Paediatrics, Obstetrics and Gynaecology

The T&F group supported 3 centres for acute care for paediatrics, obstetrics and gynaecology.

A major driver for the group has been the fact that about 90% of paediatric admissions are an emergency. The group has proposed that routine surgery for children remains in each of the 3 acute centres but for highly specialised surgery to take place in Alder Hey Children’s Hospital. A single highly specialised service was proposed for neonatal intensive care. The group would like to highlight the importance of CAMHS which is currently under review.

There was support for the principle that a large proportion of births could take place in midwifery led units. However, some obstetric procedures could be consolidated across North Wales eg teretal medicine. Further consolidation of gynaecological procedures was recommended eg cancer gynaecology. Moreover, the group supported the expansion of community based gynaecology care that would have the capacity to carry out diagnostic testing and treatment services; for example, colposcopy, post menopausal bleeding, early pregnancy assessment and hysteroscopy.
SERVICE RE-DESIGN GROUPS

CHILDREN AND FAMILIES

Introduction

The group will build upon the vision for services put forward in the consultation document ‘Designed for North Wales’, its supporting work including the benchmarking against UK best practice undertaken by Teamwork. It will develop a sufficiently detailed picture of services to inform the Regional Strategic Outline Plan and the local health economy Strategic Outline Cases.

The work of the group will also form the basis of the regional chronic disease management plan to be submitted as part of the delivery programme for Designed for Life.

Terms Of Reference

The group needs to look at services for children and families in the round but it will focus particularly on

1. The provision of surgery for children and adolescents in North Wales
2. Neonatal intensive care services for North Wales
3. The development of midwifery lead services for births
4. The shape of the obstetric services for North Wales
5. The future provision of child and adolescent mental health services. In this respect it needs to link closely with the work of the national mental health group.
## CHILDREN AND FAMILY REDESIGN GROUP

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
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<tbody>
<tr>
<td>Ruth Parry - Chair</td>
<td>Consultant medical workforce planning</td>
<td>North West Wales NHS Trust</td>
</tr>
<tr>
<td>Andrew Butters</td>
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<td>Anne Eccles</td>
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<tr>
<td>Chris Jones</td>
<td>Chief Officer</td>
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<tr>
<td>Cilla Robinson</td>
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<tr>
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<tr>
<td>Dr Brendan Harrington</td>
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<tr>
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<tr>
<td>Fraser Campbell</td>
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<td>Glyn Roberts</td>
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<tr>
<td>Heather Chapman</td>
<td>Practice Development HV</td>
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<td>Helen Jones</td>
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<tr>
<td>Jackie Baker</td>
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<td>Janet Horn</td>
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<td>Janet Roberts</td>
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<td>Janet Williams</td>
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<td>Joan Chaloner</td>
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<td>Julie Riley</td>
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<td>Mandy Cooke</td>
<td>Senior Sister</td>
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<td>Maureen Cain</td>
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<td>Pat Parker</td>
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<td>Paula Knight</td>
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<td>Steven Grayston</td>
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<td>Sue Maskell</td>
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<td>Tania Marsden</td>
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<td>Wyn Thomas</td>
<td>Chief Executive</td>
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<tr>
<td>Yvonne Johns</td>
<td>CHC representative</td>
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Designed for Life

Designed for Life is the national strategy for health services through to 2015 and was published by the Welsh Assembly Government in May 2005. It sets out an approach to designing health care service within which the current proposals for North Wales fit. A full copy of the document can be accessed via the website at www.wales.nhs.uk/norwalesecare.

The framework and definitions used in this document have been based upon the four levels of care identified in Designed for Life. These are presented below for easy reference.

These levels of care will not be rigidly compartmentalised. The aim will be to reduce barriers between services and increase integration at all points.

**Level 1: Primary Care Networks**

The role of Primary care Networks will be to provide:

- Primary care
- Health education and promotion
- Sub hospital specialist care (e.g. nurse consultant, GP/Dentists with a specialist interest)
• Diagnostics (e.g. point of care testing)
• Demand management
• Minor injuries
• GP/dental ‘out of hours’
• Secondary care outreach
• Seamless care with social care and local government
• Rehabilitation services
• Health maintenance support
• Ante-natal care
• Post-natal care
• Drop-in breast feeding services
• Children and family services
• Early intervention service
• Assertive outreach teams
• Crisis intervention

Level 2: Local Services

The role of Local Services will be to provide:

• Emergency care (e.g.)
  o Minor injuries
  o Rapid access clinics
  o Local emergency assessment
  o Emergency admissions
  o Base for emergency response community teams
  o Routine emergency medicine e.g. chest infections, cardiac failure

• Elective care (e.g.)
  o Outpatient clinic suites including designated children’s facilities for consultations, minor procedures and dental services
  o Endoscopy suites for diagnosis and treatment
  o Day care and short stay unit for routine surgery
  o Diagnostic unit including radiology (from plain film and ultrasound up to CAT scanner/MRI, pathology and ECG and echocardiography.

• Integrated care (e.g.)
  o Rehabilitation beds
  o Sub acute beds
  o Palliative care
  o Stroke unit
  o Therapies centre
  o Resource centre (for patient and carer support; voluntary sector, multi agency/multi professional teams)
Appendix 5

- Family healthcare (e.g.)
  - Midwifery-led units
  - Paediatric clinics/joint GP and paediatric clinics
  - Local diagnostic services
  - Emotional health and wellbeing services

- Mental health (e.g.)
  - Integrated partial hospital – extended day hospital
  - Outpatient clinics
  - Inpatient services
  - Day hospital
  - Liaison services

**Level 3: Acute Services**

The role of acute services will be as follows:

1. Major elective and major emergency services that cannot be decentralised to Local Services will need to be consolidated. This will ensure we can provide robust and sustainable services for the future because of the challenges of the increasing influence of sub-specialisation, higher clinical standards, clinical training, new legislation and other pressures on the workforce.

2. The services that will be further considered carefully in this context include:

   - Accident and Emergency
   - Trauma
   - Emergency and Specialist Medicine
   - Neonatology
   - Emergency Surgery
   - Paediatrics
   - Critical care
   - Cancer Services
   - Obstetrics
   - Complex Surgery
   - High tech diagnostics

3. It is anticipated that these services – or components of them – will need to be consolidated within a single “acute care centre”. In addition consideration will be given to the further development of tertiary outreach services at this centre.

4. The concept of the Acute Care Centre is to create a highly specialised facility to support the treatment of complex morbidity and acute emergency care. This will act as a back up facility for local services in providing advice, assessment, diagnosis and treatment where it cannot be delivered safely at local level and in transferring patients back when they no longer require specialist attention.
5. Major emergency and specialist services requiring critical care together with specialist services for women and children would be consolidated in a single centre, strategically located, to serve the entire catchment population. The organisation of the Centre will be built around acuity of illness rather than specialist wards.

6. The Acute Care Centre will be networked closely with Local Services to provide back-up to them in terms of specialist advice, assessment and treatment, and critical care.

**Level 4: Tertiary and highly specialised care**

1. The role of tertiary centres will be to provide highly specialised services, often with a large research and teaching component.

2. Concentration into specialist departments improves services by accessing high specification technology and expertise. Such centres within and close to Wales will play an important part of continuing to attract high calibre professionals in future.

3. Services in this context will include for example:

   - Cancer
   - Plastic surgery and burns
   - Neurosurgery
   - Cardiac surgery
   - Renal transplants
   - Specialised children’s services

Where numbers of patients are very small, we will continue to access United Kingdom Centres of Excellence.
Transition from paediatric to adult care
- Brief notes for the Children and Families Service Redesign Group

Transition from paediatric to adult care should be a well-organised and natural progression, but on occasions it can be difficult. There are a number of different arrangement options for transition, and there are recognised principles to smooth the process.

Reasons for difficult transition
- Lack of planning
- Different ethos of adult clinics and health services
- Paediatric team reluctance to pass on patients
- Patient and carer reluctance to move on
- Changing needs of young person not considered
- Young person moves to different area with work or higher education

Benefits of good transition
- Effective engagement with adult services
- Seamless provision of services
- Avoidance of unnecessary re-investigation
- Opportunity for re-evaluation of problems
- Builds confidence in adult health services

Characteristics of good transition
- Acknowledgement of emerging autonomy and changing needs of the young person
- Young person and carers/family are involved in planning of the process
- Preparation period and education for the young person
- A clear policy for timing of transfer
- Early planning for transition
- Good working relationships of paediatric and adult teams
- Joint clinics where appropriate
- A positive experience at first contact - early impressions are crucial
- Sensible, full and clear knowledge transfer
- Involvement of primary care

The most appropriate person/team to take on a young person’s health care as he/she moves into adult life will vary according to the nature of the health problem.

Transition from paediatric services may occur in various directions:

1. To primary care
2. To adult services in the DGH setting
3. To adult services provided by visiting specialists in the DGH
4. To tertiary service providers at their base
5. To local adult services and quaternary specialists simultaneously
6. To a joint service for health, education and social services
1. Transfer to primary care

*Example* - *Well controlled asthma*: in a young person seen in a hospital asthma clinic, but whose asthma is settling during teenage years, it would be more appropriate to transfer follow-up to the family doctor and practice asthma nurse. This may be the most convenient and appropriate transition, and should be against a background of good and longstanding joint working between primary and secondary care.

2. Transfer to adult service within the same hospital

*Example – Diabetes*: For a young person with diabetes, the adult diabetes team in the local DGH would most appropriately take over care. Transition may best be achieved into a young adults’ clinic covering an age range from school leaving age to mid-twenties. This clinic need not be a clinic just for transition of young people, but enough time for the first meeting should be set aside. The key worker for effective transition is likely to be the paediatric diabetic liaison nurse, who should attend the transition appointment. Clear and succinct summary about key aspects of the diabetic career of each patient should be provided for the adult services.

3. Transfer to care of a visiting specialist

*Example – epilepsy*: For a young person with epilepsy, the teenage years are crucially important times for a number of reasons including emerging autonomy, concern about peer relations, sexual health, employment, driving etc. In addition, the epilepsy story of the patient can often be complicated. For this reason it may be best to have a clinic set aside for transition, attended by the paediatric and adult medical staff and epilepsy specialist nurses.

4. Transfer to tertiary service providers

*Example – Grown up congenital heart disease*: For some young people with straightforward congenital heart disease, a transfer to the local cardiologist and team will be the most appropriate way forward. However, for more complex congenital heart disease, especially where new operations have been employed and the long term outcomes of such interventions are as yet unknown, it may be more appropriate for the young person to attend a tertiary service for long-term monitoring of cardiac function. Such a service could not realistically be provided in a local DGH setting due to the relatively low numbers, and because of constraints of available technology.

*Example – Cystic fibrosis*: More young people are surviving longer with conditions which would previously have led to their deaths in childhood. Foremost amongst these conditions is cystic fibrosis, where survival rates have changed significantly in recent decades. The combination of local chest teams and tertiary review in a regional centre is the model developed in many areas and seems sensible. The local team can provide the key elements of cystic fibrosis care, whilst the tertiary service can direct research and guide local teams in ongoing care.
5. To local services and quaternary services simultaneously

**Example – complex metabolic conditions:** there are a great number of complex metabolic conditions that may affect young people, each of which may be relatively rare. Such children and young people will invariably be under the joint care of a local paediatric team and a tertiary or quaternary specialist service. As the young person enters adulthood, and particularly if there is stabilisation of the condition, it may be most appropriate that care is handed on to the regional/supra-regional service to work alongside primary care.

6. Transfer to a joint service for health, education and social services.

**Example – a young person with disabilities:** Transition is not just limited to health issues. For young people with complex medical, social and educational needs, it is crucial that there is very well planned transition to all adult services. There are many such young people and the potential for disruption of health, social care and education is great if proper transition does not occur. This is well recognised in the National Service Framework document.

The NSF identifies the need for
- An inter-organisation system
- A key transition worker
- Access to information
- A joint organisations transition plan, as follows:

**Key actions – NSF**

5.32 **There is an inter-organisation system to identify children who will require transition into adult services in the year before their 14th birthday (in year 8).** This informs the strategic planning for all organisations.

5.33 **A key transition worker is appointed to all disabled young people at age 14.** It is their responsibility to ensure that the young people, their families and all relevant agencies are appropriately involved in the planning process. The key transition worker co-ordinates the planning and delivery of services before, during and after the process of transition, and will continue to monitor and have contact with the young person until the age of 25 years.

5.34 **Information about how to gain access to services and facilities is available to disabled young people in the local community and includes information about:** employment, housing, training, leisure, educational opportunities, access to independent living etc.

5.35 **There is one joint organisations transition plan produced for each disabled young person which forms the basis of an unified assessment within adult services and specifies arrangements for continuing support and**
5.36 The joint organisations transition plan is reviewed at least annually.

5.37 Aggregated information from joint organisations transition plans is sent to the Young Peoples’ framework partnership to inform strategic planning.

Summary

1. Transition to adult services is crucially important
2. Key features that characterise good transition are already identified
3. A number of different transition models are available, and choice of the most appropriate will depend on the nature of the health and other needs of the young person
4. One of the largest groups to consider is that of young people with disabilities, where the NSF has recommended very early planning, key transition workers, and a joint inter-organisation plan individualised for each young person.

Implications for children and families service redesign group

- Many good transition arrangements are in place across North Wales already.
- Access to appropriate adult services may be suboptimal in some areas of practice.
- Audit of transition is already being carried out in some key areas (V Klimach neurodisability, P Stutchfield diabetes, personal comm.); this could be useful to identify best local practice and areas for action
- Local transition practice should be refined and developed along the lines outlined above and detailed in the NSF
- It may be that specialist adult services across North Wales will develop expertise in specific areas that would allow more local follow-up of young people – for example, if a cardiologist were appointed in North Wales with a particular interest and expertise in grown up congenital heart disease, it would be feasible to develop a North Wales service.

Duncan Cameron
Conwy and Denbighshire Trust

References

National Service Framework for children, young people and maternity services in Wales.

Viner, R. Transition from paediatric to adult care. Bridging the gap or passing the buck? Arch Dis Child 1999;81:271-75
Briefing Paper: Future Proposals for Midwifery Led Care in North Wales.

Author: Dawn Cooper (Head of Midwifery, North East Wales NHS Trust).

1 Purpose
This paper is to inform the Children and Families Service Redesign Group (Sub Group of North Wales Secondary and Specialist Care Review) with regard to the future proposals for midwifery led care in North Wales.

2 Background
Maternity care in North Wales is currently provided from 3 district general hospitals (DGH’s). In 2006 there were 6,763 births across North Wales. As can be seen from table 1, the majority of these births took place at the main district general hospital maternity units.

Table 1: Birth Statistics for North Wales

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<th>North East Wales</th>
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<tr>
<td>Total Number of Hospital Deliveries</td>
<td>2,341</td>
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<td>Number of Home births</td>
<td>40</td>
<td>51</td>
<td>86</td>
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<tr>
<td>Number of births at midwifery led units</td>
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In recent years there has been a shift away from the medical model of care that was in operation from the 1960’s (following the Peel Report) until the 1990’s, when the Select Committee on Health (1992) advocated a review of maternity care provision. In North Wales this has resulted in a gradual transition towards Midwifery led Care for low risk women. Until recently, Midwifery Led Care for the majority of low risk women was provided during the antenatal period. Intrapartum and early postnatal care has continued to be provided at the DGH under the care of the consultant obstetrician (with the exception of women who chose a home birth and those 54 women who delivered at “home from home” units, see Table 1).

In 2004 the All Wales Normal Labour Pathway was introduced in an attempt to reduce unnecessary intervention and support the transition towards midwifery led care for low risk women during labour.
2.1 Definition of Midwifery Led Care
Definition of Midwifery led care is difficult as various terminology and models of care are used. For the purposes of this document Midwifery Led Care refers to :-

“Where a midwife takes primary responsibility for providing antenatal, intrapartum and postnatal care for women who are assessed as being at low risk of developing pregnancy complications”

3 Future Service Provision
To enable Midwifery Led Care to develop according to the definition it will be necessary for midwives to have a base in the local community. This base will be where women can access the midwife as the first point of contact for pregnancy advice and discussion with regard to their maternity care choices (House of Commons Health Committee 2003b, WAG 2006).

3.1 Booking for Midwife led Care
The midwife will perform a risk assessment (based on NICE Guidance for Antenatal Care 2003) at the booking interview, which ideally will take place at 10-12 weeks gestation. If the woman is deemed to be low risk the midwife will then become the lead carer and a plan of care will be formulated in partnership with the woman.(see Figure 1).

It is widely acknowledged that risk assessment tools have poor predictive value (Berglund and Lindmark 2000, cited in Sinclair 2002), however, they have some value in that they are crude indicators of the risk of complications (Sinclair 2002)

Studies that have been conducted to identify women who are low risk and therefore suitable for midwifery led care have identified that approximately one third of women who book for pregnancy care are suitable to be cared for by midwives as the lead professional. (Sinclair et al 2001)

In North Wales this would translate into 2,254 women would book for midwifery led care. Studies that have been conducted with regards to the efficacy of midwifery led care have indicated that; “this type of care can be offered as a safe alternative to hospital confinement (Obstetric led care) for selected pregnant women, particularly those who have previous children”. (Sinclair 2002)

3.2 Transfer Rates for Obstetric Led Care
Due to the low predictive value of risk assessment tools, there will be a number of women who book for midwifery led care who will develop complications and require the opinion of a consultant obstetrician.

It would appear from the evidence available that approximately 30% of women who book for midwifery led care, will require transfer to the care of a consultant obstetrician. The studies have also demonstrated that Primigravid women are more likely to require transfer than multigravida. (Rooks et al 1992, Sinclair et al 2001)
3.3 Midwifery Care for Women Deemed to be High Risk

It is crucial that there is equity of service provision for women regardless of their risk status. Women who are deemed to be at medium to high risk of complications will continue to have care from a named community midwife. The community midwife will be responsible for ensuring women are informed of their options for care, parenting advice and general psychological support. (see figure 1)

4 Estates Facilities

At present there are birth centre facilities at Bryn Beryl, Dolgellau, Tywyn and Denbigh. At North East Wales there is an intention to explore the feasibility of a Midwifery Led facility at Deeside Community Hospital which will be available for women in the Flintshire area.

To enable further development of midwifery led facilities, it is anticipated that an “alongside” Midwifery Led Birth Centre should be available at each District General Hospital.

5 Staffing

All 3 maternity units in North Wales have undergone a workload study using the Birth Rate Plus workload tool. This tool is evidence based and is endorsed by the Welsh Assembly Government and Royal College of Midwives. The staffing ratio recommended for Midwifery Led units is 1 midwife per 35 births. If there are other facilities offered at the Midwifery Led Unit, such as antenatal day care facilities then this ratio would alter. It is recommended that the Birth Rate Plus assessment is carried out when new facilities are developed.

6 Clinical Governance

There will need to be robust clinical governance structures in place to ensure that care of pregnant women is carried out in a safe and effective manner that is based on the best evidence available. Clinical governance systems will include:-

- Antenatal Care based on NICE guidance
- Robust audit of antenatal, intrapartum and postnatal care
- Use of All Wales Birth Centre Guidelines (2006, currently out for consultation)
- Intrapartum care according to the Normal Labour Pathway
- Rotation of midwives between high and low risk areas to maintain skills
- Clinical risk reporting on a North Wales basis
- Contribute to the body of evidence by undertaking further research with regard to risk assessment and the outcomes of midwifery led care
Figure 1: Midwifery led Care Pathway

Midwife first point of contact

Risk Assessment at booking

Low Risk
Midwifery Led Care

High Risk
Consultant Obstetrician
Led Care

Home Birth

Deliver at
Midwifery Led
Unit

Deliver at District
General Hospital

In-patient Post Natal
Care

Postnatal Care from Community Midwife in own home.
Transfer to care of Health Visitor from Day 10
onwards at midwife’s discretion


## Acronyms

<table>
<thead>
<tr>
<th>Acronyms</th>
<th>Meaning</th>
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<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
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<td>CAMHS</td>
<td>Community Adult Mental Health Service</td>
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<td>CEMACH</td>
<td>Confidential Enquiry into Maternal and Child Health</td>
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<td>CYPSSP</td>
<td>Children And Young Peoples Specialist Services Project</td>
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<td>Developing Emergency Services</td>
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<td>GPS</td>
<td>General Paediatric Surgical</td>
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<td>HCW</td>
<td>Health Commission Wales</td>
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<td>High Dependency Unit</td>
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<td>National Public Health Service</td>
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<td>National Service Framework</td>
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<td>Office of National Statistics</td>
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<td>TOP</td>
<td>Termination Of Pregnancy</td>
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