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Cardiff and Vale University Health Board

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Jan Williams OBE
Chief Executive

20 March 2012

Christine Chapman AM
Chair
Children and Young People Committee
National Assembly for Wales
Cardiff Bay
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CF99 1NA

Dear Ms Chapman

Children and Young People Committee – Neonatal Services

Thank you for your letter dated 21st February 2012 in relation to Neonatal services. Cardiff and Vale UHB welcomes the opportunity of contributing to the evidence sought by the Committee.

I will address the issues raised in your letter as follows:-

Neonatal Action Plan

Attached is the Neonatal Action plan as at the end of December 2011 and details the areas of compliance and those where continued work is ongoing. The action plan is monitored at both a Directorate and Divisional level within Cardiff and Vale and also informs the overall action plan being implemented across the Neonatal Network. The action plans draws on the support of other departments within the UHB eg Capital and Estates and cross divisional/departmental working is required to secure improvement in key areas such as the environment and staffing. Compliance with the standards are RAG rated as shown in the attached plan.

Annual Report

The latest Annual Report for the Unit is attached. This covers the period 2010/11 (January – December 2010) and the annual report is produced mid-year to ensure all data is captured appropriately to inform the development of the report. In common with the action plan, this report is monitored at the Divisional level and considered at the UHB Quality and Safety Committee. Action plans are put in place to address any issues relating to compliance with standards, staffing or environment and these are regularly monitored by the Divisional Team and any necessary remedial action is taken if there are changes to the plan required. Attached for further information is the categorisation of clinical incidents by type and severity that have arisen within the Unit during the period October 2010 to October 2011.

Investment Plans

The UHB is currently addressing two key areas for improvement where progress is required to meet the All Wales neonatal standards – adequacy of commissioned capacity and the need for an increased staffing complement.

Work is underway to restructure the physical environment on the Neonatal Unit to increase cot capacity and provide two additional spaces. The Unit is poorly designed and whilst it is fully occupied, a complete redesign is not possible. However, an incremental plan for decanting services within the Unit has been developed that will deliver this increased capacity within the first quarter of 2012. This will support the capacity requirements within the Network arrangements and specifically mitigate the shortfall within the central region.

Further consideration of the future siting of the Unit will be possible following the completion of the Children's Hospital for Wales scheduled for 2014/15.

In relation to staffing levels and skills, the Division is working in conjunction with the Nurse Director, to develop a plan to move towards full compliance with national staffing ratios for Level 1 and Level 2 care. This plan will be completed by end of May 2012 and will be considered alongside the other UHB priorities for investment by the Executive Team. The development of the South Wales Plan for future service provision across a number of specialties may have an influence over this local plan and the UHB will ensure this is factored in to the plan as necessary.

Costs associated with Cross Border transfers

The UHB does not hold this information as the Welsh Health Specialised Services Committee (WHSSC) commissions this service on behalf of all LHBs. This includes the need for cross-border flows when they become necessary and agreements with English providers of this service. WHSSC should be able to provide the data relating to this but caution must be exercised in its interpretation as each year a number of mothers have, for clinical reasons, to deliver outside of Wales particularly if a service that the mother or baby requires is not available in NHS Wales eg cardiac surgery for the newborn. WHSSC should also be able to advise whether the nature of the flow is related to clinical need or when there are occasions this is due to capacity within the Neonatal network.

Local information demonstrates that during 2010/11 there were twenty-four (24) occasions when the Cardiff and Vale Unit was unable to accommodate the total demand for services and this would have resulted in transfer both within and outside of Wales. Whilst additional cot capacity may help reduce this, it is unlikely that this can be eliminated in full due to the peaks in activity that occurs throughout the year unless excess capacity is created at significant additional cost.

The UHB experiences a small inflow of English residents which is primarily driven by two sources: English visitors to Wales who unexpectedly give birth and whose babies require neonatal care and secondly through reduced capacity within NHS England but this is an infrequent occurrence. Where this arises, the UHB makes every effort to repatriate mothers and babies as soon as clinically appropriate to release capacity for local residents.

Discussions with WHSSC and neighbouring LHBs

The Committee is aware that the Neonatal Services within NHS Wales operates as a clinical network and that cross organisational planning and collaboration is key to the success of the network. The UHB is fully engaged with the development and delivery of the Neonatal Network Plan and the day to day management of neonatal capacity across South Wales. The needs of the South Central Health Community are being addressed in conjunction with Cwm Taf LHB with particular emphasis on cot capacity across the two major sites. This will feature strongly in the discussions with the Network and WHSSC as commissioners of the service.

Medical workforce

The numbers of junior doctors in training in Neonatology and Paediatrics in general is a significant issue. The impact of the reduction in numbers and the effect of the European Working Time Directive (EWTD) is having a significant impact on the ability of all units to maintain services that meet national standards. This features highly in the discussions around the development of a South Wales Plan in response to "Together for Health".

I trust that this provides the Committee with the information it requires and I look forward to attending the Committee on 17th May 2012.

Yours sincerely

Paul Hollard
Deputy Chief Executive

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		Compliance December 2011	Issues to be addressed.	Action Planned	Lead	Timescale for Action
Standard Number	**Standard**					
OBJECTIVE 1: ACCESS TO NEONATAL CARE						
1.1	Neonatal care is commissioned to meet the local and national population need.		A formal needs analysis has not been undertaken in respect to meeting both Local and National need given growth in birth rate and regional centre status for neonatal surgery and complex paediatric conditions.	Work commenced with the new South central neonatal network to determine full extent of local and national needs.	Divisional, Direcortate and NICU leads.	Jun-12
			There is a need for more HDU level capacity as identified in the recent all Wales Neonatal Network capacity evaluation.	Engage with WHSSC to understand its stategic intents for commissioning in the South Central region of the network	Divisional & Directorate Management Teams	May-12
1.3	There is a clear referral pathway to and from all levels of care. These pathways include: feto-maternal assessment transfer of the mother antenatally (including from home to specialist centre for high risk management) neonatal transfer access for step up from level I to II and subsequent step down access for step up from level II to III and subsequent step down access to other specialist services i.e. surgery, cardiology, neurology and ECMO.		A number of pathways are underway with Obstretric colleagues. Access to levels of care is outlined by all Wales standards. Discussions ongoing with south centreal NICU community with regasrd to working together to ensure pathwyas are in place across different health boards.	Neonatal pathways to be developed as part of network and Transport Service development. Informal processes in place.	Obstretric and Neonatal colleuges in south central community Transport lead for Network	Jun-12
OBJECTIVE 2: STAFFING OF NEONATAL SERVICES						
LEVEL I Care in Level III Unit						
2.7	A nursing ratio of 1:1 is provided for babies requiring Neonatal Intensive Care. The named nurse has post registration qualification in Neonatal Intensive Care.		Current core establishments fall short of All Wales standards by 7.7wte for funded ITU and HDU capacity.There is always a named nurse on duty who holds a post registration qualification in NICU.	Senior nurse and Head of Childrens Nursing undertaking a complete review of staffing levels.	Head of Children's nursing/Divisional nurse	May-12
2.8	The unit can provide evidence that the establishment is correct for the number of Neonatal Intensive Care cots commissioned.		As above	As above 2.7	As above	May-12

2.13	Clerical and support staff are in place in all units to provide discharge support, e.g. specialist nurse, liaison health visitor. This is in addition to the clinical establishment.		supporting infastructures need to be reviewed to determine sufficency	As above 2.7	Critical Care Lead Nurse and Directorte Nurse	May-12
LEVEL II Care in Level II Unit						
2.16	A nursing ratio of 1:2 is provided for babies requiring High Dependency care. The named nurse has training in neonatal care.		As 2.7	See above 2.7	Critical Care Lead Nurse and Directorte Nurse	May-12
2.17	The unit can provide evidence that the establishment is correct for the number of High Dependency cots commissioned.		As 2.7	See above 2.7	Critical Care Lead Nurse and Directorte Nurse	May-12
2.22	A nursing ratio of 1:4 is provided for babies requiring Special Care.		as 2.7 although staffing for special care cots is made up of 75% band 4 nursery nurses and 25% registered.	See above 2.7	Critical Care Lead Nurse and Directorte Nurse	May-12
2.23	The unit can provide evidence that the establishment is correct for the number of Special Care cots commissioned.		As 2.7	See above 2.7	Critical Care Lead Nurse and Directorte Nurse	May-12
OBJECTIVE 3: FACILITIES FOR NEONATAL SERVICES,						
3.1	Neonatal facilities are commissioned based on population need, taking into account local differences.		Work needs to be undertaken with WHSSC with respect to appropriate commissioning of capacity to take account of the specific reasons for high risk maternal deliveries occuring in cardiff due to the extended paediatric expertise available in the CHfW	Engage with WHSSC to understand its stategic intents for commissioning in the South Central region of the network	Divisional & Directorate Management Teams	May-12
3.5	Support services are readily available. These include: Pharmacy, Dietetics, Therapy, Screening Genetics, Physiotherapy, Social Work, Speech and Language Therapy These include staff with expertise in the care of neonates.		Support services are available wihtit the UHB but access to therapy and social care is limited due to the paediatric demands.	This work can be picked up a spart fo the oevrall staffing review	Divisional lead for therapies with the Head of Childrens nursing	Sep-12
3.6	An agreed appropriate budget is available to purchase and maintain equipment for neonatal care to meet these standards.		All NICU equipment is part of an asset register which has a replacement programme and bids against capital udning is made when necssary.	Equipment is dependent on regular applications for replacement equipment via equipment bids and reliant on endowment fund supplements.	Directorate management team	annually
OBJECTIVE 4: CARE OF THE BABY AND						
OBJECTIVE 5: TRANSPORTATION						
5.2	Arrangements are in place in partnership between maternity and neonatal units for the timely transfer of the mother (in-utero transfer) when a high-risk situation is anticipated. Written arrangements are in place for the transfer of the neonate who requires care at a level not available at the place of birth.		In-utero transfer policy under development.	Conclude policy development	NICU Lead Clinican/Lead Obstretican and Head of Midwifery	Sep-12

5.3	Written arrangements are in place for: the transfer of a mother with a high risk pregnancy across the network. the transfer of mother and baby together when moving back to a unit near home.		In-utero transfer policy under development.	Conclude policy development	NICU Lead Clinican/Lead Obstretican and Head of Midwifery	Sep-12
5.4	Staff responsible for transfers are in addition to those of the clinical inpatient team.		For the NICU transfers, the service is provided on a 12hour day basis, 7 days per week. For maternal transportation, there is no service and escorts for transferring women out is part of the midwfery staffing levels and does result in reduced staffing levels.	Is required to be reviewed as part of the midwifery workforce.	Head of Midwifery	May-12
OBJECTIVE 6: CLINICAL PATHWAYS, PROTOCOLS AND						
6.3	Protocols are in place to ensure babies are transferred between units within the network according to clinical need. Arrangements are in place with neighbouring networks to ensure a seamless service when babies need to be transferred across in Wales or across the border to England.		Partial	Protocols are being developed by the network .	Discussion are in place with south central NICU communnity.	ongoing

APPENDIX INCIDENTS BY SEVERITY AND CLASSIFICATION

Incidents by Category and Severity

Incidents opened 24/10/10-24/10/11 in SCBU/NNU

	E	D	C	B	A	A+	A++	F	Total
Patient - Access, admissions, transfer, discharge (incl. missing patient)	1	1	0	0	0	0	0	0	2
Patient - Clinical Assessment (incl. diagnosis, scans, tests, assessments)	9	10	0	0	0	0	0	0	19
Patient - Consent, communication, confidentiality	4	0	0	0	0	0	0	0	4
Patient - Documentation (incl. records, identification)	7	0	0	0	0	0	0	0	7
Other - Infection Control Incident eg isolation of patients	2	1	0	0	0	0	0	0	3
Patient - Implementation of care and ongoing monitoring/review	2	1	0	0	0	0	0	0	3
Other - Problems with infrastructure (incl staffing, facilities)	5	1	1	0	0	0	0	0	7
Patient - Device/equipment (Medical)	8	6	0	0	0	0	0	0	14
Patient - Medication	9	0	0	0	0	0	0	0	9
Patient - Treatment, procedure	6	11	0	0	0	0	0	0	17
Totals:	53	31	1	0	0	0	0	0	85

Category A++ to E denotes the level of risk severity ranging from A+++ being severe, to E being little/no impact.