

**Health, Wellbeing and Local Government Committee**  
**HWLG(3)-18-10-p4**  
**17 November 2010**

**Welsh Assembly Government Inquiry into Betsi Cadwaladr  
Maternity and Child Health Review**

**Submission from acute paediatricians at Glan Clwyd Hospital**

We are acute general paediatricians working at Glan Clwyd Hospital in Central Area of Betsi Cadwaladr University Health Board (BCUHB), and as such, we act as advocates for children, young people, and their families in our area.

This paper outlines the concerns we have had with the current Maternity and Child Health Review

The Review was set up to consider ways of reconfiguring maternity and child health services in North Wales. The drivers for this review were concerns with the safety, quality and sustainability of maternity and child health services provided by BCUHB, the health board covering North Wales. These services are currently delivered across the community and from three acute hospital units, Ysbyty Gwynedd in Bangor, Ysbyty Glan Clwyd near Rhyl, and Ysbyty Maelor in Wrexham

We are in agreement that a review needs to take place. We acknowledge the energy and commitment of those leading and facilitating the review process, which has been a useful and illuminating process. However, we feel that the way that the initial stages of the review process have run were extremely unsatisfactory and were liable to lead to poorly informed decision making. This posed a real risk of choosing an unwise option for delivering service to children, young people and pregnant women in North Wales.

Our particular areas of concern have been

- that the starting point from the Project Board running the Review appeared to discount any version of keeping three acute units open across North Wales
- that there was a failure to engage key stakeholders in the process
- that there was a failure to consider our written input into the process or to act upon information that we supplied
- that the Project Board asked stakeholders to discount options about configuration of services without providing sufficient information to enable an informed decision. Impact assessments of the more radical options had not been undertaken
- that there was a lack of impartiality and balance in the presentations and information set before stakeholders in the second stakeholder meeting. This immediately preceded the moment when delegates were asked to consider and discount options.
- that there was an apparent wish to avoid public consultation

We acknowledge, and are grateful, that since concerns have been raised about the Review, the Project Board has taken steps to address each of these issues and has lengthened the Review

process to allow further information gathering and engagement. Nevertheless, we feel that until these concerns had been raised, there was a very real risk that far-reaching decisions affecting thousands of patients could have been taken prematurely and without the necessary detailed consideration of safety, quality, logistics and cost.

## The process of the Review, and our concerns

The Review is run by a Project Board. As part of the process, two workstreams (one for maternity, gynaecology and neonatal services, and the other paediatric services) were established to undertake the necessary groundwork to inform the larger stakeholder meetings. The first stakeholder meeting on 9<sup>th</sup> September was used to set the context for the review, examine the drivers for change and to establish the current situation. Delegates were then asked to generate as many options as possible that might address the challenges being faced. This was termed the *long list* of options.

The subsequent workstream meetings were encouraged to whittle down the *long list* of options to a *short list* to be presented to the second stakeholder meeting. Amongst the many permutations suggested, four main possibilities emerged, which were in essence:

- A keeping all three in-patient sites (Bangor, Rhyl and Wrexham) open with reduced services
- B downgrading Wrexham to a day unit and outpatients, but keeping Rhyl and Bangor open
- C downgrading Rhyl to a day ward and outpatient unit, but keeping Bangor and Wrexham open
- D downgrading Wrexham and Bangor and having a single large combined unit in Rhyl.

We were extremely concerned that it took considerable lobbying to keep any version of a three centre option (option A) on the table. We felt that although it claimed an open approach, the Project Board seemed to have started with an in-built mindset that any version of three centre model was completely unsustainable. This mindset appeared to have been reached **before** full evaluation was made of the safety, quality, logistics, sustainability and cost of the other options being suggested. To have as a starting point a mindset to rule out any version of the model of service that had evolved successfully over many years, in favour of radical new options that had not been worked up, seems extremely ill-judged and not in keeping with the principles of a formal review.

In this respect, we were glad that we were eventually able to keep a three centre option on the table for further consideration.

As paediatricians at Glan Clwyd hospital (Rhyl) we had engaged readily and fully with the process, along with our nursing, midwifery and obstetric colleagues, but we had become increasingly concerned that there was a serious lack of information, an absence of impact assessment, a failure to engage key stakeholders, and an apparent momentum gathering that would cause the second stakeholder meeting to be unfairly influenced.

Accordingly, we wrote to the Project Board to share our assessment of the different options, and to warn of our concerns about the way the process was running. This letter was sent a week before the second stakeholder meeting, and is attached as appendix 1. We received acknowledgement of receipt, but our letter appeared to have been filed away, and not included as pertinent information for the second stakeholder meeting. Given that it represented the considered views of six paediatricians intimately involved over many years with running and delivering the paediatric services at Glan Clwyd, we were surprised at this. It was not added to the list of relevant information

on the Review intranet page, it was not circulated to delegates before the stakeholder meeting, and it was not tabled at the meeting. No reference was made to it in the presentations.

No preliminary papers were circulated to delegates before the second stakeholder meetings other than the agenda (appendix 2). It was significant that the short plenary session allowing comments from the floor was scheduled to take place only **after** delegates had been invited to begin the decision making process.

At the second stakeholder meeting on 5<sup>th</sup> October, delegates were assigned to 20 different tables. In the introduction, it was explained that after some initial presentations, the delegates would be asked to consider the short list of four options (as above) and if possible, to discard two of these options. Following this, the remaining two options would then receive further examination in the workstreams, before final consideration by the Project Board who would then choose the “preferred option”. The preferred option would then be presented to the Health Board. In other words, if two options were discarded by the voting of the delegates at the stakeholder meeting, they would not be given further consideration.

We were then given a series of presentations. The speakers were presumably chosen by the Project Board, and gave what could only be described as heavily loaded presentations – heavily loaded away from the possibility of keeping three in-patient units open. Many of those present felt that the whole process was a “done deal”. It is to the great and lasting credit of the assembled delegates that considerable numbers declared themselves unable to reach a decision due to the lack of crucially important information.

Stakeholder meetings in any review process should be provided with clear, comprehensive, balanced and relevant information, including impact assessments of options under consideration. Without such information, it is clearly impossible for delegates to draw sensible conclusions.

However, the second stakeholder meeting seemed very clearly set up to influence delegates away from the option of keeping three 24 hour in-patient units open at Bangor, Rhyl and Wrexham, and towards the options of downgrading either Rhyl or Wrexham to a service without a 24 hour cover and inpatient facilities.

In the short plenary session, one of our number expressed extreme concerns with the whole process. Concerns included failure to present the opinions of the paediatricians as expressed in the letter, failure to undertake any realistic impact assessments of options involving downgrading units, failure to provide any attempt at costings of the various options, and failure to provide a level playing field for consideration of the options.

Had delegates followed the promptings of those leading the stakeholder meeting without demur, a decision of very great significance for the care of children, young people, their families and pregnant mothers could have been taken with completely inadequate assessment of the implications.

The subsequent and commendable decision of the Project Board to extend the process for further information gathering and impact assessment was an inevitable consequence of the strength of feeling expressed at the stakeholder meeting and in the immediate aftermath.

We were grateful that the Project Board subsequently agreed to circulate our letter to delegates who had attended the second stakeholder meeting, along with (to their credit) a preamble voicing our disquiet with the running of the stakeholder meeting – appendix 3

## **Specific concerns**

### **Failure to engage key stakeholders**

The Review failed to engage a voice early on from the general practitioners, one of the key stakeholder groups in the process. At the first stakeholder group meeting in Venue Cymru in Llandudno, with over a hundred delegates, not a single GP was amongst the stakeholders present. Invitations had been issued electronically to some GPs, but the wording of the invitations (appendix 4) made no mention of the potentially enormous changes in service provision that would be discussed – many of which have massive and immediate implications for their patients. A considerable number of GP practices did not receive the invitation, due (we understand) to using out of date e-mail addresses. The bland nature of the invitation was in our opinion unlikely to generate engagement from busy GPs. As a result, GPs had not been engaged in the process. This was a very significant flaw in the process.

Having drawn this problem to the attention of the project board, we were invited to consider ways in which the GPs could become engaged. We took it upon ourselves to contact a number of practices by phone, and this led to rapid engagement

### **Lack of critically important information**

The speed of the process severely limited the ability to accumulate evidence to help assess options under consideration. As a consequence, insufficient information was presented to stakeholders to consider the options in a realistic way.

A typical example of missing but crucial information was the lack of an impact assessment for transfer of patients in options B, C and D. If one or more units is downgraded, patients from there would need to be transferred in significant numbers on a daily basis. Apart from considerations of safety and quality, it is clear that this would pose major logistic challenges for the ambulance services, and would also be an operation involving significant cost. It might therefore be expected that this issue would have been carefully assessed and a clear plan placed before delegates before inviting them to discard unsatisfactory options. This was not the case. No impact assessment had been carried out whatsoever.

A further example of missing information was the lack of a detailed examination of the consequences of downgrading one of the units for the other units. Clearly, if one unit does not take in-patients, the other units must absorb these patients. This will involve an increase in physical capacity, and also an increase in staffing requirements. Again, it might have been thought that this would be crucially important information for the delegates at the second stakeholder meeting, but again, no such impact assessment had been made.

It should be added that we had supplied information to the Project Board relating to the numbers of patients potentially needing transfer in the event of downgrading one unit, along with an invitation to consider these fundamental aspects (appendix 5). This had not been followed up by the time of the second stakeholder meeting.

### **A perceived attempt to avoid public consultation**

We were concerned that the financial pressures which clearly are a major driver for the review were presented instead as as a *constraint* on the choices, with quality and safety concerns being paraded as the *drivers* of the exercise. Even on the most superficial view, this is clearly a misrepresentation.

We were informed on a number of occasions by members of the Project Board that if options were chosen on the basis of *safety and sustainability* (in other words that it was impossible to conceive any other way of preserving safety in the service) it would not necessarily lead to trigger public consultation, even if it involved major changes to services such as downgrading a unit. We were therefore drawn to the uncomfortable conclusion that the decision to limit drivers to safety and quality issues could have been a mechanism to avoid the uncomfortable spotlight of a public consultation when radical options were chosen.

At the second stakeholder meeting an impromptu show of hands from delegates indicated that an overwhelming majority of those present agreed that public consultation should take place if radical options were chosen.

We are extremely glad that the Health Board has since agreed that if “material change” is contemplated (ie downgrading of a unit), that formal public consultation via the Community Health Council will take place.

### **Representation on the Project Board**

Due to unforeseen circumstances there was poor representation of Central area on the Project Board. The two Chiefs of Staff (CoS) for Paediatrics and Maternity from Wrexham and Rhyl respectively were the original co-chairs of the Project Board, and were committed to represent their clinical programme group rather than their geographical origins. When the CoS for Maternity had to step down due to health problems, his place was taken by a CoS from Bangor.

Other members of the Project Board had been drawn almost exclusively from Wrexham or Bangor. Whilst we have no reason to doubt their impartiality, this situation sat uneasily with the widespread perception that Rhyl was in the firing line for downgrading. It would have been wise to have anticipated such perceptions and address them by organising the Project Board to include clinicians or representatives with a perspective from Central Area.

### **A Short-term Mindset**

We were concerned that the Review had a short-term emergency mindset; by which we meant an urgency and momentum that failed to consider the possibility of later change in wider circumstances, eg significant changes to European Working Time Directive, immigration law, and longer term, potential easing of financial pressures. Failure to take account of these factors may lead to irreversible decisions being taken with configuration of services which could later be regretted. In other words, once a service is withdrawn it becomes much harder to re-instate it.

### **Presentations at the second stakeholder meeting**

We felt that the presentations at the beginning of the second stakeholder meeting did not present the balanced and impartial view that was clearly required for such a process. They included:

#### *Financial Context*

This presentation provided an overview of the extremely difficult financial circumstances of the Betsi Cadwaladr University Health Board. These were sobering figures, and were put forward to support the contention that the current configuration of services is not sustainable. This may be so, but we were then by implication invited to accept an unproven assertion that moving to a two unit model of service delivery would be likely to provide an answer to the financial problems. This was put forward

without any detailed analysis whatsoever of the costs of such a radical change – both short term and long term.

Delegates were of course very aware of the adverse financial climate, but the sleight of hand suggesting that a two unit model would solve the problem would clearly have influenced them away from the first option of keeping three units open, had not attention been drawn to the absence of any detailed modelling of costing of alternative options, which would carry significant costs of their own.

#### *Accessibility – (Emergency access to hospital)*

This presentation looked at the proportion of the North Wales population that could reach an obstetric led maternity unit within one hour in the event of an emergency. Having three obstetric led maternity units clearly fulfils such a target. Downgrading Glan Clwyd hospital would still allow 98% of the population to reach either Wrexham or Bangor within one hour. It was thus presented as a feasible option that would offer acceptable and comparable levels of access to emergency obstetric care for mothers from Central area.

However, even a moment's inspection of a map of North Wales shows that the average time to get to an obstetric unit in an emergency for mothers from Central area would clearly increase significantly if Glan Clwyd hospital were downgraded. The choice of one hour as the "time target" was drawn from the recent Secondary Care Review, and conveniently gave numbers that would point to Glan Clwyd as the hospital to be downgraded if a decision to downgrade a unit was to be made. If 30 minutes were chosen as the "target time", the analysis would not support downgrading of any unit, let alone Glan Clwyd hospital.

#### *Sustainability and Deliverability - (Recruitment and training of junior doctors)*

A presentation from the Head of School for obstetrics (responsible for training of junior staff in obstetrics) outlined the challenges being faced in recruitment and in training. Delegates were invited to agree that training of medical staff is almost impossible to deliver in a three unit configuration. Moving clearly beyond his Deanery remit, the speaker then proposed that Glan Clwyd should be the unit to be downgraded – apparently ignoring the fact that a further option included downgrading of Wrexham.

Moreover, examination of the Deanery website reporting junior doctor satisfaction with training as reported in the PMETB survey (appendix 6) clearly indicates that it is entirely possible to give good training in units in North Wales.

#### *Service User Feedback – (conversations with patients and families)*

This presentation reported on a small number of conversations with patients and their families about, amongst other things, whether they would be prepared to travel "to receive good quality care". Not surprisingly, if faced with such a question, interviewees said that they valued a local service, but that if it were not available, they would be prepared to travel.

This presentation appeared to be put forward as some sort of valid consultation exercise to reassure delegates that "people wouldn't mind too much" if a unit were downgraded, provided good quality care were given in the remaining units.

The massive public disquiet that has emerged since details of the options under consideration have become more widely known clearly indicates the true feelings of patients and their families.

## **Summary**

We understand the need to review services, particularly at times when there are real concerns about safety of care, quality of care and an adverse financial climate. We acknowledge the hard work and dedication shown by those organising and running the Review.

However, we feel that the way that this Review was carried out did not fulfil the necessary requirements of a review of this importance.

We welcome the steps that have been taken to address the concerns that have been raised, and the fact that a decision has been taken to extend the Review.

Duncan Cameron

Peter Stutchfield

Ian Barnard

Lee Wisby

Markus Hesselring

(Louise Phillips) – absent on compassionate leave

Department of Paediatrics, Glan Clwyd Hospital

November 2010



## Appendix 1

### Letter from Glan Clwyd paediatricians

Dr Brendan Harrington  
Chief of Staff, Paediatric CPG, & Consultant Paediatrician  
Department of Paediatrics  
Wrexham Maelor Hospital

29/9/2010

Dear Brendan,

#### **Re: Maternity and Child Health Review**

As the review process moves to the decision making phase, we felt that we should write to let you know our agreed position on the options under consideration. Having engaged with the review process, and considered the challenges and possible solutions, we are writing to express formally our major reservations about two of the options under consideration on the shortlist.

We would also like to draw your attention to some problems within the review process itself.

#### The two centre model

There currently seems to be a very real risk that radical, inadequately thought out, and poorly costed options may be chosen. In this respect, we refer to the potential downgrading of maternity and paediatric services at either Glan Clwyd hospital or Wrexham Maelor hospital, moving to a two centre service from the current three centres. We wish to spell out clearly that we believe that choice of either of these options would have disastrous consequences for children, young people, and expectant mothers in terms of safety and quality of care, and would lead to logistical nightmares for service delivery with no clear savings.

Whilst we have energetically engaged with the review, and have been prepared to consider all options, we have been particularly concerned that it has proved so extraordinarily difficult to keep a three centre option on the table for both maternity and paediatrics.

#### *Misrepresentation of a three centre model as "unsustainable"*

The creation of the Betsi Cadwaladr University Health Board offered an opportunity to improve efficiency, rationalise services provided, harmonise clinical practice, and to develop speciality services in some clinical areas, with an overall emphasis on improving quality of care. However, finding the £70.8m savings this year to meet the allocated budget has now become the main driver in the future planning of the services, rather than considerations of what is required to provide the population of North Wales with a safe, accessible, high quality and cost effective health service.

The planning process has been devolved to Clinical Programme Groups. In an attempt to achieve the necessary savings, significant funds have been removed from all clinical budgets, immediately creating an overspend for CPGs even to maintain their present service. The financial cuts have been made to all specialities in a blunt fashion, regardless of whether they were previously profligate or prudent - many departments are of course already minimally staffed as a result of the preceding years of efficiency savings. The CPG management teams have been tasked with generating the savings to bring the budget into balance by the end of the year. Faced with such an enormous task, the view that the present service (or some streamlined version of it) is unsustainable has become prevalent, as this is seen as the only way of achieving the necessary savings. This mindset is compounded by the Board's decision to disestablish nursing and medical posts when they become vacant. This then becomes a self-fulfilling prophecy. Staff leave, their posts are not filled, the service gets under pressure, and this leads to intermittent closures, with citing of safety concerns. These closures are then presented as reasons why the current service configuration is "unsustainable".

Information provided at the stakeholder meetings highlighted closures of the units over the last year as a reason for change, whereas they in fact indicate a need for proper funding of a core service for our patients. The recommendations of Royal Colleges and professional bodies have been used inappropriately – their original purpose was to guide provision of best quality service, not to be a tool to decimate areas of service and close facilities.

#### *Failure to include paediatrics and maternity as core services*

The Unscheduled Care Review was undertaken recently to consider the provision of emergency services in North Wales. To ensure timely access to a hospital with full casualty facilities, minimising travelling time to the nearest casualty department, it was decided after extensive consultation that there should be three A+E departments at the three District General Hospitals, each supported by medicine and surgery. This decision was accepted by the Board.

However, it was not considered necessary to state that obstetrics and paediatric services should also be core services. No explanation was given as to why the same reasoning should not apply to children, who comprise 25% of the population. If adults merit the opportunity to be seen promptly and locally by an A+E department backed up by medical and surgical core services, why should children not be afforded the same level of access to high quality care? This failure to accord equal status to children and young people is reminiscent of previous eras when children's services were considered of secondary importance to adult services. A similar argument applies to expectant mothers.

To ensure that there is no increase in maternal, neonatal or child morbidity or mortality, we believe that paediatrics and maternity services must be regarded as core services alongside the three A+E departments.

#### *The potential scale of transfers in a 2 centre model*

In 2009/2010 there were 3435 emergency paediatric admissions to Wrexham Maelor Hospital, 4102 to Glan Clwyd and 4007 to Bangor. Closing one of the units at night from 8 pm to 8am would lead to a significant deterioration in the paediatric care provided to the immediate population, with a need to transfer significant numbers of children each night from one unit to another. Working with data

provided by the information department, it appears that well over 3,000 children per year would require transfer from a unit with a paediatric admissions unit and no in-patient beds. This would produce a chaotic logistical nightmare, tying up teams of ambulances every night to provide transfer. Some of these children would inevitably be quite unwell, and may need nursing or medical escorts. Transfer of children in this way inevitably leads to an increase in risk to them.

Whilst it might be the case that children would be referred for admission direct to East or West from outlying areas of the current catchment population, it remains the case that parents will continue to bring sick children to the nearest A+E. In addition, the out of hours service for our catchment population operates from the Glan Clwyd campus, so all children in the area needing review out of hours will of necessity be brought there. Similarly, ambulances will always bring those who are in need of urgent attention to the nearest A+E even if 24 hour inpatient provision is not available.

For these reasons, we are clear that there should be three inpatient units for paediatrics in BCUHB.

#### *The two centre maternity option*

Whilst we risk straying out of our territory by commenting on the options available for maternity services, we would also have very major reservations about any prospect of going to a 2 centre obstetric model, with either Glan Clwyd or Wrexham having a midwifery led unit or no unit for delivering babies at all.

There has been a progressive rise (15%) in birth rate over the past five years which with the increase in migration to North Wales is set to continue. In 2009 there were 2648 total births at Ysbyty Maelor, 2446 at Ysbyty Glan Clwyd and 2189 at Ysbyty Gwynedd.

	Caesarean section total	CS % total births	Emergency CS	Emergency CS % total	Planned home births	Home birth % total
Maelor	671	25.3%	440	16.6%	52	2%
Glan Clwyd	725	29.6%	489	20%	36	1.5%
Gwynedd	445	20.3%	265	12.1%	70	3.2%

It is doubtful whether the maternity units in Wrexham and Bangor have the capacity to take on the extra 2400 obstetric led deliveries, particularly since the stand alone midwifery led unit at Glan Clwyd is not considered feasible. The logistical implications of having two units rather than three are considerable.

If there was removal of the ability to deliver babies at Glan Clwyd hospital, we feel that this would constitute a massive deterioration in services for pregnant women from the central area. In addition to there being a major problem of access both for emergencies and for family visiting, there would be immediate safety concerns also. Whilst we do not wish to engage in shroud waving, it seems inevitable that the lives of mothers and babies will be put at risk on a regular basis. The frequency of

code 1 emergency caesarian sections in our unit are a stark testimony to the regular need for immediate obstetric interventions for mothers and their babies. Last year in Glan Clwyd hospital there were 45 code 1 sections – meaning that operative delivery should occur immediately; there were 172 code 2 sections – meaning that delivery should be achieved within 15 minutes. Removing facilities to East and West would very significantly increase the chance of obstetric or newborn catastrophe. These risks are heightened with consideration of the high rates of deprivation present in many areas of the coastal strip in Central area – mothers in such settings have less access to transport, are more likely to have high risk pregnancies, and are more likely to deliver prematurely.

Again, we feel that Obstetrics and Gynaecology should be core services available in any District General Hospital. To make provision for other adults by running medical and surgical teams to back up A+E, only to deny the same level of service to pregnant mothers, would seem to be clearly inequitable.

#### *Neonatal services*

There have been two comprehensive external reviews of neonatal services, the last being five years ago. Both have concluded that there should be only one Level 3 neonatal intensive care unit in North Wales sited at Glan Clwyd Hospital. The arguments have been rehearsed over and over again, and do not need to be revisited. This unit would provide intensive care for the North Wales Neonatal Network which has 7283 deliveries last year.

There are three Level 3 neonatal intensive care units in South Wales. These are

- University Hospital of Wales, Cardiff with a birth population of 9903 deliveries,
- Royal Gwent Newport (17 miles from Cardiff) with 5732 deliveries and
- Singleton Hospital Swansea (40 miles away) with a birth population of 9448.

These three units have received considerable resources from their Trusts to meet the BAPM standards and Welsh CYPSS neonatal standards, with each centre having a separate neonatal consultant rota, each with 7 consultants and a separate middle grade rota. With the recent WAG funding for neonatal transport services, each network will be appointing two more neonatal consultants. In addition the Royal Gwent Hospital Newport has just advertised for three paediatric consultants, to support its general paediatric service.

The failure to develop a service of comparable nature for infants in North Wales should shame us all. We do not feel that the option of commissioning all neonatal intensive care from England is either desirable, appropriate or cost effective, and were glad that it was rejected as a shortlist option at the joint workstream meeting.

In North Wales a centrally based neonatal intensive care unit must be supported by a high risk obstetric service to allow high risk babies to be transferred in utero and delivered. This consideration is yet another reason why consultant led obstetric services in Glan Clwyd should continue, and indeed develop, to provide the level of service required for mothers with high risk pregnancies.

High dependency care needs to be developed at Bangor so that babies can be transferred back when they are stable and no longer require intensive care. Unless babies are transferred back closer to

home as soon as possible, the capacity of the unit will be exceeded and babies will then need to be transferred out. There is a shortage of neonatal intensive cots in England. Mothers are having to be transported great distances to be delivered. Mothers from North Wales could face transfer to Liverpool and Manchester or beyond if there is not sufficient provision locally.

We understand that one of the main considerations for our obstetric colleagues is difficulty in recruiting medical staff. With mounting concerns about the impact of EWTD, it is very significant that Andrew Lansley and Vince Cable will be shortly opening further negotiations in Europe to prolong derogation and indeed rehash EWTD. It would be catastrophic to take major steps in reconfiguration of services if the very conditions that provoked change resolve in the near future.

### The review process

We salute the energy and commitment of those leading and facilitating the review process, which has been a useful and illuminating process. However, our concerns with the review process itself are:

- that it has failed so far to engage any voice from the general practitioners
- that the speed of the process has severely limited the ability to accumulate evidence to help assess options under consideration
- that although it has claimed an open approach, it seems to have started with an in-built mindset that a three centre model is completely unsustainable – whereas it has been happy to consider complex and potentially dangerous new options without the detailed scrutiny required
- that the financial pressures which in very large part drive the review have been downplayed, with quality and safety concerns being paraded as the focus of the exercise
- that insufficient information will be presented to stakeholders to consider the options in a realistic way
- that due to unforeseen circumstances there is poor representation of central area on the project board
- that the public have not been fully informed of the potential options under consideration, and that there is no clear mechanism for formal public consultation on the chosen option
- that it has a short-term emergency mindset; by which we mean an urgency and momentum that fails to take into account the possibility of later change in wider circumstances, eg significant changes to EWTD, immigration law, and longer term, potential easing of financial pressures. Failure to take account of these factors may lead to rash and irreversible decisions being taken which could later be regretted.

### *Missing voices in the process*

The maternity, gynaecology, neonatal and paediatric service review was established to consider options with stakeholder groups. At the last stakeholder group meeting in Venue Cymru in Llandudno, with over a hundred delegates, not a single GP was amongst the stakeholders present. Invitations had been issued to GPs, but the wording of the invitations made no mention of the potentially enormous changes in service provision that would be discussed – many of which have massive and immediate implications for their patients. As a result, GPs have not until now been engaged in this process. This is a very significant flaw in the process.

Likewise, there has been minimal consultation to date with the ambulance service, when the implications of some of the options under consideration are again massive. The prospect of transferring large numbers of children across North Wales on a daily basis is a logistical nightmare. Details of the kind of numbers potentially involved in such transfers have been made available to members of the paediatric workstreams, but these figures were not discussed at the joint workstream meeting at all. It is to be hoped that they will be presented in full for the stakeholder meeting. Furthermore, it is of concern that it is not the intention to go out to public consultation on the proposed changes, because with the inclusion of a wide range of representative groups in the stakeholder meetings, it is considered that this is sufficient to meet the legal requirements.

In summary, we are strongly of the opinion that a two centre service model for either paediatrics or maternity would be a disastrous choice, and after due consideration, we wish to indicate that we would reject such a decision. We acknowledge that to keep three centres open will require further savings and review of service delivery, and have already put forward our suggestions for these. Whilst the review process has been a useful exercise in reviewing options, we also feel that the process itself is open to criticism in a number of important respects.

We look forward to discussing these issues further with you on Thursday 30th September.

Yours sincerely,

Peter Stutchfield, Duncan Cameron, Ian Barnard, Lee Wisby, Markus Hesselting, Louise Phillips.

cc

Mary Burrows, Jane Trowman

## Appendix 2

Agenda for the second stakeholder meeting on 5/10/2010

# North Wales Maternity, Gynaecology, Neonatal and Paediatric Service Review

## Stakeholder Workshop

5th October 2010

The Hall  
Venue Cymru  
Llandudno

12.30	Registration and Refreshments
13.00	Welcome and Introduction
13.10	Presentation – Financial Context
13.20	Presentation – Accessibility
13.30	Sustainability & Deliverability
13.45	Service User Feedback
13.55	Presentation – Shortlisted options
14.10	Group Work
14.50	Refreshments
15.05	Group Work
15.45	Feedback from Groups
16.15	Plenary Session
16.30	Close

## Appendix 3

### Preamble to accompany circulation of the letter from the paediatrician, after the second stakeholder meeting.

*Dear All*

*As promised at the stakeholder meeting, I am enclosing a copy of the letter that we had sent early last week to the project board indicating our position on the options put forward. We felt it should have been included in the debate.*

*We acknowledge the enormous amount of work put in by those organising the review, and their commitment to the process. However we are extremely concerned that yesterday we were:*

- *Provided with presentations pre-loaded against the possibility of retaining any form of three acute units*
- *Expected to agree that downgrading one unit would not lead to a serious deterioration in safety and quality of care for the local population*
- *Given a presentation on service user views of extremely limited scope in the expectation that this would suffice for serious consultation with users*
- *Invited to agree that training of medical staff is almost impossible to deliver in a three unit service (whereas review of the deanery website on trainee feedback in O&G and paediatrics in some units in North Wales demonstrates good results)*
- *Asked to consider two unit options involving major changes in service configuration **without a clear and detailed picture** of how the service would be organised eg
  - *exactly how would transfers of sick patients be delivered? (apparently no impact assessment of proposed changes on ambulance services),*
  - *what would be the implications for staff in the downgrading unit?*
  - *what would be required to cope with the extra patient load at the two inpatient units?*
  - *what would be the impact on perinatal mortality etc**
- *Invited to accept as a “given” that moving to two units would solve the financial problems that we all acknowledge. We feel that the case for saving is “not proven”; after all, there will be no redundancies; the costs of transfer arrangements for patients will be enormous, staff travel or relocation costs are potentially very high etc.*

*It was not surprising that so many delegates yesterday emphasised the difficulty in making choices given the shortage of clear detailed and relevant information. It is unfortunate that the programme for the stakeholder meeting did not allow a fuller airing of views expressing reservations about the 2 centre options prior to the invitation for tables to register their choices.*

*In summary, we feel that although we are all in a very difficult situation at present, we are in danger of jumping into choosing options that lead to poorer quality, increased risk, unmanageable logistical complexity, and with unproven financial benefit.*

*We also feel that, given the nature of the proposals under consideration, full public consultation should follow any decision of the board to downgrade services in either Wrexham or Glan Clwyd, and in this respect were pleased to receive clear support in a show of hands for this, and also the reassurances of Geoff Lang in his closing remarks.*

*With best wishes*

*Duncan Cameron*



## Appendix 4

### Invitation to GPs to become involved with the Review

**From:** Julie Heath **On Behalf Of** Practice Manager - W91002

**Sent:** 10 August 2010 15:58

**To:** Janet Cameron; Tom Kneale; Alun Surgey; Glyn Roberts; Jim Seddon; Oliver Prys-Jones; Richard Barrie; Sian Woodward

**Subject:** FW: IMPORTANT: GP representative for Maternity & Child Health Review Project Board.

**Importance:** High

Dear colleagues,

BCU Health Board, is seeking a GP representative for the Maternity & Child Health Review Project Board. I would be very grateful if you have a moment to discuss with your GP's this invitation, **I can confirm that costs of locum cover would be reimbursed.**

The next meeting will be held on the **19<sup>th</sup> August 1:30 – 5:00 pm Committee Room, Abergelge Hospital, (alternatively GPs are welcome to attend any of the future dates as attached).**

If there are any GPs interested in attending please could you contact Frances Millar via the following e- mail [frances.millar@wales.nhs.uk](mailto:frances.millar@wales.nhs.uk) before 5:00pm on the 17<sup>th</sup> August. This is an excellent opportunity to influence primary care practitioners' views on reviewing the Maternity & Child Health services.

Many thanks

Kind regards

Frances

*Frances Millar*

Rheolwr Moderneiddio/ Modernisation Manager

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Eryldon, Ffordd Campbell Road, Caernarfon, Gwynedd LL55 1HU

**Ffôn/Tel:** 01286 674233/ 07989776685

**Ebost/Email:** [Frances.Millar@wales.nhs.uk](mailto:Frances.Millar@wales.nhs.uk)

*Bwrdd Iechyd Prifysgol Betsi Cadwaladr yw enw gweithredol Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr.*

*Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board.*

## Appendix 5

Information sent regarding potential numbers to be transferred if a two unit model were chosen

14/9/2010

### To the Project Board

Re a 2 site model, downsizing Glan Clwyd to an observation unit and OPD service.

As promised, I enclose a spreadsheet prepared by Geraint Parry from our information team. He looked at the time of admission of emergencies to the paediatric wards in Glan Clwyd during a 12 month period.

I asked him to divide out those that were admitted outside the time that a paediatric observation ward might be expected to run, looking at a model of an 8am to 8pm ward, and assuming that those seen later on – eg around 7pm might need a longer period of observation than to 8pm – thus would require transfer for longer observation/admission.

Of the total of 4114 emergency admissions, around 52% (2141) would have needed admission to another unit if we had purely operated an observation ward.

There are two rough peaks of admission time – late morning and early evening. The latter would be more likely to need transfer for admission.

In a subsequent calculation, I asked him to define the proportion of those emergency admissions coming in during the 8am to 7pm period that needed subsequent overnight stay. The figure was around 40% (I will check that for you – it's in another e-mail). In other words, of those that might have come in to an observation ward, 40% would end up needing to stay the night.

So potential transfers to East or West would be around 2900 per year. This averages out to about 8 per day – but given the increased activity during winter months, this might readily increase to 10 (and, on occasions, more) per day.

This would clearly tie up a lot of ambulance staff. I am certain that they would not be able to operate such a transfer of children in their current state. Even if they set up a new paediatric transport crew dedicated to shipping children East or West, the children in the evening would need somewhere to be looked after while they waited to be transferred. A transfer of one child would probably take two hours each – so you might end up with children waiting through the night to be transferred. They would not be able to arrange a transfer of 5 or 6 children at 7pm just because the observation unit was going to close.

Given that a lot of these children would be discharged the following day (average LOS 1.3 days) it would seem to be a lot of travelling for a brief period of admission.

A limiting factor to this model would be that children seen by GPs and previously sent in from Holywell area would now go straight to Wrexham; likewise those from Llandudno would go straight to Bangor. This would take some numbers off the above. But nevertheless, those ambulances would have to go further to get to a hospital, and this would also tie up ambulance time. And as you know, children from deprived areas are disproportionately high in their admission rates – so the children from Rhyl represent a big part of our admission load.

I would imagine roughly similar figures would hold for Wrexham if they became the unit that downsized to an observation ward. Although, transfer times would be shorter if Chester were picking up their admissions, and people might gradually learn to go to Chester.

Further considerations in these calculations are whether or not children would need trained nursing staff or even medical staff to accompany them if they were particularly poorly. This would be a difficult one to guesstimate – although the numbers would hopefully not be too high.

Thanks for all the hard work you have put in to this daunting task – you set about it in a very fair and positive manner. As you will have realised, I feel that we should not necessarily bow to pressure to have major reconfiguration at all costs because we are in such dire financial straits – we may well find ourselves jumping out of a cash-strapped frying pan in to a more expensive and logistically very complex fire. There are fairly sensible reasons why we have evolved into three units.

Best wishes

Duncan Cameron

## Appendix 6

Junior doctor satisfaction with training, taken from the Deanery website

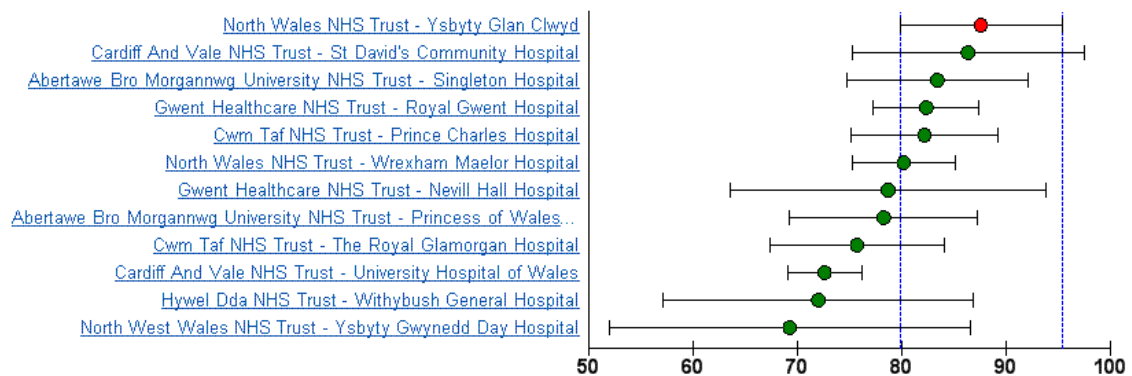
<http://reports.pmetb.org.uk/ComparativeDetails.aspx?agg=AGG24%7c2009&groupcluster=RYP1&indicator=SAT&set=Wales&group=43>

# Comparison across selected group of providers: North Wales NHS Trust - Ysbyty Glan Clwyd Paediatrics 2009 vs Wales

Trainee Survey: specialty trainees by local education provider

## Deanery Overall Satisfaction

This indicator combines satisfaction with each of the key elements of a training post and provides a global satisfaction score. It does not relate to any particular PMETB Generic Standard.



North Wales NHS Trust - Ysbyty Glan Clwyd vs Wales: Deanery Overall Satisfaction