GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Ein cyf/Our ref: CEO.1675.0917
Eich cyf/Your ref: Kelly Sursona
Gofynnwch am/Please ask for: 01267 239581
Rhif Ffôn /Telephone: 01267 239579
Ffacs/Facsimile:
E-bost/E-mail: Kelly.sursona@wales.nhs.uk
Dyddiad/Date: 04 October 2017

Swyddfeydd Corfforaethol, Adeilad Ystwyth
Hafan Derwen, Parc Dewi Sant, Heol Ffynnon Job
Caerfyrddin, Sir Gaerfyrddin, SA31 3BB

Corporate Offices, Ystwyth Building
Hafan Derwen, St Davids Park, Job's Well Road,
Carmarthen, Carmarthenshire, SA31 3BB

David J Rowlands AC/AM
Chair
National Assembly for Wales
Petitions Committee
Cardiff Bay
Cardiff

Dear David

RE: Petition P-05-768 A call for the return of 24 hour Consultant led Obstetrics, Paediatrics and SCBU to Withybush DGH

Thank you for your letter of 7 August 2017, outlining the consideration given to the Save Withybush Action Team (SWAT) Petition P-05-768 "A call for the return of 24 hour Consultant led Obstetrics, Paediatrics and SCBU to Withybush DGH", by the National Assembly for Wales' Petitions Committee.

The Health Board has been requested to comment on three specific areas which have been addressed individually below:

1. Assessment of the Impact of the Changes

Following the revision of the Health Board obstetric, paediatric and neonatal services, two independent reviews of the changes have taken place. The first in September 2015 was conducted by the Royal College of Paediatrics and Child Health but also included the Royal College of Obstetrics and Gynaecology and the Royal College of Anaesthetists.

The review, which is provided here as appendix 1, concluded that there is no clinical sense in reversing the process to date and that:

- There is no evidence of worsened outcomes in maternity or paediatric care as a direct result of the reconfiguration;
- There is an improved compliance with national and professional service standards;
- Although further work is needed to consolidate the staffing and systems, it can be seen that there is a strong future for a single service increasingly integrated across two sites.

The Review made a number of recommendations, and subsequently an action plan was developed by the Health Board and a Monitoring Group established, chaired by the Medical Director. The implementation progress of the actions is reported quarterly to the Quality, Safety, Assurance and Experience Committee of the Health Board and quarterly to the Board.

The 2015 review recommended a follow up review by the RCPCH, specific to the Neonatal Service, a year after the publication of the first report in order to monitor progress. The follow-up review of the Neonatal service was carried out in September 2016.

Three members of the previous review team, plus a Consultant Neonatologist reviewer, undertook a comprehensive document appraisal of information supplied by the Health Board. The team spent two days at Glangwili General Hospital where they spoke with Health Board staff members from the Neonatal Unit and those who work with the Neonatal Unit. The review team also met with the Community Health Council (CHC) and families on the unit. Other stakeholders were encouraged to share their views as part of the review. A report of the review findings and recommendations was written by the team.

The report found that there is no evidence of unsafe care. The RCPCH found that:

- A significant change in culture within the neonatal unit has taken place. An improvement in the morale of the staff, with good evidence of a team who are working more cohesively,.
- Therapy services are more integrated within the unit.
- The neonatal outreach service continues to flourish.
- There is an improved relationship with the Neonatal Network and the Singleton Neonatal Intensive Care Unit (NICU) with better communication and some indication of earlier repatriation of infants.
- There is a close professional working relationship between Glangwili General Hospital and Singleton Hospital, this regarded as a paradigm of engagement for other units to emulate.

In March 2017, the RCPCH report was received by the Board and the outlined recommendations and findings were approved. The action plan developed to address recommendations highlighted within the RCPCH 2016 Neonatal Report was approved during the May 2017 Board meeting. This report is provided as appendix 2.

It was agreed that a joint action plan from the two reviews undertaken would be written and progress monitored by the established Monitoring Group. Reports are regularly provided to the Health Board, the most recent of which was presented to Board in September 2017. This is provided as appendix 3.

2. Monitoring of Perinatal Mortality Rates

The Health Board routinely collects and monitors data on all births (including rates of perinatal mortality and intrapartum stillbirth) for both local review and submission to a number of Wales and UK wide surveys. This includes the nationally recognised AWPSAll Wales Perinatal Survey (AWPS) and the MBRACCE Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries Across the UK (MBRACCE) perinatal mortality surveillance report.

The Health Board reviewed the information in the 'Perinatal Outcomes Audit 2012-16 ' which was published by a retired Consultant Obstetrician & Gynaecologist on the SWAT social media Facebook site. He concluded that the reconfiguration of obstetric and maternity services in 2014 had led to a deterioration in perinatal mortality rates for babies born to mothers resident in the Pembrokeshire area, and that this deterioration is predicted to continue during the next 2 years.

The Health Board has identified a number of concerns regarding the validity of this audit and has concluded that:

- The audit methodology is not statistically valid as the overall volume of stillbirths quoted in the audit is low;
- The categorisation of perinatal mortality used in this audit is unclear;
- There are significant discrepancies between the data reflected in this audit and the validated data available from within the Health Board;
- The audit appears to utilise historical data to 2016 to inform a future predicted increase in perinatal mortality during 2017 and 2018 respectively;
- The data or audit methodology was not shared with the Health Board for validation / verification prior to publication;

- Closer analysis of stillbirths during the period does not support the audit conclusion that perinatal mortality rates are a directly consequence of the reconfiguration of obstetric services.

In response to the points raised by this audit, the Health Board further reviewed all stillbirths ≥ 24 weeks gestation, (inclusive of therapeutic terminations of pregnancy), for the calendar period 2015 to the end of the first quarter of 2017. This data has been analysed to determine the maternal county of residence, and the review presented to the Health Board's Consultant Obstetric & Gynaecology consultant group and received by the Women & Children's Directorate Quality & Safety Committee.

The Health Board's review made a number of conclusions;

Perinatal Mortality Rates

- The number of stillbirths ≥ 24 weeks gestation (inclusive of therapeutic terminations of pregnancy) has increased during 2015 and 2016 compared to 2014 although remains similar to reported rates in 2012 and 2013. These variations remain within the range which is expected to be subject to random variation as the overall volume of stillbirths is low.
- This data is also reflected in the most recent Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRACE-UK) report for 2015. The table below indicates the rates of mortality for stillbirth, neonatal and extended perinatal deaths for the calendar year 2015

	Mortality rates per 1000 births		
	*Stillbirth	*Neonatal	*Extended Perinatal
Crude	4.46	0.6	5.06
Stabilised & Adjusted	3.64	1.12	4.76

*Titles within the table above with an asterisk are defined as:

Stillbirth:	A baby delivered at or after 24+0 weeks gestational age showing no signs of life, irrespective of when the death occurred.
Neonatal death:	A live born baby who died before 28 completed days after birth.
Extended Perinatal: death	A stillbirth or neonatal death.

The MBRACE-UK reported data for 2015 highlights that whilst stillbirth rates in Hywel Dda Health Board were up to 10% higher than the average for comparative Trusts/Health Boards around the UK, neonatal mortality rates were more than 10% lower than the average for the comparative group during the same period.

The Women and Children's Directorate routinely continues to monitor and scrutinise perinatal mortality rates. During 2017 to date mortality rates are low and contrast sharply with the predicted mortality rates offered by the audit and referred to above.

Place of Residence

The review of all stillbirths across the Health Board area for the period 2015 to quarter 1 of 2017 has highlighted no significant statistical difference in rates of stillbirth per maternal county of residence as evidenced within the table below:

	Maternal County of Residence		
	Pembrokeshire	**Carmarthenshire**	**Ceredigion**
2015	7	6	3
2016	9	11	1
2017 (Qtr 1)	0	2	0

Causal Factors

In contrast to the conclusion offered in the audit referred to above, national studies consistently show that the causes of perinatal mortality cannot be attributed in over 50% of cases.

The review of all stillbirths for mothers who were resident in Pembrokeshire for the period 2015 to quarter 1 of 2017 shows that the majority of stillbirths occurred in the antepartum period, prior to the onset of labour. This information is provided within the table below:

	Categorisation of stillbirths for mothers resident in Pembs		
	Therapeutic Terminations	**Antepartum ≥ 24 weeks gestation prior to commencement of labour**	**Intrapartum ≥ 37 weeks gestation where baby was thought to be alive at the commencement of labour**
2015	1	5	1
2016	1	6	2
2017 (Qtr 1)	0	0	0

Antenatal care provision within Hywel Dda has remained unchanged since 2014 and continues to be provided locally in each county in accordance with NICE and Antenatal Screening Wales (ASW) standards. This contrasts with the conclusion offered in the audit above which attributes the variation on perinatal mortality rates directly to the reconfiguration of obstetric units in 2014.

Similarly, the low rate of neonatal deaths, as reflected in the 2015 MBRACE-UK report, contrasts with the conclusion offered in the audit that the reconfiguration of services has led to a deterioration in the quality of care provided.

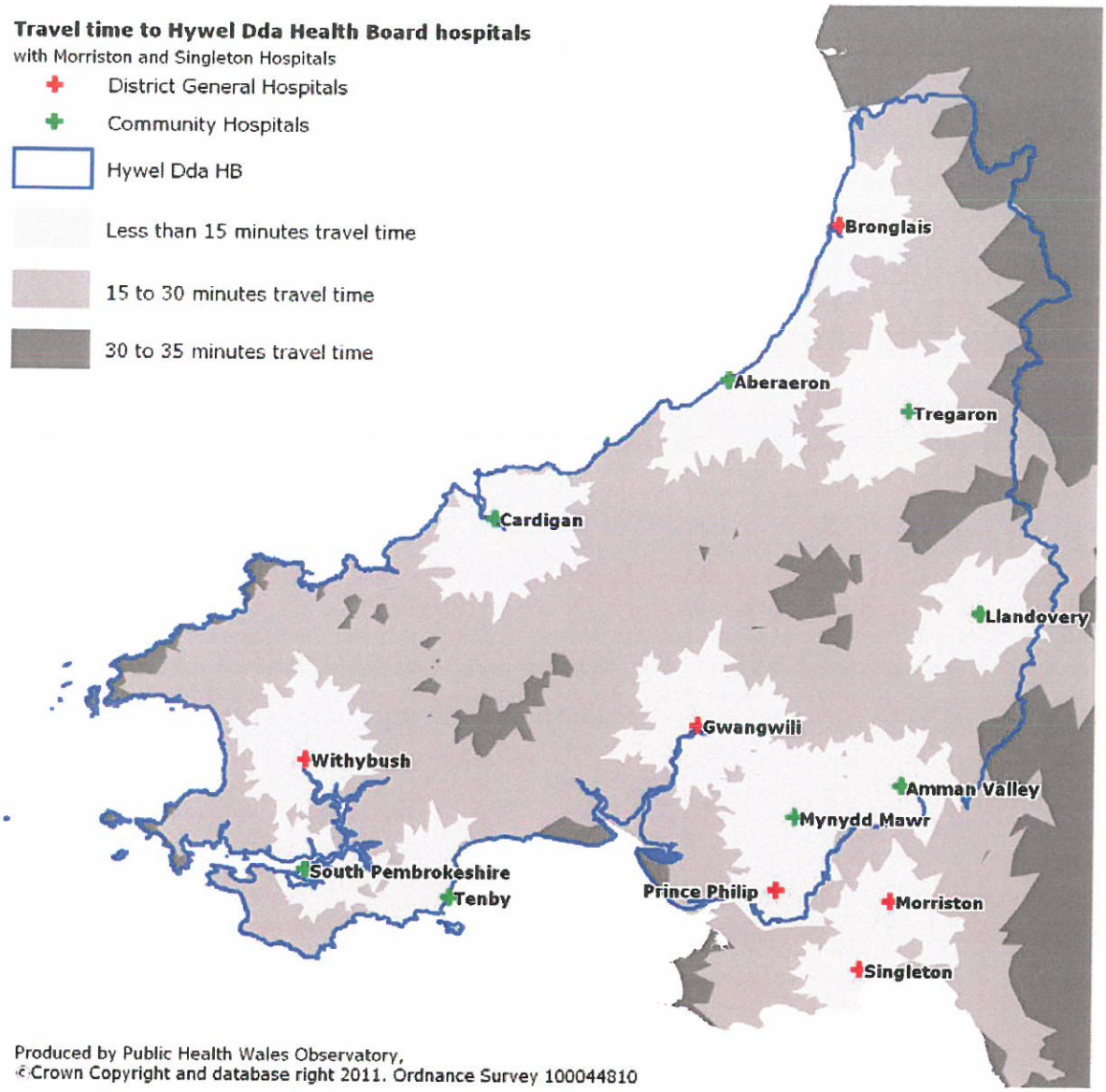
I would like to emphasise here that the two independent reviews from the RCPCH found no cause of concern regarding perinatal deaths and indeed concluded that services were safe.

The Health Board constantly strives to improve services, care and outcomes for patients, and a part of this process is the routine development of new strategies in identified areas. A number of strategies have been developed to further mitigate the risk of perinatal mortality including:

- Public health strategies for weight management during pregnancy: 'Move Baby Move', NERS
- GAP/GROW monitoring iniatives in place across all sites of the Health Board.
- Smoking cessation support including CO2 monitoring by default is in place in line with All Wales policies: 'Help me Quit'
- Monthly audits for fetal monitoring including the 'Kicks Count' initiative

Transfer times for patients to Glangwili General Hospital

Prior to the service changes in 2014, the Health Board undertook an analysis of travel times to all hospitals within the Health Board area. The map below is an extract from the Technical Documents supporting the consultation on the changes to women and children's services, (Technical Document-Women and Children's Services-Final August 2012). This illustrates the travel times for all hospitals across the Health Board area including to Morriston and Singleton hospitals within Abertawe Bro Morgannwg University Health Board, and the number of people who can access any hospital with time ranges.



The average travel times between Withybush Hospital in Haverfordwest and Glangwili Hospital in Carmarthen is 45 minutes by car, this is faster by ambulance. The Health Board continues to provide a Dedicated Ambulance Vehicle (DAV), 24 hours every day which is operated by paramediac and emergency technician staff. This ambulance is based at Withybush Hospital and is dedicated for the emergency and urgent transfer of women and children who need to transfer from Withybush to Glangwili Hospital.

I trust that this has provided you with a full and comprehensive response to the three specific areas identified in your letter. If there is any further detail you require please do not hesitate to contact me.

Yours sincerely

Steve Moore
Chief Executive