each of the MLUs in terms of increased usage, active birth supporters and midwives competence and confidence in supporting active, non-pharmacological birth.

Staff Team and Leadership Development

- Conduct medical staff job planning to provide a unified safe service which delivers professional satisfaction to staff across both sites.

- Develop a programme of opportunities for midwifery development that reflects the aspirations of service developments – these should be achieved within a 12 month period.

- In order to meet RCoA standards and secure future allocation of anaesthetic trainees further additional sessions are needed on the labour ward.

- The multi-disciplinary training opportunities for doctors, nurses and midwives are considerable and need further development. A training lead should be identified to ensure training is carried out across all groups including simulation and skills/drills.

- A programme of organisational development should be instigated to build team working and a sense of '*one service'*; across all staff groups from all three sites including community. This could be informed by the Fundamentals of Care audit, and include encouragement and time to nurture potential future medical leaders.

Governance and Accountability

- The new Band 7 maternity risk manager should administer the clinical governance programme including three monthly reports with action plans to the Trust Board and clinical directorate meetings.

- The maternity dashboard should be reviewed by the directorate Quality and Safety Committee quarterly for review and appropriate action. Review of compliance with the RCOG Maternity Standards should be undertaken immediately and upon publication of the new standards expected during 2016.

- Review of the midwifery workforce establishment using Birthrate Plus acuity tool should be completed immediately and at least every 2 years.

- Quality Improvement projects such as the Productive Ward, Releasing Time to Care should be used to involved all groups of staff in the quality improvement programme.

Public Engagement

- The Maternity Service Liaison Committee should be re-instated with membership drawn from local recent service users. Additionally the service should seek out ways to engage with the local families living in the three counties.

- A social media campaign should promote positive birth experiences / normal birth in various media and establish a user group to provide feedback and advice on improving take-up of the MLU.

- Ensure all staff in contact with expectant parents are fluent in the service arrangements, choices available for women, thresholds for transfer and outcomes.

- Facilities for birth partners, whose partner may not be in established labour, to rest and obtain a hot drink should be available 24 /7 at Glangwili.

2 Neonatal Service

Strategic Planning and patient safety:

- Implement the 'Phase 2' developments to provide adequate accommodation for neonates and families.

- Gain commitment and support from the Health Board and The Wales Neonatal Network for a strategic plan for neonatal care towards designation of the unit as an LNU.

- Conduct a training needs analysis amongst medical staff for competencies pertinent to operation as an LNU and a plan to meet those needs.

- With facilitated OD continue to develop team cohesion and a sense of 'one service'.

- Include EMRTS procedures into MLU protocols at WITHYBUSH.

- Strengthen and formalise clinical meetings with Singleton, reviewing all cases weekly and documenting discussions and actions.

- Ensure the Wales Neonatal network guidelines are available to all staff working on the unit.

- Review protocols and skills for emergency out of hours stabilisation given that CHANTS is not a 24-hour service.

- Initiate and support opportunities for the neonatal leads to join sessions at the Singleton to help sustain and further develop their neonatal expertise.

- Ensure that all consultants providing out of hours cover have some daytime involvement on the neonatal unit which could be attendance at the weekly grand round as a minimum.

- Revisit the BLISS audit with service users and develop an action plan 'you said-we did'.

- Improve accommodation arrangements for parents and communicate them clearly, perhaps utilising the CHC to audit awareness.

3 Paediatrics and Emergency care

Emergency Pathway

- Clarify the governance, decision making and pathway arrangements for paediatric attenders out of hours, particularly the relationships between paediatrics, ED and the Out of Hours GP service so patients, public and referrers are clear about whom to refer to at different times of day and what telephone support is available from the Glangwili paediatricians to diagnose, treat and discharge locally where safe and appropriate.

- Continue with the relocation of the Withybush PACU nearer to the ED.

- Audit WAST out of hour paediatric decisions around 999 destination, with a group including anaesthetists, WAST, paediatric and ED staff and revisit criteria/refresh training as necessary.

- Provide a further 12 month extension to the DAV to March 2017 reviewing again once other changes have been made.

- Ensure there are adequately qualified staff with paediatric resuscitation skills available at all times at WITHYBUSH, perhaps through a programme of training and skills
  development for the anaesthetic team with rotation to other units to maintain skills. The paediatric team should play a leading role in overseeing arrangements.

- Strengthen nurse staffing in ED through urgent appointment of Registered Children's Nurses (one per shift) to provide general paediatric expertise. Longer term consider development of Emergency Nurse Practitioner (ENP) roles, including nurse prescribers, and a 5-year plan for training and retention

- Ensure that all staff who advise members of the public are aware of the correct clinical pathway to access early treatment and safe transfer.

Paediatric Care

- Formally merge the paediatric consultant team and remove the out of hours cover for Withybush with a target date of April 2016 once the paediatric, nursing and management team are sure that appropriate emergency arrangements (training access transfer) are in place. This assurance should be supported by monitoring of all attendances out of PACU operating hours to ensure appropriate case management occurred, and identify any incidents resulting from the changes.

- Redesign job plans for consultants and speciality doctors to deliver Facing the Future standards including consultant cover at peak times.

- Ensure there is sufficient outpatient capacity for all local children to be seen in clinics at Withybush. This would be for general paediatric problems and also subspecialty clinics.

- Ensure that most investigations – uncomplicated radiology and ultrasonography, venepuncture and ECG – can be undertaken at Withybush.

- Develop a vision for PACUs as a single service for the Health Board.

- Review, with primary care colleagues, compliance with the Facing the Future Together for Child Health standards and establish a plan for implementation and audit.

- Continue development of the High Dependency service as part of the network with Cardiff as the local PICU provide and conforming to national standards[42].

- Support investment in the Community Children's Health service towards compliance with the RCN[43] and RCPCH[44] guidance for community child nursing. There is an urgent need for recruitment of Consultant Community Paediatricians.

- Develop the roles of specialist nurses, for example in epilepsy, asthma/ respiratory.

- Review scope of on-call activity and maximise the role of nurses to help reduce pressure on doctors, including development of a criteria led nurse discharge programme.

[42] RCPCH/PICS Time to Move On 2015
[43] NHS At Home – developing Community Children's Nursing DH England 2011
[44] Facing the Future Together for Child health – RCOCH 2015

4 Strengthen user involvement and public engagement

- Develop ongoing communications and engagement plan through the new committee to include
    - Pushing positive birth stories to the media and staff
    - Proactive analysis of the 'did we deliver' materials
    - Engagement of GPs with clear information about referral criteria

- Suggest CHC or user group be invited to audit/survey fathers about current arrangements and their experience of care.

- Re-establishment of the user group and MSLC.

Appendix 1 The Review team

Dr John Trounce MD MRCP FRCPCH DCH has been a Consultant Paediatrician in Brighton since 1990 covering general paediatrics and epilepsy, neonatal intensive care in the first ten years and more recently seven years as Named Doctor for Child Protection. He was Consultant Lead for Paediatrics and subsequently Clinical Director for Women & Children and during this time the service underwent a Trust merger, closing inpatient paediatrics on one site, developing a neonatal nurse model of care in the smaller hospital, designing a new stand-alone Children's' Hospital on the main Trust site and developing the paediatric curriculum for the country's newest Medical School. All of this gave a first-hand insight into the challenges, processes and potential solutions for significant reorganisation and development of paediatric services. Dr Trounce was subsequently regional representative on the RCPCH Council for five years. He has experience of other reviews including paediatric intensive care in a major centre and assessment of complaints against individuals.

Dr Anthony D. Falconer FRCOG is immediate past President of the Royal College of Obstetricians and Gynaecologists (RCOG) and has been Senior Vice President and International Officer. Dr Falconer qualified in Bristol, and trained at the Simpson Memorial Maternity Pavilion in Edinburgh. He has worked in Zambia, and lectured in Nottingham, with his final year of training at Groote Schuur Hospital in South Africa. He joined Plymouth Hospitals in 1986, and in his 28 years as a consultant made a major contribution within the region, to the development of cancer services and hysteroscopy. Dr Falconer was Clinical Director and Divisional Director with a major interest in training young doctors. Dr Falconer has worked with British and European politicians, select committees, non-governmental organizations, and other groups in addressing global issues related to women's health care and in 2012 was elected Vice Chair of the Academy of Medical Royal Colleges, also leading on medical revalidation.

Whilst President, Dr Falconer led the RCOG through a period of change in structure and function, overseeing the Governance Review and production of reports on High Quality Women's Health Care, and Tomorrow's Specialist. These works will impact profoundly on the profession and on women's services within the United Kingdom.

Dr Graham Stewart BSc,MBChB,FRCPCH,FRCP(Glasgow) has been a consultant paediatrician with a special interest in neonatology in Glasgow since 1994, with over fifteen years in clincal leadership and mangement posts. He has extensive experience in strategy and service redesign having (amongst other posts) been a member of the NHS Greater Glasgow Child Health Strategy Group for seven years, and for five years was member then Convener of the Paediatric Advisory Committee of the Royal College of Physicians and Surgeons in Glasgow, leading to the establishment of the Intercollegiate Child Health

Committee with RCPCH. Dr Stewart is Honorary Senior Lecturer in Developmental Medicine at Glasgow University and a Senior Examiner at RCPCH.

As clinical director in RHSC Yorkhill, Dr Stewart supported services in change, using organisational development to help teams move forward. He has been involved in several service redesign and reconfiguration projects and merging and closure of paediatric and maternity units and was a member of the Scottish Expert group on Acute Maternity services. In 2011 Graham led his Board's review team looking at the children's services of Western Isles Health Board and the consequent report was favourably received.

Dr Clare VanHamel FRCoA has been a consultant anaesthetist at the Great Western Hospital, Swindon since 1997. Working in a department without fixed lists she is fortunate to have a diverse anaesthetic portfolio including paediatrics and obstetric anaesthetic cover.

Clare has a keen interest in medical education and has been Severn Foundation School Director since 2009. Clare is Clinical Advisor to the UKFPO since 2012, and an important component of her education role is participating in Quality Assurance visits and reviewing Quality data submissions.

Nursing and midwifery reviewers

Jean Hawkins RN RM BA MA has led a number of strategic programmes for maternity services, children and families whilst working for the Yorkshire and the Humber SHA and in her current role as a Professional Consultant. She was a member of the North Wales RCPCH Neonatal Review Team, and her experience includes workforce planning and commissioning development to ensure local delivery of safe, sustainable services, together with establishing a network of networks for children and maternity services. Jean was for five years on the editorial board of The Practising Midwife, and chaired the North Trent neonatal network. She has been a member of a number of Department of Health (England) project boards and chaired for Sir Bruce Keogh the national review of the neonatal workforce - part of development of England's Neonatal Toolkit. Jean is currently chairing the National PHE External Reference Group for Data and Intelligence for Maternity, Neonatal and Paediatrics. She is married with two adult children, enjoys flower arranging and is training to become a demonstrator.

Dr K Elaine Madden MBE. RFN RN RM PhD registered as a fever nurse in 1974 and general nurse in 1977. She completed midwifery training in 1979 and rotated throughout the Ulster hospital maternity care setting whilst looking after her 3 children. Her career progressed in 1997 when she was appointed Labour ward sister followed by a practice development post in 1999. During this time Elaine set up multi professional meetings, teaching sessions in resuscitation and monthly real time drills which became the focus for her PhD studies at the University of Ulster:

In 2004 Elaine became Lead Midwife at the Ulster hospital and retired as Head of Midwifery & Gynaecology for the South Eastern Trust ten years later. She was involved in the design of the new maternity buildings and was instrumental in setting up the alongside MLU on the Ulster site where 50% of births are facilitated in water with an option of 7 water pools ensuite to the low risk labour rooms.

Elaine supported the opening of the first stand-alone MLU in Northern Ireland, at Downpatrick, followed by a second stand-alone unit at Lagan Valley hospital. She was an Expert Midwifery Partner for NIPEC and the DLS, an ALSO instructor, Reviewer for Midwifery Journals & Conference papers and is a member of the Doctoral Midwifery Research Society. Elaine has been involved in a number of maternity reviews, and was awarded the MBE for her services to maternity in Northern Ireland in the Queens Honours List in June 2014

Lay reviewer

Kate Branchett BA is Patient Voice and Insight Lead for the West Midlands Strategic Clinical Networks and Senate. Kate has a real passion for improving the experience and care of all patients and their families. A relative newcomer to the NHS, Kate has previously worked as a Music Teacher, National Sales and Marketing Manager for a company selling school uniform, Parent Services Administrator for the National Childbirth Trust and most recently GP Carer Support Advisor in surgeries across Worcestershire.

Kate is married and is mum to Ben, 9, Molly, 5 and William, 1. Her interest in healthcare and improving services was sparked by the extremely premature birth of her twin daughters. Izzy was born at 22w4d and did not survive. Molly, born 8 days later spent 101 days in neonatal care, and is a happy, healthy 5 year old. Kate has worked with SANDs, BLISS, NCT, her local Maternity Services Forum and the Southern West Midlands Maternity and Newborn Network as a patient/parent representative. She co-authored an inductive study 'Neonatal Palliative and End of Life Care: What Parents Want From Professionals'. Kate is vice-chair of the RCPCH Parent and Carer Panel and prior to her employment by the NHS, was also a member of the West Midlands Clinical Senate Council.

Management Support

Sue Eardley joined RCPCH in 2011 and since 2012 has led the Invited Reviews programme. Originally an engineer /project manager in the oil and gas industry Sue changed career when the first of her three children arrived, with 13 years as a non-executive and then Chair of a London acute trust, and various voluntary work including national and local user representation and as a Council member of the NHS Confederation. Sue led groups contributing both management and user input to the DH England Maternity NSF and chaired her local MSLC for four years Before joining the RCPCH Sue spent six years full time heading up the Children and maternity strategy team at the Healthcare Commission and then CQC, overseeing strategy, design and delivery of all inspections and reviews in England of maternity, child health and safeguarding.

Appendix 2 Contributors to the review

The Review team interviewed a wide range of clinical and non clinical staff from the Health Board and from those organisations which work with the services, as listed below. They are too numerous to mention individually. We also listened extensively with other staff, public, patients and their representatives through a webinar, two public meetings, one meeting in public, a web and paper-based survey, and openly available e-mail and telephone accessibility.

Staff input Hywel Dda and Withybush sites

Consultant and non-consultant Obstetricians including clinical lead
Consultant and non-consultant Paediatricians including clinical lead
Consultant anaesthetists
Midwifery managers – grade 7, 8, 9
Midwives working in community, MLU and labour ward
DAV manager, paramedics, technicians
Risk manager
Senior management – Divisional manager, Medical Director, Head of Planning
Chairman and Chief Executive
Community nursing managers
Communications team members
Emergency department staff
Administrators and HCAs

Other stakeholders

WAST representative
Neonatal Network and Singleton NICU representatives
GP representative
Community Health Council

832 online survey forms completed
25 hard copy surveys submitted
Various letters and direct communications

External communications seeking input about the review

Local MPs and Assembly members
Pembrokeshire and Carmarthenshire children's and youth centres
Local Medical Committee representatives
GP practice managers
Items in newspapers, via facebook and Health Board communications.

Appendix 3 Standards and reference documents

The following standards and guidelines were used by the review team in making their judgements and recommendations.

Women's Health

Safer Childbirth – minimum standards for the organisation and delivery of care in labour (RCOG/RCPCH/RCM/RCoA 2007) sets out UK standards for obstetric intrapartum care including consultant staffing arrangements and availability of facilities such as interventional radiology. Paediatric staffing is covered on pages 37-39 and links to BAPM 2001 standards which have since been updated.

Standards for Maternity Care - Report of a Working Party (RCOG/RCPCH/RCM/RCoA 2008) defines 30 clinical and service standards for the maternity care pathway including for neonatal care and assessment, care of babies born prematurely or requiring additional support and child protection ,

Safe midwifery staffing for maternity settings CG4 (NICE 2015) The guideline focuses on the pre-conception, antenatal, intrapartum and postnatal care provided by midwives in all maternity settings, including: at home, in the community, in day assessment units, in obstetric units, and in midwifery-led units (both alongside hospitals and free-standing).

Responsibility of Consultant On-call RCOG Good Practice No. 8 (RCOG 2009) provides interim guidance to support locums and trainee doctors pending redesign of consultant led services.

Standards for Birth Centres in England, (RCM, 2009) sets out requirements for midwife-led birth centres and Birth Centres Resource – a Practical Guide follows on from the Standards and is aimed at all who are developing a birth centre including; commissioners, managers, clinical leaders, third sector organisations, midwives and users. It is a practical tool based on actual experiences. It promotes normality and prioritises safety within midwifery practice, valuing skills by confident and competent midwives in delivering woman-centred care and autonomous decision making

Neonatal Support for Standalone Midwifery Units – a framework for practice (BAPM 2011) refers specifically to the provision of neonatal support for delivery units that are not co-located with obstetric services and where there is no immediate access to neonatal or paediatric staff.

NICE guidance CG62 - Antenatal care
NICE guidance CG190 - Intrapartum Care
NICE guidance CG37 / QS37 - Postnatal care

Evidence note for freestanding MLUs (Healthcare Improvement Scotland 2012) explains safety considerations and factors for service design

All Wales Midwife Led Care Guidelines – set out requirements for the All Wales Maternity pathway

Maternity Dashboard – Clinical performance and governance score card RCOG good practice advice No. 7 Provides guidance to urge all maternity units to consider the use of the Maternity Dashboard to plan and improve their maternity services

National service framework: children, young people and maternity services (DH England 2004) a ten-part comprehensive set of standards from conception to 19 years, Section 10 covers maternity

Maternity care facilities DH Health Building Note 09-02 (DH England 2013) Sets out requirements for labour ward and other facilities suitable for effective care.

Staffing in maternity units – Getting the right people in the right place at the right time. (King's Fund 2011) The King's Fund commissioned further research to answer a fundamental question: Can the safety of maternity services be improved by more effectively deploying existing staffing resources?

Guidance on the provision of obstetric anaesthesia services RCoA 2014 sets out requirements for staffing and procedures for maternity units.

Neonatal services

Categories of Care (BAPM 2011) sets out the definitions of intensive, high dependency, special and transitional care for neonates.

Service standards for hospitals providing neonatal care 3rd edition (BAPM August 2010) defines medical and nursing staffing levels and links closely with the NICE and DH documents and Quality Standard and Toolkit.

The BLISS Baby Charter and Audit Tool (BLISS 2012) provides a framework for units to examine key aspects of their service provision and to help staff make family centred care a reality

Paediatrics

Medical Workforce Census 2013. (RCPCH January 2015) The census data provides detailed national information on staffing grades and service provision in community services, collected by biannual member surve

Job Planning Guidance (BMA and NHS Employers, 2013) provides advice and guidance on job planning for consultants. There is a separate document for SAS doctors.

Facing the Future – a review of Paediatric services (RCPCH 2015) updates the original 2011 guidance and details ten service standards relating to clinical cover, expertise and child protection.

Guidance on the role of the consultant paediatrician in the acute general hospital (RCPCH May 2009) sets out a range of models of paediatric care including consultant of the week, resident on call and includes information on job planning, rotation and competencies for acute care

Short Stay Paediatric Assessment Units advice for commissioners and providers (RCPCH 2009) sets out models for provision of observation and assessment facilities to complement emergency care and reduce pressure on inpatient services. (this document is being revised by RCPCH in 2016)

Intercollegiate Standards for care of CYP in emergency care settings (RCPCH 2012) covers staffing, training, facilities, communications and interfaces set out in a clear style and agreed by all professional colleges involved with urgent and emergency care.

Children and Young People with Complex Medical Needs (RCPCH Intercollegiate, 2014. Developed by the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings, this supplement is aimed at all healthcare professionals working in emergency care. Relating to the Standards for Children and Young People in Emergency Care Settings published in 2012, the supplement provides five standards for the emergency care of children with complex or additional medical needs.

Spotting the Sick Child Is an interactive tool commissioned by the Department of Health in England to support health professionals in the assessment of the acutely sick child.

The acutely or critically sick or injured child in the district general hospital – a team response (DH and intercollegiate 2006 – " Tanner report") details issues around anaesthesia and other services available. It has 42 clear service and competence recommendations and provides a clear checklist when reviewing urgent care services.

High Dependency Care for children- Time to Move on RCPCH-PICS 2015 defines Level 1,2,3 Paediatric Critical care (PCC) units and sets out standards for care in Level 1 and 2 units including network working and commissioning arrangements for England.

Standards for the Care of Critically Ill Children (Paediatric Intensive Care Society, 2010)sets out measurable standards for care from arrival at hospital ED through reception, assessment, inpatient, HDU/ITU and general care across services. Sections on anaesthesia, retrieval and transfer complete the pack

Appendix of guidance to the Standards for care for Critically Ill Children (Paediatric Intensive care Society, 2010) supports the standards with checklists and tools to enable clinicians and managers to establish effective arrangements are in place. These include details of knowledge and skills required, guidance on resuscitation training, referral information, and support for families.

Safeguarding Children and Young People: Roles and Competences for Health Care Staff, (RCPCH RCN RCGP 2014). Provides a competency framework for all groups (ranging from non-clinical staff to experts), information on education and training and role descriptions for named and designated professionals. This document will help all health staff understand their responsibilities in recognising child maltreatment and how to take effective action.

Nursing

The Future for community children's nursing – challenges and opportunities (RCN 2014) sets out the current policy direction in the UK and internationally and the requirements for appropriate services to deliver improved outcomes closer to home

Maximising Nursing Skills in Caring for Children in Emergency Departments (RCN, RCPCH 2010) is for emergency department managers, lead consultants and lead nurses. It provides detailed guidance on competence development for nursing staff.

Defining staffing levels for children and young people's services (RCN 2013) updates guidance for clinical professionals and service managers regarding optimal staffing levels in areas where children and young people are nursed, by providing minimum standards and standards relating to workforce planning and workload monitoring.

Safe staffing levels – a National Imperative (RCM, 2013) sets out nurse staffing levels and contributed to NICE guidance in development

Healthcare service standards in caring for neonates, children and young people (RCN 2013) sets out the standards to be applied when caring for neonates, children and young people in all health care settings.

NHS at Home; Community Children's Nursing Services (DH 2011) shares the findings of a Department of Health review of the contribution community children's nursing services, as a key component of community children's services, can make to the future outcomes of integrated children's services.

Summary - centralising specialist care for paediatrics
Decision making is better at Consultant level in terms of clinical assessment and need for admission with lower reattendance rates and fewer children referred on to outpatient follow up. Facing the Future makes the case for fewer but larger units providing safer and more sustainable care, emphasising the need for better consultant (or equivalent) coverage when at their busiest and that paediatrics is a 24 hours per day, seven day per week speciality. With the current workforce issues of difficulty recruiting middle grades and need for further consultant expansion a consultant delivered service depends on fewer larger units and hence the need for some reconfiguration. This was generically supported in "Changing Care, Improving Quality. Reframing the Debate on Reconfiguration" (AoMRC, National Voices, NHS Confederation 2013) who supported the concept of larger units offering higher quality of care 24/7. The RCPCH's Position Statement on Reconfiguration of Children's Health Services (September 2013) again stresses that key drivers are to improve clinical quality and workforce pressures. The King's Fund "The Reconfiguration of Clinical Services. "What Is The Evidence?" (November 2014) acknowledged the relative lack of robust evidence on medical and nurse staffing in paediatrics but did support infants of extreme prematurity <27 weeks gestation or who are high risk be cared for in specialist centralised neonatal services.

Appendix 4– List of Abbreviations (to page 52)

ADHD – Attention Deficit Hyperactivity Disorder
ANNP – Advanced neonatal nurse practitioner
APNP – Advanced paediatric nurse practitioner
ASD – Autistic spectrum Disorder
BAPM – British Association of Perinatal Medicine
CC – Critical Care
CCN – Community Children's Nurse
CHANTS – Cymru Inter Hospital Acute Neonate Transfer Service
CHC – Community Health Council
CNS – Clinical Nurse Specialist
CT1 – Core training level for anaesthetics
DAV – Dedicated Ambulance Vehicle
ED – Emergency Department
EGU – Emergency gynaecology unit
EPU – Early Pregnancy Unit
EMRTS – Emergency Retrieval and transport service
ESN – Epilepsy Specialist Nurse
FMU – freestanding Midwifery unit
FtF – Facing the Future (RCPCH standards)
GMC – General Medical Council
GP – General Practitioner
HD(U) – High Dependency (unit)
HDUHB – Hywel Dda University Health Board
HoM – Head of Midwifery
IC – Intensive care
ITU – Intensive Therapy Unit
LNU – Local neonatal unit
MLU – Midwife led unit
MSLC - Maternity Services Liaison Committee
NICU – Neonatal intensive care unit
OOH – Out of (normal working) hours
PACU – Paediatric ambulatory care unit
PICU – Paediatric Intensive Care Unit
PPN – Partial parenteral nutrition
RCM – Royal College of Midwives
RCN – Royal College of Nursing
RCoA – Royal College of Anaesthetists
RCOG – Royal College of Obstetricians and Gynaecologists
SAS – Specialty and Associate Specialist (doctors)
SC(U) – Special care (unit)
SPA – Special Programmed Activity
ST1, ST2 – Specialty trainee levels of training for paediatrics
TC – Transitional care
WAST – Welsh Ambulance Service (NHS) Trust
WGH – Withybush General Hospital
WTE – Whole Time Equivalent

Appendix 5 – You said, we heard

A5 – 1 Introduction

The RCPCH committed as a component of the review to provide staff and those who had recently used the service an opportunity to contribute their experiences to the review team. We were clear that we could not respond to specific complaints, but wished to gain a flavour of how the service was working under the new arrangements.

We did this through several means between 1st July and 31st August 2015.

- A webinar which generated seven participants
- An online survey which generated 832 responses online and 15 paper responses
- Attendance at HDUHB 'Let's talk health' meeting
- A dedicated public meeting with an estimated 300 people attending
- Publication of an email address for direct contact used by 5 people

We have read every written contribution and noted those expressed at the public meetings. We have also taken into account the helpful report from the CHC which conducted a similar exercise in parallel. We have also been provided with information from the Health Board's feedback and complaints processes.

Given the anecdotal nature of many the responses, it was never our intention to conduct systematic quantitative analysis of the submissions, nor quote every individual cases except where these are indicative of a more general finding. Our focus was on the impact of the change on the service and any 'quick wins' that we could recommend to improve quality and reduce problems or confusion for families using the service.

We are aware that many of the themes picked out below were a result of the rapid process of transition and are being addressed, either through the transport group, the organisational development programme or 'bedding in' of the changes and new procedures. Implementation of this report's recommendations should further address the issues raised and the development of a comprehensive feedback and engagement programme by the Health Board is also a positive step.

A5 - 2 Highlights – messages from service users

The main theme underlying most service user responses is a concern about safety and reliable access to services, particularly in emergency situations and out of hours. Many appear anxious and frightened about what they perceive to have been dangerous changes to their local services.

1. Access to Glangwili

- Increased travel time to Glangwili especially from more remote areas e.g. Fishguard (over an hour)
- Particular concern for non-drivers, single parents, those with disabilities/access needs, low income
- Increased cost e.g. petrol or taxi (e.g. reportedly £120-140 each way from Milton) or childcare (which some said they did not have access to at all)
- Poor/no transportation links especially late at night/Sundays
- Insufficient ambulance/transport to/from Glangwili (see below)
- People reportedly stranded at Glangwili after discharge with no way to get home
- Patients discharged/partners ordered to go home late at night after little/no sleep – concerns about how safe it is to drive
- Some have reported unable to get to Glangwili (due to one/some of the above) and having spent anxious evenings at home with sick children waiting to be able to take them to Withybush at 10am
- Patients admitted whilst partners/carers/children unable to visit

2. Ambulance/DAV

- Insufficient ambulance/transport cover between the 2 sites
- When transporting patients to one site ambulance ends stuck there leaving the other area uncovered
- Slow to access some of the more rural areas (e.g. over an hour in St David)
- Children being transported to Glangwili from Withybush by ambulance but parents unable to join them as need to travel in car to ensure transport at discharge – very scary experience especially for young children

3. A40

- Road poorly maintained/unsafe driving conditions
- Only main access route between 2 sites
- Often closed due to road works/weather/flooding

4. Services at Withybush

- Removal of specialist care for problematic/premature deliveries at Withybush
- Concern about services for epileptic children, especially during the night – extra travel/safety
- Parents with asthmatic children concerned about late night services, issues with wheezing/travel times/safety
- Removal of antenatal classes leaving women uncertain and anxious about what will happen when they go into labour

- Community team late for visits as they don't know the area
- Lots of comments about how excellent the staff and services were prior to the changes, and confusion about why these have now been removed – particularly compounded by issues at Glangwili (see below)
- Increased waiting times in ED (4 hours+)
- Unhappy having to be transferred to Glangwili at 10pm
- Many positive comments about the staff and services which are still available

a. MLU

- Many positive comments about the staff and services available at the MLU
- Some suggested the service could be expanded with more birth rooms and separate toilets
- However there was some concern about using the service in case complications arise

5. Services at Glangwili

- Long waiting times to be seen on arrival (A&E and appointments)
- Significant overcrowding in wards, with beds very close together, lots of noise, lack of beds available, some left in corridors
- Reports of women arriving to give birth/have caesarean/be induced and being turned away and difficulty getting admitted – some of whom say they were then rushed back in an ambulance hours later
- Reduction in play therapy services available as space used for beds after the changes
- Poor signage/directions on site
- Services not very child friendly with little/no children's area
- Lack of space for partners/carers to sit/stay with staff often ordering them to leave, comments of authoritarian staff attitude, partners reportedly sleeping in cars overnight, women unhappy at going into labour alone
- Lack of parking available (1+hour to get parking space)
- **'**….There were only 4 bathrooms for 30ish women. And only 2 of them had baths, which were broken or in poor condition**'**

a. Cleanliness/quality of care

- Patients waiting several hours past due for regular medication/analgesics, having to remind staff for meds
- Several felt that if they weren't healthcare professionals themselves knowing what to ask/look out for, they would have had extremely poor care
- New mothers reporting being left alone on wards with no support/advice on how to care for their babies
- Being unclear who to contact with pre/post-natal queries
- Poor cleanliness on wards
- Patients feeling rushed

b. Staff

- The vast majority of people who had visited reported that staff were doing the best they could in extremely difficult and busy circumstances however were concerned about the resulting reduction in quality of care and safety

- Some reports of rude, unhelpful and disinterested staff members, reception staff were specifically mentioned several times
- Some staff spoke Welsh which the women from Pembrokeshire could not understand
- Poor support for women who have had miscarriage
- Some women felt like asking questions/needing support was being perceived as a nuisance, especially difficult given lack of antenatal classes.
- Felt those who had been transferred from Withybush hadn't been properly inducted – unaware of local protocol

6 Continuity of care/communication

- Appointments regularly cancelled/deferred as understaffed
- Lack of continuity of care/communication between the 2 sites
- Differing reports of when children's ward closes (6/8/9/10pm)
- Patients transferred from Glangwili but on arrival staff unaware and without notes
- Confusion about where care is being delivered across the 2 sites, patients unclear about where their appointments will be, compounded by appointment letters arriving late
- Patients reporting poor communication at shift changes, repeating problems and what has happened to multiple sets of healthcare professionals
- Feel like Health Board has not communicated changes and future plans well, not responsive to queries
- Lack of communication about services available e.g. breastfeeding group

7 Other

- Patients being told by staff they would have been worse off it they had had gone to Glangwili
- Report of being encouraged to seek private midwifery care for some problems
- Many said they heard lots of negative reports about the services/conditions/staff at Glangwili and were extremely anxious about going there
- Some reporting they were considering leaving the area, were re-considering having further children
- Concern about how Glangwili will cope with the increased population over the summer
- Friends/family/media making women feel scared about their pregnancy – making things worse

A5 - 3 Highlights – messages from healthcare professionals

1. Staffing

a. Planning

- General lack of staff planning and organisation of - paediatric teams , A&E, maternity
- Decreased community cover and a need for more community midwives (Geographical area they are now covering is too large)
- Lack of clarity around rotations and insufficient support for junior doctors
- Increased absence and sickness levels, leaving already understaffed teams under increased pressure, with staff working extra hours **'**The same midwife caring for me was supposed to finish her shift at 9pm she did not leave until 12:45am and was back in work at 7am the following morning.**'** (quote from staff member& service user)
- Concern about use of consultants and anaesthetists who have not worked in maternity for 10-20 years (unclear on which site this is)
- Glangwili - Need for more consultants, doctors and nurses. High sickness and general discontent amongst staff
- Withybush:
    - Perception that staffing levels were previously fine as recruitment was ongoing
    - Nursing and Medicine work in silos
    - Reliance on staff in PACU to stay on past 10pm if patients not transferred out by 10pm
    - Inconsistent paediatric staffing

b. Environment

- Glangwili:
    - Poor environment in labour ward, reports of a bullying, punitive culture. Complaints of unsympathetic or obstructive behaviour by colleagues, e.g. when trying to admit **'**no beds/not my problem**'**.
    - Tension and US and THEM culture between staff from different hospitals
    - Concerns from staff that overcrowding and lack of resources are leading to an unsafe environment for patients & resulting impact on personal satisfaction, stress etc.
    - Frustration over **'**offensive press reports**'** and lack of reply
    - Feel unable to deliver necessary level of care - low morale
    - Having to deal with upset, angry patients/parents who have experienced long waiting times/transfer between hospitals/transport issues/accommodation issues
    - Midwives from Withybush used to a certain level of autonomy that isn't there at Glangwili – leading to tension/dissatisfaction
- Withybush - fear of whistle blowing and a culture of fear and bullying. Staff afraid to speak out.

c. Leadership/management

- Need better support from band 7 and management
- Feel there is a bullying style from management
- Lack of support on occasions for junior paediatric doctors from some of their senior team.

- Lack of visibility from health board and management about what they are doing and how services will be improved. Feeling thee has been more engagement with public than with staff.
- Withybush:
    - Absence of leadership in A&E
    - No effective multidisciplinary team leader
    - Lack of communication between management/HB and staff around changes, written and verbal statements from staff around concerns ignored leaving staff feeling alienated, vulnerable and underprepared

d. Future recruitment/retention of staff

- Concerns over how they will recruit experienced doctors with good clinical skills to paediatrics and A&E
- Reportedly numerous doctors and midwives leaving due to the changes and new working environment
- Long way for people to travel to work if on shifts due to poor road network – recruitment/retention
- Midwives - unhappy overworked, resting on goodwill which is going/gone
- Withybush:

    - Great decline in workload, no emergency caesareans, no children's surgery unless there is a guarantee that the child can go home before the paediatric ward closes. This has led to a loss of skills for nurses, anaesthetists, doctors and surgeons
    - significant adverse effect on the working lives of consultant and middle grade doctors
        - Uncertainty around future plans for services.

e. Positive comments

- On both sites there are reports of skilled, dedicated staff trying to deal with a difficult situation, with ward staff supporting each other.
- Some have reported that the amalgamation has improved training and learning opportunities:
    - **‘**The movement of maternity services is necessary to concentrate acuity on one site, so that training and exposure of staff to learning opportunities is increased**’**.
    - **‘**Centralisation of neonatal services has led to standards being met. Stabilisation of middle grade Rotas. Acknowledgement from deanery for moving training forward. Increased resource for directorate in terms of capital, staff, and standardisation of policies leading to quality care**’**
- Glangwili - Whilst there have been some areas of tension and difficulty some have reported that staff are slowly gelling

2. General organisation

a. Implementation of changes

- Many feel that after several years of discussions about the changes the implementation was rushed, without sufficient infrastructure and staffing in place
- Delays to phase 2 of the reconfiguration causing frustration with many wards often at capacity

b. Guidance for staff

- Withybush:
  - Service runs 10-10 but there is still confusion over referrals and many GPS still not sure of service provided. Some patients have been told different hours. **'**Want 'clear protocols/ procedures in place with consultation from all parties involved in particularly out of hours emergency paediatric care and paediatric day surgery.**'**
  - No provision after 7pm for admission of children e.g. child needing surgery having to be transferred pre/post op, dependent on urgency. There is a lack of clear guidance following changes. Paramedics bringing paediatric patients to A&E out of hours for fear of the 40 minute drive to Glangwili No guidance on transferring children e.g. some paramedics refuse due to complexity of situation.
  - GPs and A&E appear not to know that ward 9 is still operational and regularly give patients and ambulance crews the wrong advice on PACU referrals resulting in Pembrokeshire patients making long and unnecessary trips to Carmarthen.

c. Ambulance/patient transfer service

- Concern that ambulances are frequently being used to transport patients to Glangwili which then end up doing emergency calls in that are leaving the ambulance cover in Withybush depleted.

d. Communication between the sites

- Notes stuck in Glangwili when patients will be reviewed in Withybush, dictating of notes/letters to inform everyone of the admission
- different consultants assigned to the care of the patient depending on who is on take
- Suggestion: **'**Better communication. An induction period to allow integration of the two services. None was given apart from a short tour of the unit in Carmarthen**'**

e. Positive comments

- Quote from staff member working across all 3 sites: 'Children are not staying in hospital without reason, our stays overnight have decreased, whilst our assessment numbers have increased. There seems to be a more efficient work up of starting treatment and/or referral onwards to a specialist centre if needed.'
- Some comments that staff are starting to understand the benefits of the new model

3. Services at Glangwili

a. Space

- Overall lack of provision for the expansion – comments calling for more beds, labour beds, space in HDU and Nursery 1, accommodation and room for parents, office space, seminar room, room/space to break bad news
- Overcrowding and lack of space leads to increase in noise making sleep/rest difficult for patients

b. Facilities

- Labour ward not fit for purpose - **'**One lady last week…stated she left Labour ward…without having a wash or shower because there was no toilet or shower attached to her Labour ward room.**'**
- Obstetric unit in not fit to deliver 2000 women. The environment is poor, and very medicalised leading to poor working environment for staff and poor quality of care for women.
- No equipment to deal with neonatal emergencies
- **'**The facilities at Glangwili have not been improved as promised. The consultant led unit has not been updated and there has been no real increase in capacity. A second theatre has not been built. Phase 2 was expected to urgently follow Phase I, but in a year, nothing has happened. There is a real risk to patient safety, as we are working in an environment that is not fit for purpose.**'**

c. Care/Capacity

- Overall feeling the staff are doing their best however services running above capacity, with services seeming stretched even at low capacity. Comments on staffing level of paediatrics and PACU (medical and nursing)
- Long waiting times, concerns about the quality of care. The A&E department reportedly regularly abuse the admission system to benefit their waiting times not the patient.
- Increase in number of complaints from patients about standard of care following reconfiguration

d. Positive comments

- Some have reported the staff are working well with a good patient environment, with more neonatal nurses recruited, and the amalgamated nursing settled down and happier.
- Positive comments about the midwifery led unit and PAU and **'**…New nursery and rooms great Standard of Care High Meeting many neonatal Standards**'**

4. Services at Withybush

a. MLU

- Many mothers to be are concerned about the safety of giving birth so far away from the main obstetric unit in Glangwili and so the MLU in is underutilised.
- Lack of joined up approach with midwives, community midwives, GP's, obstetricians and ANC in the promotion of the MLU for those women who meet criteria
- Concern from staff that low initial take-up of MLU will lead to the Health Board shutting it down before the team have a chance to build women's confidence in using it

b. Services

- Reportedly scanning paediatric patients (ultrasound) from the other sites as they cannot cope however no children's ward or neonatal services. Staff have received calls to arrange for Withybush inpatients in Glangwili to return there their scans
- Feeling that either due to its geographical situation or the proportionally higher number of children with complex needs that Withybush should have been the main medical centre not Glangwili.
- Impact on other services

c. Positive comments

- MLU highly praised by staff and the women who use it
- however it is going to take time to develop confidence of MLC women to use the service
- Staff doing their best to provide gold standard care under extremely difficult circumstances

5. Other

- Concerns that changes have been detrimental to services which will impact the area's desirability as a tourist destination, particularly for pregnant women, impacting the local economy
- Concerns will lead to the long-term depopulation of areas west of Whitland
- Concerns that the A40 repeatedly blocked by road traffic accidents and bad weather in the winter impairing travel between the 2 sites
- Impact of increased travel for some staff transferred from Withybush to Glangwili – issues of road (as above), poor train connections especially on Sundays.
- Feeling that the most disadvantaged women being hit hardest resulting in them disengaging from care completely as they do not or cannot travel so far to check e.g. reduced FMS/borderline BP.
- Community midwives working 7 ½ shift then being on call, no breaks at all and hitting their 14 hour in 24 hour max and not being able to hand over