Dr Chris Overton
Chairman SWAT
5th October 2017
Your Ref P-05-768

Mr David John Rowlands AM
Chair – Petitions Committee
National Assembly for Wales
Ty Hywel
Cardiff Bay
Cardiff
CF99 1NA

Dear Mr Rowlands

I am writing in response to the letter from Steve Moore, CEO Hywel Dda Health Board, dated 4 October 2017. Firstly we need to differentiate the data in the audit which has been shared with you and Mr Moore's response. He spends quite a lot of his response labelled "1. Assessment of the impact of changes" not actually responding to the audit data.

Once again he returns to the findings of the RCPCH reviews, which relied on old data predominantly from before the changes in the first review, and no perinatal data in the second review. He kindly includes the very long review documents but I addressed these in my last letter and they are irrelevant to the question asked. For completeness may I repeat that the standards are predominantly related to arbitrary medical rota compliance rather than patient care. The remits given to the RCPCH on both occasions they visited were very tight and to suit the question masters, Hywel Dda and the previous health minister, Mark Drakeford. Maternity care was only really added at the last minute for the first and excluded totally for the second visit. The claim that services were/are safe and sustainable and have led to improved patient outcomes is still unfortunately not evidence based. May I also add that it is now 3 years since the service changes were brought in and we are still at the outline business case stage for any improvements in infrastructure.

"2. Monitoring of Perinatal Mortality Rates" one would expect to be a robust answer to counter the audit data I presented but he relies on calling into question the validity and veracity of the data and uses the typical statistical argument that the numbers are very low. These numbers are babies that have been lost forever. The categorisation was alluded to in

the audit and was the same as the AWPS dataset using their terminology. I note that the release of my audit seems to have stimulated some interest within Hywel Dda over and above simply reporting data to the national audits (which are always way behind in their data collection and reporting).

On page 4 he suggests that the Health Board have reviewed data from 2015 to the end of March 2017. He admits that the rate of perinatal mortality increased during 2015 and 2016 and tries to soften this by claiming that they are ***similar*** to 2012 and 2013. He quotes the 2015 MBRACE report but, in actual fact, he is using a different and incorrect data set when comparing with the perinatal mortality data in my audit. The AWPS report of 2014 was lauding the fact that the perinatal mortality rate had been falling consistently over several years. Not so in the 2015 report. Perinatal Mortality is defined as a combination of all stillbirths over 24+0 weeks and early neonatal deaths within the first 7 days of life. This is the data set that the AWPS use and because of the overall numbers they report them in triennia, which is why my audit reports in the same way in order for there to be a true comparison.

On page 5 Mr Moore claims that during 2017 rates are low however there is a problem with the Health Board's data. In the table for place of residence it claims that in the first quarter 2017 there were none for Pembrokeshire and Ceredigion and 2 for Carmarthenshire. This is incorrect as there were early neonatal deaths on 11th January 2017 from Pembrokeshire and 13th March 2017 in Ceredigion. These appear to have been "lost" from his report. If Mr Moore had included April 2017 there would have been 3 more, 2 from Pembrokeshire and 1 from Carmarthenshire making a total of 7 in the first 4 months of 2017. I put in a DATIX (HD32358) on one of the cases in April for two reasons; firstly, it is my genuine belief that the lady was so determined to deliver in Pembrokeshire, even though she wasn't allowed to, she delayed attending Glangwili and instead went to Withybush A&E (when it was too late) and secondly, the record of this stillbirth was recorded incorrectly as antepartum and not intrapartum. If the perinatal mortality rate were to match the first 4 months then it would be 28 deaths for 2017, again a big increase over previous years. No one would know this for another 2 years, when goodness knows how many unnecessary deaths might have occurred if we had to wait for national audits to report. This is why I produced my audit and felt duty bound to share it and petition the Welsh Government not to sit on it's hands this time. Worryingly, as mentioned in my email, my sources have informed me that there were 6 stillbirths during the month of August alone. I fear that the committee needs to read

the Northwick Park report from about 10 years ago. There was a forced merger of hospital maternity services which led to disharmony there and this resulted in many additional maternal deaths. Currently these service changes seem only to have impacted on babies.

Mr Moore is correct in his assertion that it is often difficult to work out why a baby is lost antenatally. There are a few cases where it is clear cut, such as excessive and unexpected bleeding or missed poor growth. However let us look at the service changes and try to evaluate what may have contributed to these excess cases. The way the service is provided is very different now. There is no local consultant unit or SCBU. The facilities available antenatally in Pembrokeshire were significantly reduced and more travelling to Glangwili was required for lots of women. The number of local community midwives was perhaps reduced by 50%, because there was an exodus of predominantly experienced midwives who did not want to work in Carmarthen and had already retired, but had previously returned to work in Withybush as they can retire at 55 but often work until 65, and community midwives were moved to Glangwili to prop up the inpatient service as there were not enough staff organised for the combined unit in advance. Women in Pembrokeshire had felt comfortable knowing that their local hospital had a full range of maternity services with consultants and a SCBU at hand 24/7. The fear factor and increasing anxiety for especially the vulnerable groups increased dramatically in August 2014. Instead of being able to hop on a bus, ask a friend for a lift or pay for a taxi to get to your local hospital, people with no transport (and usually little money) are expected to get to Glangwili at all times of the day or night, and many times a week if there are problems discovered. The equality impact assessments showed quite clearly that every vulnerable group in Pembrokeshire would be disadvantaged and yet in the third document attached they have a brief mention on page 5 where it is recognised that the assessments were done. The Health Board recognises these problems but does not give any detail of possible remedies.

The lovely map is smoke and mirrors as it is showing the travel times for pregnant women before the changes. The whole of the west of Pembrokeshire is now black, an option which does not appear on this map because on this map there was a consultant unit and SCBU in Pembrokeshire. Mr Moore tries to make you believe that travel times are now fine but he stresses between hospital travel times only and gives no mention of the additional 45 minutes it takes to get to Withybush from some western areas of Pembrokeshire. This is why in 1970 it was decided to build a new hospital in Pembrokeshire and gradually improve the care

of the local population. The removal of these services in 2014 was a retrograde step.

It may appear pedantic but I have to point out that the third attachment is dated 28/09/2017 and yet talks about a future meeting concerning Paediatrics on Friday 22/09/2017. It also talks about the outline business case for improvements and is hoping for full business case to be approved 3 years after the changes. These improvements are documented in the RCPCH reports as urgent.

I would also like to counter some of Mr Moore's Paediatric claims by referring you to Dr Gustav vas Falcao's television interview earlier this year which is readily available on the internet. Dr Vas Falcao was a highly respected Paediatrician for many years at Withybush but left in part because of bullying by management and his disappointment over the reduced quality of care for Pembrokeshire patients. Finally it is notable that CHANTS is still only for 12 hours a day and the health board's piece de la resistance must be on page 36 where it calls for the "Pushing of positive birth stories"!

It still seems that the most important aim for Welsh Government ministers and Hywel Dda management is to discredit my up to date data rather than address the very real problems these service changes have caused the people of Pembrokeshire.

On behalf of SWAT and the people of Pembrokeshire I would be grateful if you would consider this letter in the next committee meeting and please act quickly if you want to save lives.

Yours sincerely

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Chairman SWAT
Consultant Obstetrician (retired)