

Health, Wellbeing and Local Government Committee

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Royal College of Paediatrics and Child Health

The RCPCH is grateful for the opportunity to submit to the Health, Wellbeing and Local Government Committee on neonatal care. It welcomes the recent announcement of increased funding for neonatal services in Wales, but wishes to highlight the pressures facing paediatric and neonatal care in Wales and the non-sustainability of the current model of delivery.

Neonatal networks and transport

Neonatal services across the UK are facing increasing pressures, with a 9% increase in the demand for specialist neonatal services over the last 3 years. In Wales the year on year increase in the birth rate has significantly increased the demand for specialist neonatal care. The pressures within Wales have been confounded by the absence of clearly defined networks of care, and in difficulties in transferring infants between units. This has often resulted in a blocking of intensive care cots by infants requiring high dependency care, leading to a disparity between availability and occupancy of cots.

Therefore the RCPCH strongly welcomes the recent announcement by the minister for approximately £2M in funding for the establishment of neonatal networks across Wales with a comprehensive neonatal database, and the provision of a neonatal transport network. We are aware that the NHS in Wales faces major challenges over funding and provision of services, and so this commitment to develop services is very significant. Importantly this development has led to closer cooperation between the lead neonatal units and the evolution of a clear consensus on how to progress network based neonatal care.

There is widespread acceptance that the geography of Wales decrees that there will not be a one size fits all answer to neonatal transport in Wales, and this is reflected in the models of care being proposed for transport in the South and North. We believe that the proposals are pragmatic and deliverable within the funding provided.

Development of 24 hour neonatal transport

We believe that the model of neonatal transport proposed is achievable within the funding provided, and will offer appropriate care for the vast majority of infants. Although the perfect model of neonatal care is a full 24 hour transport system, we would suggest that it is appropriate to first assess the 12 hour transport model and then calculate the demand on a full 24 hour service. We believe that in a challenging financial environment, future investment into neonatal services might better be channelled to provision of cots.

Sustainability of current neonatal services

A central tenet of the proposed model of neonatal care is the sustainability of the number of paediatric inpatient units offering care to newborn infants, usually co-located with consultant led obstetric units. The RCPCH in Wales believes strongly that the current model of care is not sustainable, and that unless there is a planned redesign and reconfiguration, this will inevitably occur through crisis.

Pressures on Neonatal and Paediatric Services in Wales

Wales has too many paediatric inpatient (and neonatal) units with too many middle grade rotas. There is an urgent need to decrease the number of inpatient paediatric (and neonatal) units and significantly increase the number of consultants in Wales, coupled with improved transport services, a comprehensive community paediatric nursing service and the availability of local enhanced primary care services

Paediatric services commonly comprise three tiers: a junior tier delivered by relatively inexperienced doctors, previously at 'senior house officer' level but now including FP1 and FP2 doctors; a middle tier delivered by more experienced doctors with training at or beyond the level of MRCPCH (usually registrars, ST3/4+ doctors or non-training grade doctors with a similar level of experience); and a senior tier normally delivered by consultants.

The Royal College of Paediatrics and Child Health (RCPCH) recommends what is self-evident under sensible clinical governance arrangements, that there needs to be a 24/7 'safety net' at all acute units admitting sick children. A similar safety net needs to be provided for those units delivering babies who are at risk or requiring advanced resuscitation - usually consultant-led obstetric units. This cover is almost always provided by the middle tier.

Although in larger busier units there may be separate middle doctors covering paediatrics and neonatology, in smaller units this is usually provided by a single doctor. There are no opportunities for rota sharing with other specialties; paediatrics is specifically excluded from 'Hospital at Night' arrangements. There are no opportunities to employ nursing staff to deliver this middle grade role; the only acceptable substitute for a paediatric middle grade doctor is for a consultant to provide the safety net cover. Units that cannot maintain a suitable safety net arrangement should be viewed as non-viable, but the interdependency of paediatric services with A&E provision and consultant-led obstetric provision ensures that the impact of this is considerable.

Wales has proportionately more paediatric inpatient units and more children's beds than other countries in the UK. Scotland with potentially the greatest geographical service delivery challenges has the lowest number of inpatient units at 1.73 units per 100,000 children; while Wales is noticeably higher than the other countries at 2.5 inpatient units per 100,000 children. Similar trends are seen for

paediatric beds per 100,000 children.

Of the 215 neonatal units in the UK in 2007, 13 were in Wales. Wales and Northern Ireland had a proportionately higher number of BAPM level 3 neonatal units than other countries within the UK. The RCPCH census of the Paediatric medical workforce in September 2007 identified a total of 249 career-grade doctors in Wales and, with the exception of Northern Ireland; Wales had the lowest proportion of consultants to career-grade doctors within the UK. Although the number of consultants in Wales is not markedly dissimilar to the rest of the UK, the proportionally greater number of inpatient services means that there are fewer paediatricians per acute on call rota than in the rest of the UK.

However the current crisis and the need to redesign the provision of paediatric and neonatal services results from the decreasing availability of middle grade doctors. The European Working Time Directive (now officially referred to as the Working Time Directive - WTD) and came into force in 1998, and since then the maximum number of hours worked by junior doctors in the UK has decreased to 58 hours per week in 2004, to 56 hours per week in 2007, and to 48 hours per week in 2009. Under exceptional circumstances there is the opportunity to apply for the short term derogation of specific rotas from 48 to 52 hours.

Paediatrics appears to be the specialty under greatest pressure, and as a region Wales has also faced considerable difficulties in recruiting staff, and this is reflected in the applications for derogation of rotas. In 2009 the UK government applied for the derogation approximately 200 rotas across the whole of the UK. Of these 20% were for paediatric rotas, a third of which were in Wales. It is noteworthy that derogation was applied for all paediatric rotas in Wales, and that paediatrics accounted for over 2 of 3 derogated rotas in Wales. Despite this all paediatric units in Wales are struggling to maintain services, and the situation appears to be worsening.

The RCPCH believes that there must be a redesign of paediatric and neonatal services in Wales resulting in the reconfiguration of the current provision. This can occur either in a planned manner, or as a result of crisis, but the number of acute units will need to decrease. This will have significant financial and political cost.

Summary

The RCPCH strongly welcomes the investment in neonatal services in Wales, and this has acted as a spur to greater cooperation between neonatal units in Wales. However the limits on junior doctors' working hours and the consequent need for increasing numbers of junior doctors has determined the non viable nature of the current provision of services resulting in non- sustainable pressures on neonatal services in Wales (and the rest of the UK). Wales has too many paediatric inpatient and neonatal units with too many middle grade rotas. There is an urgent need to decrease the number of inpatient paediatric and neonatal units and move towards a consultant delivered service, coupled with improved transport services, a comprehensive community paediatric nursing service and the availability of local enhanced primary care services. The needs of patients and the highest possible quality of care are pivotal - the prerequisites for future services must be quality, safety, sustainability and accessibility.