Maternity & Child Health Review

PAEDIATRIC AND CHILD HEALTH WORKSTREAM

Review of the Evidence for the Case for Change

1. INTRODUCTION

2. POPULATION HEALTH NEED

2.1 North Wales Demography
2.2 Impacts of Deprivation
2.3 Maternal and child health in North Wales – key population health issues

3. ASSESSMENT OF CURRENT SERVICES

3.1 Current Configuration
3.2 Demand
3.3 Medical Workforce
3.4 Nursing Workforce
3.5 Therapies Workforce
3.6 Finance

4. STANDARDS & EVIDENCE

4.1 NHS Annual Quality Framework (AQF) 2011/12
4.2 Population Health Need – Evidence Base
4.3 Safe Guarding Children and Young People
4.4 Quality Standards
4.5 Medical Workforce
4.6 Nursing Workforce

5. ASSESSMENT OF SERVICE GAPS

5.1 Population Health Need
5.2 Quality Standards
5.3 Medical Workforce
5.4 Nursing Workforce
5.5 Therapies Workforce
5.6 Financial

6. CASE FOR CHANGE

7. CONCLUSION AND RECOMMENDATIONS

7.1 Conclusion
7.2 Recommendations

APPENDIX 1: WORK STREAM MEMBERSHIP
APPENDIX 2: GLOSSARY OF TERMS
1. INTRODUCTION

1.1. The imperative of delivering safe services, attaining national quality standards of care combined with the impact of challenges in the recruitment of staff, changes in employment legislation and planned changes in medical education have required the Health Board to undertake a review of current paediatric and child health services. The Health Board carries a legacy of services and facilities that in some cases may be preventing the improvement and development of interventions and care that is needed to improve the health of the population. The initial focus of the review has been to consider the current services and determine whether there is a case for change.

1.2 This and other reviews form part of the strategic direction of the Health Board which is using the Triple Aim\(^1\) to:

- Improve the health of the population (prevention, early intervention and responsibility)
- Enhance the patient/user experience including quality, access and reliability (focus and evidence base for greater gain)
- Reduce or at least control per capita cost of care (value for money)

1.3 A Project Board has been established to co-ordinate the review. As these services are intrinsically inter-linked, it is acknowledged that the impact on each needs to be considered within the overall review process.

1.4 The Review Project Board established two clinically led work streams; one for Maternity, Neonatal and Gynaecology services and the other for Paediatric and Child Health services, with a view to identifying the evidence for a case for change. The membership of the Paediatric and Child Health work stream is set out in Appendix 1. This report should be read in conjunction with the Maternity, Neonatal and Gynaecology work stream report.

1.5 The work stream has been tasked with reviewing the evidence for the case for change for Paediatric & Child Health services delivered to the North Wales population. In order to undertake this task, 6 task and finish groups were established to review and analyse the evidence, which would then feed into the next phase of the Review process. The identified groups were::

- Population Health Need
- Demand
- Standards
- Medical Workforce
- Nursing Workforce
- Economics

\(^1\) Betsi Cadwaladr University Health Board 5 year Strategic Framework
1.6 There are an increasing number of factors which are placing considerable pressures on existing services and will impact on the future sustainability of services. The initial task for this work stream has been to gather evidence to clarify whether there is a case for change in the structure and/or pattern of working in the current services, to ensure sustainability and the delivery of high quality services expected of a modern health care provider.

1.7 This paper sets out the context for the case for change. The over-riding aim of services is to improve health, provide safe services and deliver the best possible standards of care for children, young people and their families in North Wales. In this paper there is a clear focus on national policies and standards, addressing local population health need demonstrating that the care provided is high quality, and making the best and most cost-effective use of resources.

1.8 National standards for Women's, Children's and family services set clear expectations for safety, efficiency and value for money. This paper seeks to establish the principles upon which safe and sustainable care can be provided. The review compared current services alongside these recognised standards.

1.9 National strategy provides a clear direction for health improvement through upstream prevention. It recognises that the burden upon acute hospitals is unsustainable and promotes the delivery of care closer to the patient’s home when it is safe and appropriate to do so. This is supported by the establishment of national targets within the Annual Quality Framework\(^2\) to reflect the requirements for workforce redesign, as well as meeting national guidelines and clinical policies. These aspects are all encompassed in the current assessment.

\(^2\) NHS Wales Annual Quality Framework 2011/12
2. POPULATION HEALTH NEED

2.1. North Wales Demography

2.1.1 North Wales has a population of 678,500 and covers an area of approximately 2,500 square miles. Each area within North Wales has contrasting needs, which broadly equate to rural and urban differences. The population of North Wales is predicted to increase to over 700,000 by 2033.

2.1.2 The few densely populated areas in the region are situated around urban centres, such as Rhyl and Wrexham. Flintshire and Wrexham are the unitary authorities with the highest population density.

2.1.3 Data shows that 20.8% of the population of North Wales is under the age of 18, compared with 21.2% in Wales as a whole.

Table 1: All Children aged 0 to 18 years, North Wales, 2009

<table>
<thead>
<tr>
<th></th>
<th>Thousands</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Wales</td>
<td>149.4</td>
</tr>
<tr>
<td>Isle of Anglesey</td>
<td>15.0</td>
</tr>
<tr>
<td>Gwynedd</td>
<td>25.6</td>
</tr>
<tr>
<td>Conwy</td>
<td>23.5</td>
</tr>
<tr>
<td>Denbighshire</td>
<td>21.1</td>
</tr>
<tr>
<td>Flintshire</td>
<td>34.1</td>
</tr>
<tr>
<td>Wrexham</td>
<td>29.9</td>
</tr>
</tbody>
</table>

Source: ONS

2.1.4 The number of children and young people in the population will remain fairly constant, it is anticipated that in 2033, young people will account for a smaller proportion of the total population than in 2008, while older people will account for a higher proportion.

2.1.5 Despite the fact that in the future children and young people may account for a smaller proportion of the total population, actual numbers of children and young people may rise due to the projected rise in both birth rates and total fertility rates.

2.2 Impacts of Deprivation

2.2.1 The Welsh Index of Multiple Deprivation (WIMD) is a geographically based deprivation measure and is derived from a broad range of factors, including income, employment, health, education, and access to services. It is well documented that areas of deprivation often have higher levels of need in relation to many different measures of health such as levels of smoking related diseases, injuries, alcohol and drug related diseases, teenage pregnancy and mental health issues.
2.2.2 A proportion of the North Wales population resides in areas of deprivation. 12% of Lower Super Output Areas (LSOA) within North Wales are in the most deprived fifth in Wales. Denbighshire contains three out of the top five most deprived areas in Wales, while Wrexham contains the second highest percentage of LSOAs in the most deprived fifth in Wales.

2.2.3 Lifestyle factors are linked to deprivation and are an important contribution to health inequalities. Rates of smoking and obesity levels have been shown to be higher in areas with high levels of deprivation. Consumption of fruit and vegetables and levels of physical activity have been shown to be lower in areas with a high level of deprivation.

2.2.4 Deprivation impacts significantly on child health. Rates of infant mortality, child mortality, injuries and teenage pregnancy have been shown to be significantly higher in areas with high levels of deprivation.

2.3 Maternal and child health in North Wales – key population health issues

2.3.1 There is variation in maternal and child health outcomes across North Wales, with geographical variation in low birth weight (LBW) rates linked to areas of high deprivation. The LBW rate for North Wales is 5.5% compared to a Wales average of 5.8%. The LBW rate in the Middle Super Output Area (MSOA) area with the lowest rate in North Wales is 2.9% compared to 8.2% in the area with the highest rate. There are six MSOA areas in North Wales with LBW rates over 7.4% which is significantly higher than the Wales average.

2.3.2 There is variation in teenage conception rates in North Wales. Teenage pregnancy is a positive life choice for some young women. However, many teenage mothers and their children are at greater risk of suffering poor social, economic and health outcomes.

Conceptions and outcomes, numbers and rates per 1,000 females aged 15 to 17 years, North Wales, 2008

<table>
<thead>
<tr>
<th>Area</th>
<th>Number</th>
<th>Rates per 1,000 women aged 15-17</th>
<th>Maternities</th>
<th>Abortions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>38,783</td>
<td>40.5</td>
<td>20.4</td>
<td>20.1</td>
</tr>
<tr>
<td>Wales</td>
<td>2,578</td>
<td>44.3</td>
<td>24.8</td>
<td>19.5</td>
</tr>
<tr>
<td>Isle of Anglesey</td>
<td>58</td>
<td>41.5</td>
<td>16.4</td>
<td>25.0</td>
</tr>
<tr>
<td>Gwynedd</td>
<td>82</td>
<td>38.1</td>
<td>20.0</td>
<td>18.1</td>
</tr>
<tr>
<td>Conwy</td>
<td>93</td>
<td>43.4</td>
<td>21.9</td>
<td>21.5</td>
</tr>
<tr>
<td>Denbighshire</td>
<td>95</td>
<td>48.6</td>
<td>26.6</td>
<td>22.0</td>
</tr>
<tr>
<td>Flintshire</td>
<td>106</td>
<td>35.8</td>
<td>17.6</td>
<td>18.3</td>
</tr>
<tr>
<td>Wrexham</td>
<td>116</td>
<td>46.9</td>
<td>27.1</td>
<td>19.8</td>
</tr>
</tbody>
</table>
2.3.3 Smoking and obesity have a high prevalence in the population and can impact on rates of miscarriage, maternal death, neonatal deaths, congenital anomalies, admission to neonatal care and low birth weight.

2.3.4 In 2005, 37% of mothers in Wales reported smoking at some stage during their pregnancy or the year before and 22% smoked throughout their pregnancy. The highest rates of smoking were found in mothers aged less than 20 years and 20-24 years. Although this has improved in 2010 (33% and 16% respectively) mothers in Wales are more likely to smoke and less likely to give up than in other UK countries.

2.3.5 Exposure to second hand tobacco smoke is an important cause of morbidity in childhood. It increases risks of asthma, ear infections, respiratory infections, bacterial meningitis and sudden infant death. The cost to the health service from exposure to second hand smoke in childhood is significant.

2.3.6 Rising levels of childhood obesity, high levels of smoking among teenage girls and alcohol use are important factors in the future health of the next generation of mothers and could have a large impact on the future use of maternity and neonatal services.

2.3.7 Rates of admission for childhood injuries are significantly higher in Gwynedd and Anglesey than the Wales average. Most injuries in nought to five year olds occur in the home. Injuries are a largely preventable cause of ill health, are linked closely to deprivation and impact greatly on health service use by children and young people.

2.3.8 Immunisation is a highly effective and cost effective health care intervention. Rates in parts of North Wales currently fall below the 95% uptake rate required to protect the population from outbreaks of serious infectious diseases.

2.3.9 Interventions to promote breastfeeding are cost effective and can reduce demand on health care services.
3. ASSESSMENT OF CURRENT SERVICES

3.1 Current Configuration

3.1.1 The acute elements of the services under review are based on historical service configurations, and currently operate from three District General Hospitals (DGHs) in North Wales; being, Ysbyty Gwynedd in Bangor (YG), Ysbyty Glan Clwyd in Bodelwyddan (YGC) and Ysbyty Maelor in Wrexham (YMW). These services are supported by a wide range of community-based teams, and all aspects of the service are considered in developing future models.

3.1.2 Currently, Acute Paediatrics and Neonatal care are delivered by staff employed by Paediatric and Child Health Services. Due to the strong link between maternity and neonatal care, neonatal services are considered within the Maternity, Neonatal and Gynaecology Work stream.

3.1.3 Children and young people receive the majority of their health care from Primary Care services. These are being configured within localities addressing prevention, self care, treatment, rehabilitation and long term care. The driving principle should be that district general hospitals only provide those specialist services that cannot be delivered effectively, safely, and efficiently in communities.

3.1.4 There is also a wide range of community based teams that deliver paediatric and child health services. Some joint health and social care multi disciplinary teams are currently being developed, including co-location to ensure effective integration. They will support the identification of needs and delivery of services for particular groups. These teams promote more proactive management, early intervention and better coordination of care to prevent the early deterioration of patients and to keep them well in their own homes. However there is variation in this development across North Wales.

3.1.5 Many children and young people have services delivered in England and there is scope to consider providing some services more locally.

3.2 Demand

3.2.1 Acute Demand

3.2.1.1 Many factors influence the demand for paediatric and child health services, including demography, birth rates, fertility rates, population distribution, deprivation, epidemiology of disease e.g seasonal increases in respiratory infections, congenital anomalies, chronic diseases and lifestyle factors e.g. effects of exposure of children to second hand tobacco smoke.
3.2.1.2 The number of paediatric admissions each year by unit is:

<table>
<thead>
<tr>
<th>Year</th>
<th>YG</th>
<th>YGC</th>
<th>YMW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Admissions</td>
<td>08/09</td>
<td>4031</td>
<td>5271</td>
</tr>
<tr>
<td></td>
<td>09/10</td>
<td>4232</td>
<td>5107</td>
</tr>
<tr>
<td>Emergency Admissions</td>
<td>08/09</td>
<td>3016</td>
<td>4213</td>
</tr>
<tr>
<td></td>
<td>09/10</td>
<td>3319</td>
<td>4114</td>
</tr>
<tr>
<td>Day Cases</td>
<td>08/09</td>
<td>587</td>
<td>563</td>
</tr>
<tr>
<td></td>
<td>09/10</td>
<td>589</td>
<td>546</td>
</tr>
<tr>
<td>Elective Inpatient</td>
<td>08/09</td>
<td>428</td>
<td>495</td>
</tr>
<tr>
<td></td>
<td>09/10</td>
<td>322</td>
<td>447</td>
</tr>
</tbody>
</table>

- These figures are counted across the financial year.
- Admissions to YMW include those seen in the Paediatric Assessment Unit (PAU).
- Bed numbers are similar despite differences in size of population under 18 years.

3.2.1.3 Whilst caution is needed in viewing the crude numbers, the total number of admissions appear higher in central and west, despite the childhood population being proportionately smaller than in Wrexham. Elective inpatient information appears similarly higher. It must also be noted that patient flows do not match geographical boundaries and that Chester takes a proportion of Flintshire and Wrexham residents, in the same way Shropshire and Powys also use services in Wrexham.

3.2.1.4 The number of paediatric beds available in the 3 units are:

<table>
<thead>
<tr>
<th>No. of Beds</th>
<th>YG</th>
<th>YGC</th>
<th>YMW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward</td>
<td>28</td>
<td>34</td>
<td>22</td>
</tr>
<tr>
<td>PAU</td>
<td>Not operating</td>
<td>Not operating</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>7am – 9pm Mon-Fri</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10am – 4pm W/E</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weekend</td>
<td>19</td>
<td>21/19</td>
<td>22</td>
</tr>
</tbody>
</table>

Bed numbers across the three acute hospital sites are similar despite differences in size of population under 18, again it must be noted that the three paediatric units all run differing operational policies e.g. generally children over the age of 16 are not admitted to the paediatric ward in YMW, whilst in YGC they are often admitted to the adolescent ward.
3.2.1.5 The mean occupancy of the paediatric wards at midnight is:

![Mean Occupancy -Paediatric Wards at Midnight](image)

- In some months, no data was collected (eg April 07)

3.2.1.6 The number of paediatric ward closures in 2010 were:

<table>
<thead>
<tr>
<th></th>
<th>YG</th>
<th>YGC</th>
<th>YMW</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Closures</td>
<td>9</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Time Closed</td>
<td>107</td>
<td>54</td>
<td>107.25</td>
</tr>
<tr>
<td>Reason</td>
<td>Insufficient Staffing/no beds/no cubicles</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- In the last 16 months, Paediatric Ward closure details for BCUHB have been collected. There is no reliable data prior to this.
- During the last year, there have been 24 occasions when one or other of the paediatric wards in the three acute hospitals in Betsi Cadwaladr University Health Board (BCUHB) has closed, either due to insufficient staffing, being full or no cubicles being available or a combination of these.
3.2.1.7 The outpatient activity in the 3 acute units is shown below and demonstrates that outpatient activity has increased across all 3 sites between 2008-2010.

<table>
<thead>
<tr>
<th>New patients</th>
<th>Attended</th>
<th>DNA</th>
<th>Total</th>
<th>DNA Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>YG</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>1244</td>
<td>91</td>
<td>1335</td>
<td>6.8%</td>
</tr>
<tr>
<td>2009</td>
<td>1309</td>
<td>138</td>
<td>1447</td>
<td>9.5%</td>
</tr>
<tr>
<td>2010</td>
<td>1574</td>
<td>126</td>
<td>1700</td>
<td>7.4%</td>
</tr>
<tr>
<td><strong>YGC</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>1584</td>
<td>143</td>
<td>1727</td>
<td>8.3%</td>
</tr>
<tr>
<td>2009</td>
<td>1626</td>
<td>142</td>
<td>1768</td>
<td>8.0%</td>
</tr>
<tr>
<td>2010</td>
<td>1724</td>
<td>132</td>
<td>1856</td>
<td>7.1%</td>
</tr>
<tr>
<td><strong>YMW</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>1472</td>
<td>105</td>
<td>1577</td>
<td>6.7%</td>
</tr>
<tr>
<td>2009</td>
<td>1475</td>
<td>96</td>
<td>1571</td>
<td>6.1%</td>
</tr>
<tr>
<td>2010</td>
<td>1556</td>
<td>74</td>
<td>1630</td>
<td>4.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Review patients</th>
<th>Attended</th>
<th>DNA</th>
<th>Total</th>
<th>DNA Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>YG</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>5043</td>
<td>126</td>
<td>5169</td>
<td>2.4%</td>
</tr>
<tr>
<td>2009</td>
<td>4790</td>
<td>744</td>
<td>5534</td>
<td>13.4%</td>
</tr>
<tr>
<td>2010</td>
<td>4156</td>
<td>655</td>
<td>4811</td>
<td>13.6%</td>
</tr>
<tr>
<td><strong>YGC</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>3846</td>
<td>538</td>
<td>4384</td>
<td>12.3%</td>
</tr>
<tr>
<td>2009</td>
<td>3817</td>
<td>442</td>
<td>4259</td>
<td>10.4%</td>
</tr>
<tr>
<td>2010</td>
<td>3921</td>
<td>306</td>
<td>4227</td>
<td>7.2%</td>
</tr>
<tr>
<td><strong>YMW</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>4147</td>
<td>816</td>
<td>4963</td>
<td>16.4%</td>
</tr>
<tr>
<td>2009</td>
<td>4412</td>
<td>777</td>
<td>5189</td>
<td>15.0%</td>
</tr>
<tr>
<td>2010</td>
<td>4447</td>
<td>803</td>
<td>5250</td>
<td>15.3%</td>
</tr>
</tbody>
</table>

3.2.1.8 The new to review outpatient ratio for the 3 acute units is below. This can be compared to a target of 2.1.

<table>
<thead>
<tr>
<th>New to Review</th>
<th>YG</th>
<th>YGC</th>
<th>YMW</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>4</td>
<td>2.4</td>
<td>2.8</td>
</tr>
<tr>
<td>2009</td>
<td>2.4</td>
<td>2.3</td>
<td>3</td>
</tr>
<tr>
<td>2010</td>
<td>2.8</td>
<td>2.3</td>
<td>2.8</td>
</tr>
</tbody>
</table>
3.2.1.9 The North Wales Adolescent Unit was commissioned in 2010 to provide Tier 4 inpatient care for young people with severe mental health conditions. The unit has been unable to commission all the acute beds due to the inability to recruit and retain key staff. This resulted in a number of young people requiring placement in specialist units in England.

3.2.2 Community Demand

3.2.2.1 The nature of the work in community paediatrics is more diffuse and varied than that in the acute sector. It is difficult to gather comparable data in the community across the three areas of BCUHB. There are different practices in different areas, which have a historical basis – for example, in some parts of BCUHB neuro-disability is taken on by acute paediatricians and in other areas by community paediatricians. Although these children and young people are small in number, they often have very high levels of clinical need. For some aspects of community paediatrics the service operates across the whole of North Wales, for example, the on call rota for Child Sexual Abuse assessments.

3.2.2.2 Community child health services have statutory responsibilities in relation to fostering and adoption, with the more formal recognition of the medical input with the appointment of a doctor responsible for fostering as well as adoption.

3.2.2.3 Although the routine school health medicals have disappeared there is a statutory duty to provide advice to the local education department, to assess children who are being statemented. In addition school health will provide a service for those children with ADHD, and other behaviour problems that are impinging on their ability to learn, and those referred as a result of a school entry questionnaire/screening by the school nurse. There is also an opportunity to see children with chronic conditions decreasing the necessity for hospital visits and admissions.

3.2.2.4 Community doctors are involved in assessment of those children who have failed their developmental screening performed by the health visitor, and will be involved with the Child Development Team, working closely with the other members of the wider team.

3.2.2.5 Community services have also traditionally been involved with the assessment of children who have been abused. A number of community doctors have now been forensically trained and will see children who may have been sexually abused. This addition involves out of hours services which encroach on the ability to provide day time services.
3.2.2.6 Data gathered by the task and finish group begins to quantify parts of the community workload across BCUHB. In itself it does not provide evidence either way with respect to a “case for change” but we are able in part to quantify the workload in ways that will guide future option appraisals. This information is available in the work stream reports.

3.3 Medical Workforce

3.3.1 Current medical staffing based on whole time equivalents (WTE) at March 2011 is:

<table>
<thead>
<tr>
<th></th>
<th>YG</th>
<th>YGC</th>
<th>YMW</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant - General</td>
<td>5</td>
<td>5.8</td>
<td>6</td>
</tr>
<tr>
<td>Consultant– Neonatologist</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAS</td>
<td>1.6</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Juniors</td>
<td>14</td>
<td>20</td>
<td>17</td>
</tr>
<tr>
<td>Specialist Registrar</td>
<td>7</td>
<td>5</td>
<td>4.6</td>
</tr>
<tr>
<td>FTSTA</td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>SHO</td>
<td>8.2</td>
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</tr>
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<tr>
<td>FY2</td>
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<td>2</td>
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</tr>
<tr>
<td>FY1</td>
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<td>2</td>
<td>1</td>
</tr>
<tr>
<td><strong>Community</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant</td>
<td>2.4</td>
<td>1.65 (1 vacant)</td>
<td>3.9</td>
</tr>
<tr>
<td>SAS</td>
<td>2.4</td>
<td>6.5</td>
<td>3</td>
</tr>
<tr>
<td>Juniors</td>
<td></td>
<td></td>
<td>0.2</td>
</tr>
<tr>
<td><strong>CAMHS/LD</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant</td>
<td>3.3</td>
<td>4 (+ 2 in NWAS)</td>
<td>2.5</td>
</tr>
<tr>
<td>SAS</td>
<td></td>
<td>1</td>
<td>0.8</td>
</tr>
<tr>
<td>Juniors</td>
<td></td>
<td>0.5</td>
<td></td>
</tr>
</tbody>
</table>

Table notes/definitions
- A Trust doctor is a direct employee of BCULHB (may be on a permanent or fixed-term contract).
- FY doctors are in training in the Wales Postgraduate Deanery Foundation Programme (number indicates in which year of training they are in the 2 year Programme).
- ST doctors are in training in the Wales Postgraduate Deanery Specialty Training Programme in Paediatrics (number indicates in which year of training they are in the 8 year Programme).
- FSTSTA doctors are in Fixed Term Specialty Training Appointments (usually for 6 or 12 months). They are appointed by Wales Postgraduate Deanery, and to the same standard, to fill any unoccupied slots in the Specialty Training Programme in (number indicates in which year of training the unoccupied post is in the 8 year Programme).
- Staff Grade and Associate Specialist doctors are direct employees of BCULHB on permanent contracts.
- FY1 doctors are not thought to be suitable to provide neonatal cover.
** The Wales Postgraduate Deanery has recommended taking ST3s off the Tier 2 (middle grade) rota and putting them on the Tier 1 rota instead.

- Currently the single neonatologist does 1:6 on call for neonatology alone. Other consultants provide the neonatal on call as well as that for general paediatrics
- These figures are drawn from current medical staffing records, and from clinical leads, and represent a snapshot of current staffing.
- There is an ongoing flow of doctors moving in and out of BCUHB
- There are some vacancies and posts affected by maternity leave

3.3.2 The numbers of medical rotas currently running are as follows:

<table>
<thead>
<tr>
<th>Grade</th>
<th>YG</th>
<th>YGC</th>
<th>YMW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant - General</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Consultant - Neonatal</td>
<td></td>
<td>1/6</td>
<td></td>
</tr>
<tr>
<td>Middle grade General/Neonatal</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Junior doctor General</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Junior doctor Neonatal</td>
<td></td>
<td>1</td>
<td>9-5 Week days</td>
</tr>
</tbody>
</table>

3.3.3 Investigation of previous recruitment shows that some posts are hard to recruit to, including community paediatricians, consultant neonatologists, middle grade doctors and paediatric medical staff

3.4 Nursing Workforce

3.4.1 A detailed workforce plan has been developed. Some of the key issues identified are:

- There is a higher than average sickness rate within acute children’s nursing services (5-6%). This factor, plus issues such as maternity leave levels contribute to pressures relating to capacity in current service configuration and present ward managers with difficulty in assigning staff to covering all shifts adequately.
- The 12 hour shift pattern is currently used as the norm. This is effective in terms of reducing staff handover time. However, recently new ways of working have included annualised hours, rotational posts and increasing the flexibility of staff to work in different settings within children’s services.
- Nurses do not presently work flexibly across sites. Maintaining competencies and skills in both acute children’s and neonatal nursing is difficult and resource intensive. New contracts are more flexible and annualised hours have been trialled.
- Training for children’s nurses is offered within North Wales. This meets present demand.
- Children’s nursing is highly gender specific. The age profile of nurses is also different across acute and community. Average age of
community nurses is higher compared to those working in acute settings. Health visiting has a much higher age profile than other children’s nurses.

- Current staffing levels do not allow all available beds to be staffed at all times.
- Staff training and education post registration is difficult to fully maintain due to staffing levels and the demands of staffing wards safely.
- Extended roles and practice have resulted in nurses undertaking roles traditionally performed by doctors and allied health professionals without always providing additional resource to the nursing profession.
- The Wales Audit Office profiled all children’s wards in Wales and found that the ratio of registered nurses to supporting staff in BCUHB was heavily weighted towards registered nurses. It recommended that BCUHB change this ratio over time.

3.5 Therapies Workforce

3.5.1 The therapies workforce is an integral part of the delivery of paediatric and child health services and includes physiotherapy, speech and language therapy, occupational therapy, dietetics and art therapy. These services support children and families with a wide range of conditions and in a variety of settings such as home, school, community clinics, outpatients and inpatient hospital settings.

3.5.2 Consideration of the input from therapies services is essential when considering the delivery of multi-disciplinary / team services ‘around the child’. Some of the key issues in relation to the therapies workforce include:

- Important to consider the existing contribution of therapists to key determinants of health and early years development e.g. in feeding/nutrition, communication, education, mobility
- Variation in the way some therapy services are provided across North Wales
- Need to ensure any change to service delivery model includes consideration of therapy services and close working with therapy CPG

3.6 Financial Context

3.6.1 The financial context for the UK Public Sector is provided by the latest Government’s Comprehensive Spending Review (CSR) published in October 2010. This provided a policy lead in the protection of health services in cash terms (but not real terms) from the wider and more stringent public sector spending reductions. The CSR provided the framework for budgets for the devolved administrations for the three year period commencing in 2011/12.
3.6.2 In response to the funding provided by the UK Government, the Welsh Government published their budget in February 2011 detailing planned allocation income for Health Boards. Following this the Welsh Government detailed the annual allocation income for 2011/12 on 18\textsuperscript{th} February 2011. This confirmed that core health spending would be protected in cash terms. In practice this means that Health Budgets have a real terms reduction when inflation and service pressures are required to be met from a fixed cash budget.

3.6.3 The BCU Health Board has a statutory duty to deliver a balanced budget in each financial year. The Health Board plans to do this by planning and redesigning services that maintain financial sustainability while having patient safety and service quality as a priority.

3.6.4 In order to deliver a balanced budget with inflation and service pressures, the Health Board has required a cash releasing savings target of 7.5\% in 2010/11 and 6.1\% in 2011/12. These targets reflect the current inflation and service pressures but also include an underlying deficit brought forward from legacy organisations which has been reduced to £20.3 million (1.75\%) for 2011/12. The Health Board currently anticipates savings targets of a further 2.9\% for 2012/13 and 3.6\% for 2013/14.

3.6.5 While Corporate Departments have taken a larger share of the required savings, the Children and Young People’s CPG has a savings target of 4.0\% for 2011/12. This includes new inflation and service pressures of 4.1\% with additional funding provided from other services to cover the recurrent deficit brought forward. The Children and Young People’s CPG had a 0.77\% overspend in 2010-11.
4. STANDARDS & EVIDENCE

4.1. NHS Wales Annual Quality Framework (AQF) 2011/12

4.1.1 The AQF is the key quality and performance management agreement between Welsh Government and Health Boards in relation to the delivery of health improvement and health services. The AQF emphasises the need for sustainable improvement, and highlights the climate within which the current NHS reforms and the current Review need to be undertaken: “The establishment of new integrated Local Health Boards creates an unparalleled opportunity to create integrated health services. We must think in terms of whole system working, of creating well-designed care pathways where patients receive joined-up services at the right pace and the right time.”

4.1.2 In relation to the AQF and population health improvement, it is a primary responsibility of LHBs to identify inequities in health outcomes across their LHB area, to identify actions to address such inequities, to deliver and report on those actions. The Public health Strategic Framework – Our Healthy Future’ highlights the importance of early intervention and prevention. This also links clearly to the emphasis on achievement of the Child Poverty Targets - and the ongoing political imperative to reduce the gap in health outcomes.

4.1.3 In considering the case for change and the potential re-configuration of services, the NHS in North Wales must consider the key aims of the 5-year programme set out in the AQF:
- do more to protect and improve health for all
- create integrated services
- deliver and sustain excellent services to meet the needs of patients and
- maximise clinical outcomes

4.1.4 Although the AQF places less reliance on targets, it does highlight that: “It is far better that local organisations measure and manage themselves to make service excellence their prime aim, whilst adopting a policy of full transparency to their communities.”

4.1.5 A key consideration of the AQF is to ensure the full engagement of clinicians and to provide strong clinical leadership. This aspect will also be maintained within the current Review process.

By the end of 2011/12, each LHB must:

- Deliver against the targets for which the organisation is responsible for within its local Children and Young Persons Plan, and especially those relating to child health, health inequalities and child poverty.
More specifically, there should be demonstrable local progress with achieving the child poverty targets relating to infant mortality, low birth weight and teenage conceptions.

- Set and deliver against the key targets identified within ‘Our Healthy Future’ through the development of a Local Public Health Strategic Framework. This should be integrated with operational service planning and include the high impact areas identified by the National Preventions and Promotion Programme Board. The key interventions with the greatest impact on preventable disease include:
  - Implementing best practice on smoking cessation
  - Reducing the burden of alcohol misuse
  - Improved health at work

4.2 Population Health Need – Evidence Base

4.2.1 A review of the published evidence highlights that in order to improve outcomes for children and families services need to:
- Invest in the early years of life (pre birth to 5 years) as a high priority. This was one of the strongest themes arising from the published evidence appraisal.
- Target services to address the specific needs of the population e.g. areas of high socio-economic deprivation where outcomes are poorer.
- Improve population outcome in particular to address health inequity
- Move away from crisis management and invest in core services and effective partnership working to deliver preventative and early interventions using family based approaches

4.3 Safeguarding Children & Young People

4.3.1 Improved outcomes for children can only be delivered and sustained when key people and bodies work together to design and deliver more integrated services around the needs of children and young people. That change needs to be led and managed at local level and supported nationally. The aim is to move to a position, both locally and nationally, where:
- The well-being of children and young people is at the heart of the Welsh Government’s policy for children and their families as set out in Children and Young People: Rights to Action (2004), which aims to make sure that all key people and bodies are working in partnership to achieve shared outcomes.
- Key local services are integrated, where appropriate, around the needs of children and young people, and children and young people are actively involved in developing and evaluating the services which are provided for them.
- Key people and bodies work well individually and together through universal, targeted and specialist services to safeguard and promote the welfare of children.
• Children and young people and their families receive effective support at the first sign of difficulties.

4.4 Quality Standards

4.4.1 One of the key considerations for the current review is an assessment of the national standards that apply to the services under review.

The standards include:
• Caring for Critically ill Children (2003)
• Children and Young People Specialised Healthcare Services standards (13)
• European Working Time Directive
• “Facing the Future” - Standards for paediatric services” RCPCH (December 2010 & April 2011)
• Royal College of Nursing; Guidance on Safe Staffing Levels in the UK (2010)
• NHS Wales Annual Operating Framework (AOF) 2010/11 and Annual Quality Framework (AQF) 2011/12
• National Service Framework for Children, Young People and Maternity Services in Wales (Children’s NSF)

4.4.2 A review of the published evidence highlights key aspects needed in relation to the delivery of high quality paediatric and child health services:
• Paediatric and child health services need to take a whole systems and integrated approach, particularly in relation to providing more care for children in community settings and primary care.
• There has been a rise across the UK in the number of children presenting to A&E departments, often with conditions that could be managed in primary care. New and innovative ways for improving outcomes for children presenting for urgent or unscheduled care need to be explored as a matter of urgency. Closer working between paediatricians and primary care and the use of multi professional teams are cited as examples.
• Paediatric Assessment Units can be useful in providing a more efficient clinical service for children with self limiting illness. Particularly useful in areas where full inpatient beds are difficult or distant from the initial point of contact.

4.5 Medical Workforce

4.5.1 Information has been sought from medical staffing and from rota organisers and key documents have been considered.
• A review of the published evidence highlighted that across the UK, the impact of the EWTD on the speciality of paediatrics is significant. Paediatrics as a specialty is short of medical staff at all levels and this will impact on achievement of EWTD compliance. Royal College guidance offers suggestions to paediatric services on achieving compliance
• By August 2011, BCUHB will have to meet the legal requirements of the European Working Time directive (EWTD) which limits the number of hours that junior doctors can work to 48 Hours per week.
• Guidance from the Wales Postgraduate Deanery suggests that the current training configuration for paediatric, neonatal, obstetric and gynaecology in Wales is unsustainable. The Wales Deanery considers that the number of training rotas across Wales needs to be reduced from 17 to 12.
• The Royal College of Paediatrics and Child Health (RCPCH) document “Facing the Future- Standards for paediatric services” December 2010 sets standards that are part of a movement towards consultant delivered care. The standards call for a greater degree of consultant presence than has previously been the case, and this will inevitably mean changes in working practices for some consultants.

4.6 Nursing Workforce

4.6.1 Royal College of Nursing; Guidance on Safe Nurse Staffing Levels in the UK (2010) recommends:
• An average size district with 50,000 children requires 20 WTE community children’s nurses
• General children’s wards/dept. Nurse to Patient Ratio:
  Under 2 years 1:3
  Other ages - day 1:4
  Other ages - night 1:5
• High Dependency Care (level 1) 0.5 nurse to 1 patient or 1:1 in cubicles

4.6.2 Caring for Critically Ill Children (2003) standards require a ratio of 1:1 care by appropriately qualified nursing staff for a critically ill child.

4.6.3 CPHVA (Community Practitioners & Health Visiting Association) advises on recommended Health Visitor (HV) caseload size 1 WTE HV per 250 average case loads. This does not consider delivery of health visiting through skill mix.

4.6.4 CPHVA and WAG school nursing Framework 2010 advises 1 registered school nurse per high school with average caseload of 1,500-2,000.
5. ASSESSMENT OF SERVICE GAPS

5.1 Population Health Need

5.1.1 Assessment of health need has highlighted variation in child health outcomes across North Wales including in low birth weight, infant mortality and teenage pregnancy rates.

5.1.2 In order to improve population health outcomes and reduce inequity there needs to be a coordinated, systematic and evidence based approach to addressing key areas of health need. Integrated working with partners is essential.

5.1.3 To address current gaps, the population health task and finish group recommends that future paediatric and child health services across North Wales should:
  • Invest in core services to deliver early intervention in the early years, ensuring effective partnership working using family based approaches.
  • Ensure there is systematic, coordinated approach to implementing evidence based interventions in relation to tobacco cessation, reducing levels of obesity, improving mental well being, teenage pregnancy and sexual health and ensuring target immunisation uptake rates are achieved.

5.2 Quality Standards

5.2.1 An assessment of the current service status set against key recommendations provides an indication of the current North Wales status against these standards, and where future service options need to consider potential shortfalls.

5.2.2 Current services do not meet some quality standards – evidenced by the described closures of paediatric wards and staffing issues. The main reasons for the shortfall in meeting some of the key standards have been highlighted by the task and finish group and include:
  • The impact of the EWTD which is a statutory requirement and limits the number of hour’s junior doctors can work to 48 hrs per week.
  • Insufficient registered nurses to meet the critical care standards and the Royal College of Nursing recommended staffing levels, e.g. to meet 80% occupancy, BCUHB would require approximately an additional 23 nurses.
  • Insufficient numbers of junior doctors across BCUHB.
  • Staffing levels and funding insufficient to ensure that nursing and medical staff attend training to maintain and develop skills.

5.2.3 The evidence review highlighted the need for services to provide more early intervention and care for children in primary/community settings. It also highlighted the importance of reviewing how unscheduled care...
for children is provided, considering models such as Paediatric Assessment Units and working with Primary Care. There is potential for current services to develop these evidence based approaches further, particularly in terms of assessing if services can be provided in different ways in order to address the current gaps in achieving standards and workforce issues.

5.3 Medical Workforce

5.3.1 BCU is currently compliant with EWTD but it will be difficult to comply following end of derogation in August 2011

5.3.2 Proposals from the Wales Postgraduate Deanery require a change within BCUHB from 3 combined paediatric and neonatal rotas (1 on each site) to 1 general paediatric training rota and 1 neonatal training rota across BCUHB. The paper represents the beginning of a discussion about reconfiguration of training.

5.3.3 If recommendations from the Royal Colleges, BMA and Deanery are consistently recommending training rotas that comprise 10 doctors, as highlighted above, the current arrangements in BCUHB will not be sustainable, although the timing of implementation of changes is uncertain.

5.3.4 The impact of the RCPCH standards moving towards consultant-delivered care may lead to a decrease in the overall number of paediatric inpatient units in Wales with those that remain requiring increased numbers of consultants to staff them.

5.3.5 The recent round of Deanery recruitment has not produced any more staff for vacant paediatric middle grade posts in North Wales. Adding these to Trust grade vacancies and maternity leave vacancies, and allowing for compliance with EWT, the total number of vacancies is 9.9 out of 24 (YG 5.4, YGC 2.5, YMW 2). It will not be possible to run full rota’s on all 3 sites with this number of doctors based on the current working practices.

5.4 Nursing Workforce

5.4.1 Current staffing levels do not allow all available beds to be staffed at all times. Staff training and education post registration is difficult to fully maintain due to staffing levels and the demands of staffing wards safely.

5.4.2 Service is unable to meet RCN recommended staffing levels for general inpatient care at all times.

5.4.3 The Wales Audit Office profiled all children’s wards in Wales and found
that the ratio of registered nurses to supporting staff in BCUHB was heavily weighted towards registered nurses. It recommended that BCUHB change this ratio over time.

5.4.4 A more flexible and sustainable service model is required across North Wales, which allows the unscheduled care element to be provided and supports staff to gain transferrable skills.

5.4.5 Caseload and activity data examined in associated reports show BCUHB to have the highest Health Visiting caseloads in Wales. School Nurse caseloads and acute ward staffing levels are average when compared with the rest of Wales.

5.4.6 The Welsh Audit Office has identified that we have too many children's beds per head of population. This is an even greater factor when considering that some areas routinely do not admit anyone over 16 years of age.

5.4.7 New roles and extended practice undertaken by nurses improve efficiency and patient care, but need to be clearly identified as supernumerary to the core nursing establishment.

5.4.8 The North Wales Adolescent Unit was commissioned in 2010 to provide Tier 4 inpatient care for young people with severe mental health conditions. The unit has been unable to commission all the acute beds due to the inability to recruit and retain key staff. This has resulted in a number of young people requiring placement in specialist units in England.

5.5 **Therapies Workforce**

5.5.1 There are challenges across the therapy services which provide services to children. Currently there is some variation in the way in which services are delivered across North Wales. Examples of issues include local caseloads that are in excess of the nationally recommended levels (e.g. in physiotherapy and occupational therapy) and challenges in recruiting and training specialist staff and the need to develop more flexible ways of delivering services e.g. in dietetics and Speech and Language therapy. Therapy services however form an essential part of the multi-disciplinary team providing services to children and it is important for these issues to be considered in shaping future paediatric services. In considering examples of best practice, there are clear opportunities for therapists to:

- develop extended roles
- further deliver the health promotion/prevention and early intervention agenda
5.6 Financial

A financial summary is shown as follows:

5.6.1 The financial position for the Children’s and Young People’s Services CPG as at the year end 2010/11 was an over spend of £300,000 on a budget of £39.1 million (0.77%). Within this, the financial position for Paediatrics (excluding neonates) as at the year end 2010/11 was an over spend of £98,000 on a budget of £35.4 million (0.28%).

5.6.2 The Children’s and Young People’s CPG has a savings target of 4% or £1.537 million for 2011/12. While significant savings of £1,880,000 were delivered in 2010/11, a significant proportion of these were delivered non-recurrently through vacancy control and slippage requiring a sustainable solution to ensure the quality and safety of patient services for the future.

5.6.3 Approximately 93% of the Women’s Services CPG budget allocation relates to pay. Hence the review will focus on the rationalisation and organisation of staff resources to deliver safe, high quality services to patients.

5.6.4 Additionally there are budgets relating to Paediatric services within the Continuing Healthcare currently held outside the Children & Young People’s CPG but which will be transferred in during the first half of the financial year 2011/12. This transfer is currently expected to provide an additional cost pressure of £1.1 million on a budget transfer of £4.0 million.

5.6.5 BCUHB has external contracts with various English healthcare providers for Children and Young People services totalling £10.9 million, the actual costs for 2010-11 being £12.4 million providing an additional cost pressure of £1.5 million.

5.6.6 The CPG has concluded that without significant investment in the current pattern of services, service delivery will need to be improved and achieved through service rationalisation and reconfiguration. This will ensure that the future service pattern can manage the service demand effectively with service quality and patient safety as the priority.

5.6.7 There is scope to provide more cost effective, non specialist paediatric services locally within North Wales for those patients currently travelling to English providers. The impact of the repatriation of activity (from Alder Hey and the Countess of Chester Hospitals) and the development of new services for North Powys residents will be a major consideration in designing services for the future. These changes will contribute to the clinical sustainability and financial security of services, and will be a key component of the options generated by the review process.
6. CASE FOR CHANGE

<table>
<thead>
<tr>
<th>Area</th>
<th>Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Health Need</td>
<td>The health of children and young people across North Wales can be improved.</td>
</tr>
<tr>
<td></td>
<td>People’s health, including children’s health, varies according to where they live in North Wales.</td>
</tr>
<tr>
<td></td>
<td>Evidence from research into the different ways paediatric services are provided across the world shows how to improve population health and reduce inequity. There needs to be a coordinated and systematic approach to addressing people’s health needs which learns from this evidence. Such a coordinated and systematic approach needs to integrate work between colleagues in primary care, secondary care and partners, particularly local authorities.</td>
</tr>
<tr>
<td></td>
<td>One of the strongest themes arising from the evidence is the need to invest in services for children in their early years as the highest priority.</td>
</tr>
<tr>
<td></td>
<td>Current services are mainly reactive, focused too often on crisis management. The published evidence highlights clearly the benefit that results from focusing children and family services on preventing ill health and on intervening early when health issues are identified.</td>
</tr>
<tr>
<td>Quality Standards</td>
<td>The current system does not always meet national quality standards and is therefore unsustainable.</td>
</tr>
<tr>
<td></td>
<td>The reasons for this are primarily down to the time staff can be given to develop the experience and expertise they need to work safely. For example the European Working Time Directive (EWTD) limits the amount of time staff can work in a week, radically changing the hours doctors, in particular, work.</td>
</tr>
<tr>
<td></td>
<td>To improve safety and quality, services need to learn from research into ways of delivering more services in primary care and in the community and in the delivery of unscheduled care.</td>
</tr>
<tr>
<td>Medical Workforce</td>
<td>The impact of the EWTD, the unsustainability of current training rotas and the move to consultant delivered care will have a considerable impact on how paediatric services are delivered in future.</td>
</tr>
<tr>
<td></td>
<td>The current configuration of services will be increasingly difficult to sustain notably in terms of the availability of medical staff including medical training.</td>
</tr>
</tbody>
</table>
| Nursing Workforce | Within the current configuration, the service is not always able to meet RCN recommended staffing levels for general inpatient care.  
Staff training and education following registration is difficult to fully maintain.  
Nursing staff working in the community have high caseloads. This makes it difficult to do the preventative and early intervention work which makes the most difference to improving health. |
| Therapies Workforce | There are challenges with caseloads that are higher than the nationally recommended levels (for example, in physiotherapy and occupational therapy). There are also challenges in recruiting and training specialist staff. |
| Financial | Betsi Cadwaladr University Health Board has a statutory obligation to plan and manage services within the allocation income it receives.  
To achieve a break-even position the Health Board has a savings target of 6.1% for 2011-12, with further savings required through the planning period. The Children and Young People’s CPG has a savings target of 4% for 2011-12.  
So far, a significant proportion of the required savings have been delivered non-recurrently through vacancy control and slippage. This will be addressed within the service review to achieve sustainable services that have service quality and patient safety as a priority.  
The impact of the repatriation of activity (Alder Hey, Countess of Chester) and the development of new services for North Powys residents is also a major consideration in the improvement, clinical sustainability and financial security of services, and will be a key component of the options generated by the review process. |
7. CONCLUSION AND RECOMMENDATIONS

7.1 Conclusion

The conclusion of the work stream is underpinned by a number of key drivers for change. The most notable include:

1. **Improving population health**: A more systematic and coordinated approach to addressing population health and implementing practice based on scientific evidence is required to reduce inequities and to improve health for children and families in North Wales.

2. **Improving safety and quality**: Actions are required to improve the safety of services and patient experience, and to make sure the achievement of quality standards is consistent and can be sustained. This includes aspects relating to both the medical and nursing workforce.

3. **Sustainable skilled workforce**: Actions are required to achieve workforce stability including compliance with workforce standards, retaining training capability and developing appropriate skills.

4. **Cost Effectiveness**: Actions are required to ensure that services are cost effective and financially sustainable.

The findings of the work of the clinically led Paediatric and Child Health Work stream conclude that there is a clear need for a change to the way that existing paediatric and child health services are delivered across North Wales.

Variation in service delivery, outcome indicators, public health data and problems with safely staffing and maintaining compliance with standards for high risk specialities indicate that maintaining the status quo is not in the best interest of the population.

Clinical Governance is a primary driver which will ensure that safety is not compromised.

The work stream has concluded that change is needed in order to ensure good governance and specifically to:

- improve the health of children, young people and families across North Wales;
- ensure the delivery of services which are safe, which are informed by and learn from scientific evidence and which meet recognised national policies and standards
- enhance our patient’s experience including quality and reliability of care;
These reasons for change are consistent with the ‘Triple Aim’, which through better population outcome and patient experience also ensures that services provide good value for money and are sustainable.

Partnership working between the NHS and its partner organisations, notably local authorities and the voluntary sector is essential.

7.2 Recommendation

The Project Board for the review of Maternity, Neonatal, Paediatrics and Gynaecology, therefore recommends that the work stream proceeds to generate and review options which address the needed changes.
APPENDIX 1

Paediatric and Child Health Workstream Members:
Duncan Cameron, Consultant Paediatrician, YGC (Chair)
Philip Minchom, Consultant Paediatrician, YMW
Mair Parry, Consultant Paediatrician, YG
Peter Gore-Rees, Clinical Director (Central) / Consultant Child & Adolescent Psychiatrist, Denbighshire
Val Klimach, Consultant Community Paediatrician, Conwy
Siobhan Jones, Locum Consultant in Public Health
Gail Barton-Davies, Service Manager, Children & Young People CPG (West)
Liz Fletcher, Clinical Nurse Manager, Children & Young People CPG (Central)
Paula Knight, Paediatric and Neonatal Service Manager, Children & Young People CPG (East), YMW
Brendan Harrington, Chief of Staff, C&YP CPG
Yvonne Harding, Associate Chief of Staff (Nursing), C&YP CPG
Cilla Robinson, Associate Chief of Staff (Operations), C&YP CPG
Carol Salmon, Local Authority representative
Maria Skudlarz, TU representative
Chris Jones, Planning Manager
Gillian Breese, GP, Penrhyn Bay Practice
APPENDIX 2
GLOSSARY AND ACRONYMS

Annual Quality Framework 2011/12 (AQF) was issued under the ministerial letter EH/ML/002/11 and outlines the requirements of the NHS Wales for the year ahead.

Child Poverty Targets relate to the The Child Poverty Act 2010 which set targets to meet in order to attempt to eradicate child poverty by 2010

Clinical Programme Group (CPG) acts as advocates within Betsi Cadwaladr University Health Board for individual clinical specialities. CPGs are responsible for cost profiles, use of resource and efficiencies based on evidence and best practice. CPGs account for changes in technology and practice and deal with local operations as well as strategic development.

Congenital Anomalies is a condition which is present at the time of birth which varies from the standard presentation

Deanery. The Wales Deanery is responsible for commissioning, overseeing and monitoring the provision of education and training for doctors and dentists in postgraduate training posts in the NHS across Wales. The Deanery also helps to oversee the provision of Continuing Professional Development for General Medical and Dental Practitioners across Wales.

Lower super output area. Lower super output areas (LSOAs) describe a geographical area which contains approximately 1000 - 1500 people. There are 1896 LSOAs in Wales.

Maternity, Neonatal and Gynaecology. Secondary care services provided in the acute hospital-based and community setting for:

  Maternity - the period for which a woman is pregnant or has just given birth
  Neonatal - newborn babies during the period immediately after birth
  Gynaecology - dealing with the health of the female reproductive system

Middle Super Output Areas (MSOAs) describe a geographical area which contains an average population of 7,500 and a minimum of 5,000. There are 413 MSOAs in Wales and 96 in the BCUHB area

Paediatric and Child Health. Includes secondary care services for children (excluding newborn) i.e. hospital inpatient, day case, outreach and outpatient services, community based services (community paediatricians, health visiting, school nursing, etc) and Child & Adolescent Mental Health services (CAMHs).

Primary Care refers to services provided by GP practices
ACRONYMS

BCUHB   Betsi Cadwaladr University Health Board
CAMHS   Child and Adolescent Mental Health Services
CPHVA   Community Practitioner and Health Visitor Association
DGH     District General Hospitals
DNA     Did Not Attend
ADHD    Attention Deficit Hyperactivity Disorder
EWTD    European Working Time Directive
LD      Learning Disability
NWAU    North Wales Adolescent Unit
PAU     Paediatric Assessment Unit
PMETB   Postgraduate Medical Education and Training Board
RCN     Royal College of Nursing
RCPCH   Royal College of Paediatrics and Child Health
YG      Ysbyty Gwynedd / Gwynedd Hospital
YGC     Ysbyty Glan Clwyd / Glan Clwyd Hospital
YMW     Ysbyty Maelor Wrecsam / Wrexham Maelor Hospital

The Welsh Government (WG): is the devolved government of Wales formally known as Welsh Assembly Government (WAG) Welsh Government was officially opened by the Queen on the 13th May 2011.